

# Sexual and Reproductive Health for All

Reducing poverty,  
advancing development  
and protecting  
human rights



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September 2010

Publication available at: <http://www.unfpa.org/public/home/publications/pid/6526>

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# 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 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 report, ***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? The report recognizes the complexity of the task, which deals not only with the most personal of decisions and cultural norms, but the daunting realities of bringing any form of healthcare to all, even in some of the world's poorest countries. At the same time, the report maintains that ensuring sexual and reproductive health for all, in its broadest sense, is one of the surest and most effective ways to respect human rights, to promote equitable and sustainable development, and to achieve the Millennium Development Goals.

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.

***Eight lives: Stories of reproductive health*** gives a human face to our work. This publication tells the story of eight women who have endured—and overcome—the plight of poor sexual and reproductive health.

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  
September 2010

# Acronyms and abbreviations

<b>CEDAW</b>	Convention on the Elimination of All Forms of Discrimination against Women
<b>FGM/C</b>	Female genital mutilation/cutting
<b>GDP</b>	Gross domestic product
<b>G8</b>	Group of 8 industrialized nations
<b>HPV</b>	Human papillomavirus
<b>ICPD</b>	International Conference on Population and Development
<b>IMF</b>	International Monetary Fund
<b>MDG</b>	Millennium Development Goal
<b>NGO</b>	Non-governmental organization
<b>ODA</b>	Official development assistance
<b>STI</b>	Sexually transmitted infection
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNDP</b>	United Nations Development Programme
<b>UNESCO</b>	United Nations Educational, Scientific and Cultural Organization
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>WHO</b>	World Health Organization

# Why invest in sexual and reproductive health?

Investing in sexual and reproductive health is one of the surest and most effective ways to promote equitable and sustainable development and achieve the Millennium Development Goals (MDGs). If we can reach the poorest and most vulnerable populations with reproductive health information and services, we can save many lives and improve countless others. We will also make significant strides in reducing poverty, advancing development and protecting human rights. Here are some of the reasons why.

*Investing in sexual and reproductive health is one of the surest and most effective ways to promote equitable and sustainable development and achieve the Millennium Development Goals*

## Investing in sexual and reproductive health:

- **Reduces poverty.** Having fewer children, with more time between their births, enables families to invest more in each child's education, food and health. It puts fewer demands on household, community and environmental resources. And it can have benefits at the national level if governments use the opportunity created by lower fertility rates to invest in young people and establish a policy environment that spurs economic development through expanding opportunities and increased productivity, often called a 'demographic bonus'. Moreover, enabling women to take decisions about whether and when to bear children creates opportunities to pursue activities such as education and employment, which contributes to the development process and to poverty reduction.
- **Further primary education, especially for girls.** Progress on sexual and reproductive health contributes to another es-

sential development goal—universal access to primary education. Fewer children means that families and governments can spend more per child. This is especially important for girls, whose education is often sacrificed when resources are limited. Furthermore, averting early marriage and unwanted pregnancy, keeping girls safe from sexual harassment and abuse, and providing them with information and privacy necessary for personal hygiene encourages them to stay in school in primary grades and beyond.

- **Promotes women's rights and gender equality.** If women cannot make free and informed choices about sex and reproduction, gender equality will not be achieved and any sense of empowerment will be stifled. The right to make decisions and to access information and services relating to partnerships, marriage, sexual relations and the bearing of children—free of coercion, violence and discrimination—are fundamental to women's equality and well-being. Furthermore, having choices in the sphere of sexuality and reproduction can empower women to pursue other opportunities and to participate in social and economic life outside the home.

*If women cannot make free and informed choices about sex and reproduction, gender equality will not be achieved and any sense of empowerment will be stifled*

- **Strengthens health systems.** Investing in sexual and reproductive health contributes to dramatic improvements in health worldwide and strengthens health systems more generally. In fact, the ability to meet reproductive health needs is a signal indicator of the overall coverage and accessibility of services in the health system. Training healthcare

providers in a rights-based approach can have a positive effect on the quality of care in general. Similarly, improved skills in counselling, which is central to comprehensive sexual and reproductive healthcare, can have an impact in other areas. Investments in basic and emergency obstetric care can bolster the quality of care and help providers deliver other services more effectively. Furthermore, bringing women and vulnerable groups into the healthcare system provides an opportunity to identify people at risk, offer HIV prevention information and services (including voluntary counselling and testing for HIV and prevention of mother-to-child transmission), and diagnose and treat other sexually transmitted infections (STIs).

- **Saves lives and improves health.** Death and disability related to sexual and reproductive health accounted for nearly one third of the disease burden for women of reproductive age in 2004. Care before and during pregnancy and delivery and after childbirth saves women's and children's lives and prevents disabilities. Prevention of unwanted pregnancies can curb recourse to abortion, including unsafe abortion, and reduce maternal deaths. And sexual and reproductive health information and services can reduce the prevalence of STIs, including HIV, to which women and girls are especially vulnerable. Sexual and reproductive healthcare can also be a way to engage men as well as address gender roles and responsibilities, gender-based violence, sexual abuse and harmful practices.
- **Ensures environmental sustainability.** Averting unwanted births and having smaller families can reduce stress on fragile environmental areas and slow unplanned urban growth. The combination of chronic poverty, environmental degradation, rapid population growth, desertification, drought and water scarcity threatens food security and, in some situations, can lead to acute humanitarian crises. Smaller family size may enable households, including vulnerable and women-headed households, to use natural resources, such as water, forests, farmland and coastal areas, in more sustainable ways, and to be better able to prevent environmental degradation and adapt to climate change.

## What have we achieved so far?

The last 20 years have seen mixed progress in access to sexual and reproductive health and in exercising rights related to sex and reproduction. Even as the wealthy have seen gains in ac-

*The wealthy have seen gains in accessing reproductive healthcare, but those excluded by poverty, gender, ethnicity, disability, residency status, situations of conflict or other forms of marginalization have often been left behind*

cessing reproductive healthcare, those excluded by poverty, gender, ethnicity, disability, residency status, situations of conflict or other forms of marginalization have often been left behind.

## Positive changes in policies, laws and development approaches

Sexual and reproductive health is increasingly recognized in international human rights law, particularly in the areas of adolescents' rights, maternal health and family planning. Moreover, changes in policies, laws and development approaches at the international, regional and national levels have helped to advance the realization of sexual and reproductive health and human rights, even though implementation has lagged. Critical to these change processes have been civil society actors, including women's rights groups and community and faith-based organizations. In addition, several initiatives aimed at strengthening health systems, usually in the context of harmonization and alignment in support of country-led processes, demonstrate heightened donor attention to reproductive health.

## Insufficient progress in maternal health

Advancements in maternal health have been painfully slow compared to those in other areas. Nonetheless, new United Nations estimates confirm an overall pattern of significant, if insufficient, progress on reducing maternal mortality. It is clear that widely recognized methods can save thousands of lives and should be more widely implemented. These lifesaving measures include contraceptive services; maternal care (antenatal, assisted delivery and emergency obstetric services) and newborn care; and access to safe abortion services, where not against the law, and reduction of and treatment for unsafe abortion.

## Still high fertility in the poorest countries

Over the last quarter century, in many regions, women have started having fewer children. However, in the least developed countries, fertility levels are still high. The use of all forms of

contraception has increased dramatically since the 1960s, although growth has slowed in recent years and disparities have persisted or even grown within countries. In least developed countries, an estimated 24 per cent of women of reproductive age who are married or in union still have an unmet need for family planning.

### ***Challenges in reaching adolescents***

Reaching the largest cohort of young people in human history with sexual and reproductive health information and services has proved a formidable challenge, despite some progress over the last several years. The adolescent birth rate dropped between 1990 and 2000, but the decline has slowed, and disparities are actually widening. The average age at which people marry has been on the rise, helping to simultaneously bring down fertility rates and bring about improvements in health and educational attainment. Nevertheless, many women in developing countries still marry at a very young age. Access to sexuality education has increased and studies show that these programmes generally do not promote early or risky sexual activity, but rather have a positive impact on young people's initiation into and frequency of sex, number of sexual partners, whether or not they use condoms or other contraceptives, and attitudes around gender and sexuality.

### ***Lagging fulfilment of women's rights***

Globally, the centrality of gender equity and women's rights has been recognized. Researchers and activists have worked to expose levels of violence against women and girls and to bring about change through policies and programmes. The UN General Assembly adopted the Declaration on the Elimination of Violence against Women, and the Commission on Human Rights appointed a Special Rapporteur on violence against women. Since then, many countries have developed policies on the issue, though implementation has lagged. Increasingly, female genital mutilation/cutting is also being recognized as a violation of human rights. In practice, an encouraging generational trend is found: adolescent daughters of women who have undergone the procedure are being cut at a much lower rate than their mothers.

### ***A slowdown in the HIV epidemic and progress in treatment***

In 2008, some 33.4 million people were living with HIV worldwide, approximately three times the number in 1990.

Encouragingly, new infections have slowed globally. Sub-Saharan Africa remains the most heavily affected region. Rising prevalence in Eastern Europe, Central Asia and other parts of Asia, where injecting drug use has driven the epidemic, is increasingly caused by sexual transmission. Evidence suggests that in places where the epidemic is stabilizing, promising behaviour changes are being seen among adolescents aged 15 to 19. Tremendous strides have been made in the number of people on antiretroviral therapy. For every two people starting treatment, however, five people are newly infected with HIV.

### ***Effective approaches to preventing and treating other sexually transmitted infections***

Successful experience in several countries shows that effective STI prevention and care can be achieved by using a combination of responses, including promotion of safer sex; encouraging the use of health services for diagnosis and treatment; prevention and care at the primary healthcare level; and a case management approach. Recently, research and programmatic attention has highlighted the potential role of reducing sexually transmitted infections among men as a means to reverse the HIV epidemic and other diseases.

### ***Still limited male involvement***

Despite growing recognition that men need to be involved in sexual and reproductive health, both as partners and for their own benefit, progress has been slow. Male condoms constitute only about 6 per cent of total modern methods used, pointing to the fact that contraception is still left largely to women.

### ***Innovative uses of technology***

Progress has also been made in the development and use of technology, including improvements and developments in contraceptives and new ways to diagnose and treat STIs. The expanding use of mobile phones has increased access to health-related information and education, offered providers new tools for learning and for patient follow-up, enabled people to call for help or for transport in cases of emergency, and improved data collection and registration systems in developing countries.

## **Where do we go from here?**

While these gains are encouraging, they can only be sustained and expanded with a renewed and heightened commitment

by governments, donors and civil society, bolstered by adequate and predictable funding. Fundamental to achieving sexual and reproductive health for all is a human rights-based approach that promotes equity and fairness; laws and policies should prohibit and sanction harmful practices, gender-based violence and discrimination in accessing healthcare and exercising relevant rights.

*Fundamental to achieving sexual and reproductive health for all is a human rights-based approach that promotes equity and fairness*

The following areas for action, if undertaken seriously over the next five years, would quicken the pace of positive change and bring us that much closer to achieving the MDGs:

**Increase national commitment and integrate sexual and reproductive healthcare into development planning.**

National governments must make a meaningful commitment to providing adequate funding and to incorporating sexual and reproductive health into national development planning mechanisms, such as poverty reduction strategy papers. Policy-makers also should develop and implement a framework of policies, regulations and guidelines as well as mechanisms to ensure multisectoral collaboration across ministries and agencies.

**Reach the most vulnerable.** To use scarce resources effectively, as well as to advance social justice, policy-makers and other stakeholders should aim to reach and serve poor and marginalized groups. National and local contexts vary enormously, requiring analysis and consultation to identify who is most vulnerable and to eliminate root causes. While working towards universal health coverage in the long-term, policy-makers need to build social protection floors. Risk-pooling measures, such as community-based insurance and savings plans, can help to protect poor families. Vulnerable groups should participate in developing and monitoring policies and programmes, which helps to ensure responsiveness and contributes to sustainability.

**Strengthen health systems.** Essential to achieving sexual and reproductive health for all is strengthening healthcare systems for equitable, efficient and sustainable delivery of good-quality services. Sexual and reproductive healthcare

services should be incorporated into the minimum healthcare package at all levels of the national health system, especially at the primary level. A core package of sexual and reproductive health would include a range of services: family planning; maternal and newborn care; safe abortion (where not against the law) and post-abortion care; STI/HIV services. They would also address gender-based violence and harmful practices. In locations where services are limited or difficult to access, other ways to deliver care should be created, for example, mobile units and services at the workplace. Adequate training and compensation for health workers, especially midwives, is key. Medical and public health training should include content on sexual and reproductive health. Affordable, high-quality commodities, including barrier methods of contraception and STI/HIV test kits and diagnostics, must be available. Donor funding would need to roughly double to meet projected contraceptive needs in 2015.

**Integrate HIV and sexual and reproductive health.** Integration of sexual and reproductive health and HIV prevention and care needs to happen at all levels. Policies, strategic plans, budgets and institutional mechanisms should be closely linked. Key HIV services, such as access to condoms, voluntary counselling and testing, the prevention of mother-to-child transmission and antiretroviral therapy should be integrated with other sexual and reproductive health services, either at the same facilities or by referral. The essential package of sexual and reproductive health services should be available to people living with HIV. Integration also means confronting the norms and attitudes that hinder progress in sexual and reproductive health and rights, including the fight against HIV. This would include providing sexuality education to young people and supporting girls and women to develop decision-making and negotiating skills.

**Involve community organizations and address social norms.** Sexual and reproductive health for all will not be achieved by the health sector alone. Addressing the roots of poor sexual and reproductive health demands challenging social norms around gender, sexuality and reproduction and reaching people at the community level. This can entail community and media campaigns to provide reproductive and sexual health information and to encourage attitudes and behaviours that are supportive of gender equality and good health. Community-based and faith-based groups can offer information, build skills, foster use of health services, and even deliver services, especially to hard-to-reach populations.

**Respond to the needs and realities of adolescents and engage men.** The health sector needs to provide healthcare that meets the needs of young people. The specific approach and services will vary, depending on the context, but key elements are conducting outreach to attract young people, creating an appealing and comfortable environment, and ensuring confidentiality and privacy. Young people need more than access to services; they also need information as well as opportunities to build self-confidence and problem-solving skills. Reviews of sexuality education programmes have found that the most effective interventions address not only taboos around sexuality, but also norms around gender. Sexuality education strategies should also consider the diversity of youth and develop varied strategies for boys and girls, different age groups, and young people who are out of school or otherwise inaccessible. Meanwhile, both healthcare and sexuality education programmes should be available and inviting to men—not as an afterthought but as a central strategy. Men need information and services to address their own sexual and reproductive health needs (including adopting male methods of family planning and preventing the spread of STIs), as well as to support women's health and empowerment in a variety of ways.

**Improve monitoring and evaluation.** Using resources effectively requires feedback to inform policy-making and budgeting. The definition and use of indicators and data should consider equity issues, which necessitates disaggregation by sex, age, wealth and marital status. Given the multidimensional and life-long nature of sexual and reproductive health and rights, it is important to look at social determinants, as well as outcomes, of sexual and reproductive health. National governments may need technical assistance to strengthen their health information management systems. Finally, it is

essential to build the capacity of affected communities and civil society organizations to monitor the implementation of policies, programmes and budgeting processes.

*Both healthcare and sexuality education programmes should be available and inviting to men—not as an afterthought but as a central strategy*

**Make it happen.** At a time of scarce resources and daunting global trials, investing in sexual and reproductive health is a clear and direct path to resolving a host of development challenges, to advancing human rights and to breaking the cycle of intergenerational poverty. Moreover, it would more than pay for itself in progress made and resources saved across all the MDGs.

By working towards the goal of universal access, including to HIV prevention and treatment, we can improve and save millions of lives. Doubling current funding from \$12 billion to \$24 billion a year for reproductive health, including family planning and delivery and newborn care, would reduce maternal deaths by 70 per cent and newborn deaths by over 40 per cent. At the same time, it would speed up progress in other essential aspects of health, human rights and poverty reduction.

It is clear what needs to be done. Experience over the last few decades has provided substantial evidence of what works and, at a time of increasingly limited resources, those approaches can and should be adapted, replicated and scaled up. What is required now is the commitment and resources to make it happen.

# Reproductive health: An evolving concept and expanding agenda

In 1994, the Programme of Action of the International Conference on Population and Development (ICPD) redefined reproductive health, putting individual rights at the centre, while also stressing larger social, cultural and economic contexts in which people operate. It defined reproductive health as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, and to its functions and processes.”

The document, which was adopted by 179 countries, goes on to say that achieving such a state “implies that people are able to have a satisfying and safe sex life and that they have the

capability to reproduce and the freedom to decide if, when and how often to do so.” Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as other methods to regulate fertility, in compliance with national law. It also implies the right to access appropriate healthcare services that will enable women to have a safe pregnancy and childbirth and that will provide couples with the best chance of having a healthy infant. According to the Programme of Action, “Reproductive health includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.”

## Box 1 Sexual and reproductive health involves five key components

The definition of reproductive health adopted at the ICPD went beyond earlier definitions, recognizing the importance of women’s empowerment and human rights as well as links to other aspects of health and development. Accordingly, the earlier programmatic focus on family planning—one essential aspect of sexual and reproductive health—has been replaced by a much broader definition of reproductive health, encompassing not only family planning, but also maternal and newborn healthcare; prevention, diagnosis and treatment of sexually transmitted infections, including HIV; adolescent sexual and reproductive health; cancer screening; and infertility counselling. In addition, issues such as the elimination of gender-based violence, harmful practices, coercion or abuse, and gender inequalities, are integrally related. Governments agreed that abortion, when not against the law, should be safe and that post-abortion care should be available. Finally, access to comprehensive sexuality education is essential. In 2004, the World Health Organization (WHO) outlined five components that are necessary for good sexual and reproductive health:

- Ensuring contraceptive choice and safety and infertility services
- Improving maternal and newborn health
- Reducing sexually transmitted infections, including HIV, and other reproductive morbidities
- Eliminating unsafe abortion and providing post-abortion care
- Promoting healthy sexuality, including adolescent health and reducing harmful practices.<sup>1</sup>

**Source:** UN Millennium Project. 2006. *Public Choices, Private Decisions: Sexual and reproductive health and the Millennium Development Goals*. New York: Millennium Development Project.



Sexual health is closely related to reproductive health; it entails the ability to express one's sexuality free from the risk of sexually transmitted infections (STIs), including HIV, unwanted pregnancy, coercion, violence, stigma and discrimination. It means being able to have an informed, satisfying and safe sex life, based on a positive approach to sexuality and mutual respect between partners.

## The paradigm shift to reproductive health

The ICPD was the culmination of prior developments and the inspiration for a process that continues today. Prior to the 1990s, the focus of global policy discussions regarding reproduction was on controlling women's fertility as a means to limit rapid population growth; health was often regarded as an 'entry point' for the provision of family planning. After years of organizing, women's groups and their allies succeeded in raising awareness of the importance of the broader health and social contexts of fertility and parenthood, and of sexuality, gender and human rights to population and development. These shifts culminated in a series of United Nations conferences in the 1990s, including the Vienna Human Rights

### Box 2 Reproductive rights are human rights

The ICPD Programme of Action articulated and affirmed the idea that reproductive rights embrace human rights that are already recognized by national laws, international human rights agreements and other relevant UN consensus documents. Article 12 of the 1979 *Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)* states:

*1. States parties shall take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to healthcare services, including those related to family planning. 2. Notwithstanding the provisions of paragraph 1 of this article, States parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.*

Article 12 of the *International Covenant on Economic, Social and Cultural Rights* states "...the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," and requires governments to ensure that all people can access healthcare services, commodities and facilities.

Articles 23 and 25 of the *Convention on the Rights of Persons with Disabilities* stipulate that:

*States parties must ensure the rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education; and sexual and reproductive health respectively.*

Conference of 1993, the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing. As a result of these milestone events, the world's governments endorsed consensus documents that recognized the complex links among population growth, sexual and reproductive health, gender equality, consumption and production patterns, sustainable development and human rights. These international agreements underscored that reproductive and sexual health and reproductive rights are integrally related to women's rights and well-being, which in turn are key to achieving social and economic development.

*Sexual and reproductive health and rights are integrally related to women's rights and well-being, which are key to social and economic development*

### **Since Cairo and Beijing, more attention to sexual health**

In the 15 years since the UN conferences in Cairo and Beijing, the HIV pandemic, growing awareness of gender

violence and concern about adolescent health has brought more focused attention to sexuality and sexual health and the particular risks that women face. Subsequent meetings of the UN General Assembly to review progress on the ICPD Programme of Action also helped to enhance and advance implementation of an approach that encompassed both sexual and reproductive health. The ICPD+5 review, for example, resulted in agreement on concrete targets and benchmarks on the provision of reproductive health services; access to a wide range of contraceptive methods and to basic and emergency obstetric care by skilled attendants; and the prevention of STIs, including HIV, among young people. In addition, governments agreed to train and equip healthcare providers to ensure that where abortion is legal, it is both safe and accessible. Increasingly, sexual and reproductive health and rights are recognized as fundamental human rights. Many organizations have debated the definitions of and relationships between sexual health, reproductive health and human rights, including the world's largest non-governmental reproductive health organization, the International Planned Parenthood Federation, which issued a Declaration on Sexual Rights in 2008 for their membership and to stimulate wider discussion.

### **Box 3** The dialogue on sexual and reproductive health and rights continues

Global discussion on the concept of reproductive health emerging from the ICPD and on the extent of government responsibilities and obligations continues today.

In a February 2004 report, Paul Hunt, the Special Rapporteur on the Right to Health, recommended that "increased attention be devoted to a proper understanding of sexual health and sexual rights, as well as reproductive health and reproductive rights. The contents of sexual rights, the right to sexual health and the right to reproductive health need further attention, as do the relationships between them.... These rights, however, have to be understood in a broader human rights context that includes sexual rights."

In 2008, Mr. Hunt addressed the UN Human Rights Council Panel on Maternal Mortality and the Human Rights of Women, saying that:

*...the right to the highest attainable standard of health tells us what a good health system requires. The health system requires a comprehensive plan for maternal health—the plan must have some basic features, like a budget, otherwise it is of limited use. The health system requires basic data which are disaggregated so that we know which disadvantaged groups to target. It requires outreach programmes to reach those disadvantaged groups. It requires an effective referral system from one level of maternal healthcare—or from one facility—to another. It requires a basic 'basket' of maternal health-related services, including information about family planning, antenatal care, emergency obstetric care and so on. These services must be of good quality.*

In June 2009, the United Nations Human Rights Council agreed unanimously to pass a resolution on Preventable Maternal Mortality, Morbidity and Human Rights.

## Integrating sexual and reproductive health into primary healthcare

A key thrust of the ICPD was a call to integrate sexual and reproductive health into primary healthcare. Since that time, recognition has grown of the need to strengthen health systems overall, and as a prerequisite for achieving universal access to reproductive health. This coincided with a growing consensus that the 'right to the highest attainable standard of health' requires a functioning health system that is open and available to all. Achieving universal access to reproductive health means taking measures to eradicate inequities by eliminating barriers to access, whether they be economic, structural or cultural. It requires government action, usually a mix of financing, legislation and regulatory mechanisms that help to ensure universal access and good quality services. The goal is to maximize fairness and ensure health coverage for all, which necessitates deliberate efforts to reach and serve the very poor and other vulnerable and marginalized groups.

*Recognition has grown of the need to strengthen health systems overall, and as a prerequisite for achieving universal access to reproductive health*

Universal access to reproductive health requires that a system is in place that includes health facilities, trained personnel, a steady supply of relevant commodities and interventions at the household and community levels. A comprehensive package of sexual and reproductive health services, embedded within a functioning health system, covers the areas of contraception; antenatal care; maternity and post-natal care; safe abortion, when not against the law; post-abortion care; and prevention, diagnosis and treatment of STIs, including HIV.<sup>2</sup> A unified approach includes comprehensive sexuality education and the protection of human rights through community-based interventions that foster local participation from the inception of relevant programmes to their implementation and evaluation.

### Stimulating demand and use

In addition to steps to improve the supply of healthcare services, efforts must be made to stimulate demand and use by promoting knowledge, attitudes and behaviours that support sexual and reproductive health and human rights. This necessitates multiple and creative efforts to promote healthy

behaviour and the use of health services, including health information and education at the household and community levels. This may involve the use of various media (such as public service announcements or radio or television melodramas), community mobilization and campaigns, school-based programmes, and efforts by the private sector and faith-based organizations. It requires accurate information about sexual and reproductive health as well as methodologies to cultivate attitudes that value and foster gender equality and non-discrimination. It also calls for the development of decision-making and communication skills, especially among women and young people. And it requires that men pay attention to their own sexual and reproductive health and to that of their partners.

## Reproductive health and the Millennium Development Goals

The expansive definition of reproductive health established over years of negotiations was not specifically referred to in the Millennium Development Goals (MDGs) adopted by world leaders in 2000. Instead, individual aspects of the concept were distributed among several MDGs, which are regarded as mutually reinforcing. Gender equality is addressed in goal 3; reducing maternal mortality is included as a target in goal 5;

### Box 4 The Millennium Development Goals are mutually reinforcing

The eight Millennium Development Goals aim to eliminate poverty and chart a path to equitable and sustainable development:

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development.

All of the MDGs are interdependent and several of them directly relate to the approach to population and sexual and reproductive health envisioned at the 1994 ICPD, especially goals 3, 4, 5 and 6.



newborn health is essential to goal 4; and combating the spread of HIV is a target of goal 6 (see Box 4 for a list of the eight MDGs.)

When the MDGs were first established, goal 5 (Improve maternal health), had only one target: to reduce maternal mortality by three fourths by the year 2015, from the 1990 level. In 2005, world leaders recognized that eradicating extreme poverty, improving children's and women's health, promoting gender equality, halting HIV and ensuring environmental sustainability would be impossible without also guaranteeing that all people (including adolescents and young people) are able to access sexual and reproductive health information and services. Accordingly, in 2007, universal access to reproductive health was added as a second target to goal 5, now referred to as MDG5.B.

UNFPA, the United Nations Population Fund, recognizes and uses the broader ICPD-based definition of reproductive health, inclusive of sexual health. However, to call attention to this more expansive definition, it generally uses the term 'sexual and reproductive health' in contexts not restricted to maternity.

### *Quantifying progress in sexual and reproductive health*

Targets were set for each of the MDGs, to be achieved by 2015. The interrelated targets for Millennium Development Goal 5 are:

- Target 5.A: Reduce maternal mortality by three quarters.
- Target 5.B: Achieve, by 2015, universal access to reproductive health.

For each of the targets, indicators were developed to measure progress. The indicators are markers that capture progress towards essential elements of the larger goal. Two indicators were selected to measure achievement of target 5.A:

- Maternal mortality ratio
- Proportion of births attended by skilled health personnel.

Achievement of universal access to reproductive health (target 5.B) is challenging to evaluate. Four indicators were therefore selected for measuring progress:

- Contraceptive prevalence rate
- Adolescent birth rate
- Antenatal care coverage (at least one visit and at least four visits)
- Unmet need for family planning.

Adolescent birth rate is included because of the large cohort of youth in developing countries and their multifaceted social, cultural, emotional and physical vulnerabilities. It also affirms how important it is to reach people with information and services, appropriate to their age and needs, starting from childhood and extending through the life cycle. The contraceptive prevalence rate and unmet need for family planning are intended to be used together, to help ensure that family planning services are available, accessible and rights-based. Because unmet need is designed to measure women's underserved but stated desire to space or limit pregnancies, it points to whether rising contraceptive prevalence rates are responsive to and respectful of women's preferences and rights. Finally, antenatal care coverage emphasizes the need for a continuum-of-care approach within sexual and reproductive health services and to the obligation to provide services for the full range of needs.

To measure progress towards the larger principles contained in the concept of sexual and reproductive rights, these indicators can be combined with indicators for goal 4 (infant mortality rate) and goal 6 (HIV prevalence among 15-24 year olds; condom use at last high-risk sex, knowledge of modes of transmission and means of prevention, and proportion of population with advanced HIV infection with access to antiretroviral drugs). Interestingly, recent policy discussions often address the health-related MDGs together.

# How sexual and reproductive health reduces poverty, advances development and protects human rights

Ten years after the Millennium Summit, the eight MDGs continue to provide a universal framework for development and poverty reduction. The MDGs are closely linked and interdependent: each one both fosters and requires progress in all the others. Nevertheless, at a time of economic crisis and funding constraints, governments, donors, civil society organizations and social movements must make tough decisions about allocating resources. The question they are asking is: How do we best invest our time and resources?

With only five years left to reach the MDG targets, investing in sexual and reproductive health, firmly embedded in the context of human rights, is one of the surest ways to advance economic development, social justice, individual and collective dignity and well-being, and environmental sustainability. It would more than pay for itself in progress made and resources saved across all the MDGs. While the links between development targets—and the strategies to reach them—are multiple and complex, it is clear that sexual and reproductive health contributes to development in numerous ways.

*Investing in sexual and reproductive health would more than pay for itself in progress made and resources saved across all the MDGs*

## Promoting development, fighting poverty and eradicating hunger

Sexual and reproductive health information, education and services contribute to economic and social development, poverty reduction and the eradication of hunger. Establishing a causal

relationship between population and reproductive health on the one hand and poverty reduction on the other is challenging, because there are many factors and because change is slow and cumulative. Nonetheless, research has suggested that a fall of 5 per thousand people in the birth rate in 45 countries during the 1980s would have led to a one-third drop in the incidence of poverty.<sup>3</sup> Poverty is associated with large family size, with the poorest countries facing the highest population growth rates.<sup>4</sup> Bringing down rapid population growth, by reducing fertility to desired levels, can often mean a transition to a higher level of working people relative to those who depend on them. In high-fertility settings, it is primarily children who depend on those who work; and in countries that are further along in the demographic transition, it is mostly growing populations of older people who are dependent. If a country takes advantage of this ‘demographic bonus’ (a higher proportion of working people) by investing in healthcare, education and infrastructure and by creating the policy framework needed for just and equitable development, it can build the potential for strong economic growth and development.<sup>5</sup>

Just as countries with high population growth can benefit from lowered fertility rates, leading to a higher proportion of the population that is economically productive, households can benefit from smaller families, creating the potential to increase income and accumulate assets. Children in larger families may have less access to education, healthcare and food, with girls often at a particular disadvantage.<sup>6</sup> People living in households with a large number of children tend to be more vulnerable and less upwardly mobile than those with fewer children. A study in Nicaragua, for example, found that living in a household with four children or more meant lower social mobility. It also discovered that differences in poverty levels due to socio-demographic factors, such as the number

of children in the household, were larger than poverty differences due to economic factors, such as changes in gross domestic product (GDP).<sup>7</sup> Research on factors determining poverty in Nairobi also found a strong association between being poor and living in households with a lot of people or a high proportion of children.<sup>8</sup> Studies in Honduras and Colombia suggest that meeting the unmet need for family planning would raise the incomes of the poor by 10-20 per cent or more in cases of extreme poverty.<sup>9</sup>

*Children in larger families may have less access to education, healthcare and food, with girls often at a particular disadvantage*

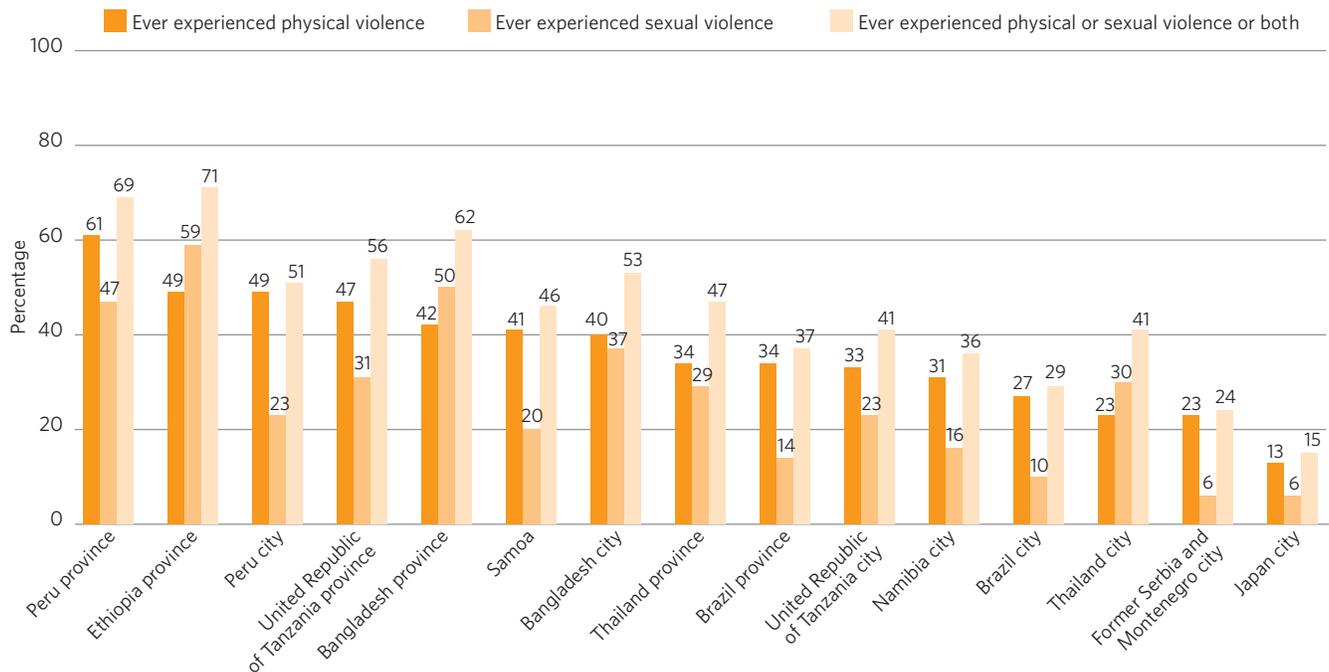
## Securing gender equality and women's rights

Access to sexual and reproductive health information and services offers women the means to control their own bodies and to decide whether and when to have children. Women's ability to control their fertility can create opportunities for increas-

ing their skills and participating in the workforce or other activities outside the home. Moreover, access to sexual and reproductive health services can create opportunities to challenge gender norms that underlie harsh violations of women's human rights, including violence, discrimination, coercive sex, 'honour' crimes, crimes of passion, early marriage and other harmful practices.

Violence, or the threat of violence, denies women the possibility of exercising other human rights, such as the right to work, to attend school, to associate freely with others, and to preserve one's mental and physical health. Sexual violence—rape, incest, sexual abuse—is used to repress women, a situation exacerbated in situations of conflict or other instances when vulnerabilities are heightened. Indeed, sexual violence in conflict is now considered a weapon of war, as defined by UN Security Council Resolution 1820. The most common form of violence that women experience, however, is at the hands of someone they know (see Figure 1). A WHO study in ten countries found that between 15 per cent and 71 per cent of women had been subjected to physical and/or sexual violence by a husband or partner at some point in their lives. Between 4 per cent and 12 per cent of women reported that they had

**FIGURE 1**  
Substantial proportions of women experience physical and sexual violence at the hands of intimate partners



Prevalence of lifetime physical violence and sexual violence by an intimate partner, among ever-partnered women, by site

Source: WHO Multi-Country Study on Women's Health and Domestic Violence against Women: Summary report of initial results on prevalence, health outcomes and women's responses.

been abused during pregnancy. Younger women are even more likely to suffer intimate partner violence. The study found that many women recounted that their first sexual experience had not been consensual.<sup>10</sup> Violence against women is associated with STIs, including HIV, unintended pregnancies and poor maternal health outcomes, such as miscarriage, low birthweight and foetal death, as well as poor mental health.<sup>11</sup> According to WHO, “depression, anxiety, psychological distress, sexual violence, domestic violence and escalating rates of substance use affect women to a greater extent than men across different countries and different settings.”<sup>12</sup>

*Access to sexual and reproductive health services can create opportunities to challenge gender norms that underlie harsh violations of women’s human rights*

Women suffer from mental health disorders, such as depression and anxiety, at higher rates than men due to risk factors related to gender roles and to negative life experiences and events related to reproductive health. Thirteen per cent of women suffer mental health problems within one year of giving birth.<sup>13</sup> And the experience of sexual violence often leads to post-traumatic stress disorder, a condition that affects more women than men.<sup>14</sup>

### **Preventing harmful practices**

Gender inequality also fosters harmful practices, such as prenatal sex selection, which is leading to growing imbalances in the ratio of boys to girls, especially in Asia. Gender discrimination and son preference have contributed to a sex-ratio imbalance as high as 130 male births per 100 female births.<sup>15</sup> In 2005, six countries reported sex-ratio imbalance levels above 108: Armenia, Azerbaijan, China, Georgia, India and the Republic of Korea.<sup>16</sup> More research is needed, especially in countries such as Georgia, to understand this phenomenon. In others, notably the Republic of Korea, the ratio has returned to more normal levels.

Female genital mutilation/cutting (FGM/C), the partial or total removal of the external female genitalia, is another destructive practice stemming from gender inequity and repressive attitudes toward female sexuality. Degrees of severity vary significantly. While usually carried out on young girls between the ages of 4 and 14, it is also performed on babies and on women about to marry or give birth. The procedure is often

carried out by people without training, using crude instruments, such as scissors or broken glass, and without administering anaesthesia. Immediate consequences include severe pain, shock and blood poisoning. In the long run, the effects can include infertility, obstructed labour, urinary incontinence and increased susceptibility to HIV infection. Haemorrhaging and infection can lead to death.<sup>17</sup> It is estimated that 100 million to 140 million girls and women have experienced some form of FGM/C<sup>18</sup> and that, every year, another 3 million girls in sub-Saharan Africa, Egypt and Sudan are at risk of the procedure.<sup>19</sup> The extent of the practice varies even within regions. For example, in West Africa, prevalence is 99 per cent in Guinea, 71 per cent in Mauritania, 17 per cent in Benin and 5 per cent in Niger.<sup>20</sup> Female genital mutilation/cutting is also practised in some Asian countries, the Arabian Peninsula and within immigrant communities worldwide.

### **Meeting the needs of the largest generation of young people in history**

In 2010, an estimated 1.7 billion people in the developing world are under the age of 15, and 1.1 billion are between the ages of 15 and 24. In the least developed countries, about 60 per cent of the population is under the age of 25.<sup>21</sup> Meeting the sexual and reproductive health needs of adolescents is vital to development. Without access to sexuality education and sexual and reproductive health services, adolescents and young people, especially girls, face daunting challenges—unintended pregnancy; unsafe abortion; maternal mortality; violence; STIs, including HIV; exploitation (including the exchange of sex for food or money); and discrimination on the basis of sexual orientation or gender identity.

*In the least developed countries, about 60 per cent of the population is under the age of 25; meeting the sexual and reproductive health needs of adolescents is vital to development*

### **Sexual and reproductive health information and services**

Early marriage and early pregnancy are risk factors for young women’s health and well-being. The percentage of girls who are married before the age of 18 varies by country and region—from 48 per cent in South Asia to 29 per cent in Latin America and the Caribbean. Research has found an as-

sociation between marrying before the age of 18 and marriage to a man at least five years older,<sup>22</sup> which often contributes to an uneven power relationship within the household.<sup>23</sup> Early marriage is also associated with early pregnancy. In developing countries, more than 40 per cent of girls have their first child before they reach the age of 20, and some 14 million girls give birth before the age of 18 every year.<sup>24</sup> These young mothers may be forced to drop out of school or to stop working outside the home, thus risking a fall into deeper poverty. They are also more likely than adult women to die, experience complications, or suffer lasting health problems related to childbirth. Pregnancy-related risks, including unsafe abortion, are the leading cause of death for women aged 15 to 19 worldwide.<sup>25</sup> Indeed, roughly one quarter of the 20 million unsafe abortions annually occur among adolescents in this age group.<sup>26</sup> Girls who become pregnant within two years of starting to menstruate often begin their pregnancy with lower nutritional reserves.<sup>27</sup> One of the most devastating outcomes of early pregnancy is obstetric fistula, a result of obstructed labour when girls' bodies are not fully mature, which leaves a hole through which faeces or urine can leak. This condition, which is both preventable and treatable, can result in life-long pain, infection, shame, ostracism and even death.

Despite the risks associated with early pregnancy and childbearing, levels of unmet need for family planning among sexually active girls aged 15 to 19 are higher than among older women.<sup>28</sup> At young ages, most girls wish to delay a first pregnancy or to space their births, rather than to limit them. Nonetheless, gaps in information or inadequate access to supportive services for family planning and the prevention of STIs, including HIV, reduces the use of protective measures. This is true for both married and unmarried young people, although research shows that unmarried women who are sexually active are more likely to want to use contraception, usually to delay childbearing. This higher total demand among young unmarried women leads to both higher rates of contraceptive use and higher rates of unmet need than among their married counterparts, particularly in sub-Saharan Africa.<sup>29</sup> Young people, especially unmarried women, often face policies or attitudes that prevent or discourage them from seeking services.

*Pregnancy-related risks, including unsafe abortion, are the leading cause of death for women aged 15 to 19 worldwide*



Young people are disproportionately affected by STIs, including HIV. Worldwide, people between the ages of 15 and 24 account for 40 per cent of new HIV infections.<sup>30</sup> Here again, young women are particularly vulnerable, for social, cultural and biological reasons. In the most affected countries of sub-Saharan Africa, women aged 15 to 24 are three times more likely to be HIV-positive than young men.<sup>31</sup> In Cambodia as well, three young women are infected for every young man. In parts of the Caribbean, the ratio is two-to-one.<sup>32</sup> Early marriage is often a risk factor: research in more than 25 developing countries found that at least 80 per cent of unprotected sexual encounters among adolescent girls occur within marriage.<sup>33</sup> Older men are more likely to have had previous partners and to be HIV-positive, thus exposing their younger sexual partners to infection.<sup>34</sup> Young married women who have moved away from their friends and families and are socially isolated tend to have less power to refuse sex or negotiate condom use. Vulnerability is also physiological, which is discussed in the section below on HIV.

### **Protection from violence**

Young people also suffer from high levels of violence. A survey in 21 countries found that 7-36 per cent of girls and 3-29 per cent of boys suffered sexual abuse over the course of their

childhood.<sup>35</sup> Some young women experience sexual abuse in school: in Malawi, for example, 71 per cent of primary school students who reported forced sex said that the incident occurred at school.<sup>36</sup> The effects of abuse during childhood can be devastating, and include poor mental health, fewer years of schooling, substance abuse, engaging in risky sex, and perpetrating violence later in life. According to a WHO multi-country study,<sup>37</sup> many women reported that their sexual debut was coerced (24 per cent in rural Peru, 28 per cent in the United Republic of Tanzania, 30 per cent in rural Bangladesh and 40 per cent in South Africa). For many of these women, the forced sex was within marriage.<sup>38</sup> Coerced sex can cause abrasion and tearing, especially in the delicate tissues of women not yet fully mature, thereby increasing their susceptibility to HIV infection.

## Strengthening health systems

Investing in sexual and reproductive health contributes to dramatic improvements in health worldwide and strengthens health systems more generally. For example, training healthcare providers in a rights-based approach, so that they treat their clients with respect and with due regard for their right to privacy, confidentiality and non-discrimination, can have a positive effect on the quality of care overall. Similarly, improved skills in counselling, which is central to comprehensive sexual and reproductive healthcare, can have an impact in other areas. Preparing health systems to respond to obstetric emergencies, including pain management, infection control, Caesarean sections and blood transfusions, can enable them to better handle other emergencies related to bodily trauma. Additionally, many sexual and reproductive healthcare interventions are 'non-schedulable', that is, they must be available whenever they are needed, not at a provider's convenience. The ability to meet reproductive health needs, in fact, is a signal indicator of the overall coverage and accessibility of services in the health system.

*The ability to meet reproductive health needs is a signal indicator of the overall coverage and accessibility of services in the health system*

Enhancing access to sexual and reproductive healthcare can also contribute to increased use of health services in general. It connects women to the health system, encouraging them to

return, perhaps bringing family members, for other services. Sexual and reproductive healthcare also can be a way to engage men as well as to address men's roles and responsibilities, gender-based violence, sexual abuse and harmful practices.

## Saving the lives of women and children

Death and disability related to sexual and reproductive health accounted for nearly one third of the disease burden for women of reproductive age in 2004.<sup>39</sup> In fact, unsafe sex was the second largest cause of lost years of healthy life, or burden of disease globally, particularly in less developed countries, that year.<sup>40</sup> Access to prevention and care could dramatically reduce mortality and ill-health among women and children by preventing transmission of STIs, including HIV, and averting maternal and infant deaths and disabilities.

For women in many developing regions, especially sub-Saharan Africa and Southern Asia, giving birth is especially risky: every day, about 1,000 women die of complications from pregnancy or childbirth globally.<sup>41</sup> Nearly all of these deaths are preventable. And for every woman who dies, 20 to 30 others suffer lasting health problems, many of which can be debilitating, including obstetric fistula.

Avoiding unintended pregnancies saves lives. An estimated 215 million women in the developing world have an unmet need for modern contraception. These are women who are using no method of family planning or are using less effective methods (such as withdrawal, periodic abstinence and/or folk remedies). The direct benefits of meeting this need for contraception and for maternal and newborn healthcare include two-thirds fewer unintended pregnancies, a 70 per cent reduction in maternal deaths, and a 44 per cent decrease in the death of newborn babies. Unsafe abortions would decline by 73 per cent, from 20 million to 5.5 million (assuming no change in abortion laws), and the number of women with abortion complications requiring medical attention would fall from 8.5 million to 2.3 million.<sup>42</sup>

A mother's death can lead to the death of her baby. Thus reducing maternal mortality saves the lives of children, too. Infant death can also be averted by delaying childbirth and by spacing births.<sup>43</sup> Child mortality would decrease by 13 per cent if all women could delay their next pregnancy by at least 24 months. It would decrease even more if the interval

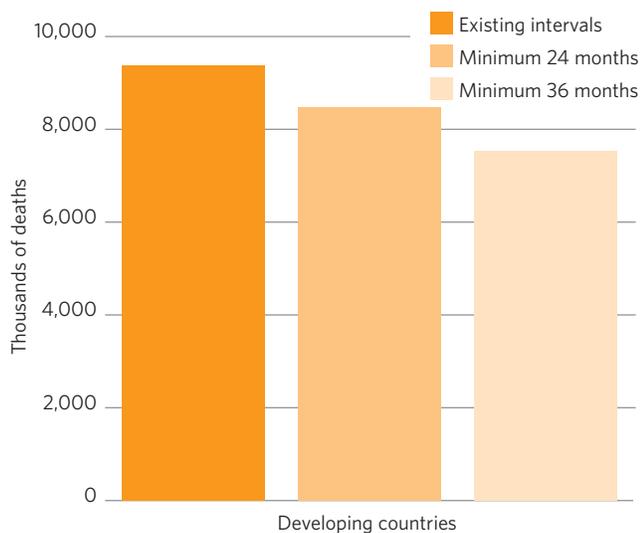
between births approached 36 months (see Figure 2).<sup>44</sup> Birth spacing improves the nutritional status of both women and children. Babies born more than two years after the last child are less likely to be born prematurely or underweight.<sup>45</sup> Low weight at birth, in turn, increases the likelihood of death or poorer physical or cognitive development.<sup>46</sup> Addressing early pregnancy would also lower child mortality. Births to adolescent girls are more likely to lead to the death of a child before his or her first birthday.<sup>47</sup> An infant is 60 per cent more likely to die during the first year of life if the mother is under the age of 18. Even if the child survives, he or she is more likely to suffer from low birthweight, malnutrition and late physical and cognitive development.<sup>48</sup>

*Child mortality would decrease by 13 per cent if all women could delay their next pregnancy by at least 24 months*

## Preventing HIV and other sexually transmitted infections

Investing in sexual and reproductive health helps to prevent STIs, including HIV—the world’s leading cause of death

**FIGURE 2**  
Child deaths are averted by longer birth intervals



Annual number of under-five deaths with existing birth intervals and minimum intervals of 24 and 36 months, developing countries

Source: *International Journal of Gynecology & Obstetrics*, April 2005.

by infectious disease and the number one killer of women of reproductive age.<sup>49</sup> HIV can slow economic growth, widen inequalities and cause severe strains on affected households. In Botswana, modelling suggests that HIV has increased the share of households below the poverty line by 6 per cent and increased the percentage of individuals living in poor households by 4 per cent.<sup>50</sup> In Asia, analyses by the Asia Development Bank and the Joint United Nations Programme on HIV/AIDS (UNAIDS) indicate that HIV will slow the annual rate of poverty reduction by 60 per cent in Cambodia, by 38 per cent in Thailand, and by 23 per cent in India between 2003 and 2015. HIV affects vulnerable populations disproportionately, often exacerbating conditions of poverty. For example, the financial burden related to HIV for the poorest households in India amounts to 82 per cent of annual income, while the comparable burden for the wealthiest families is slightly more than 20 per cent.<sup>51</sup> Data from Botswana show that HIV results in a decline in per capita household income of 10 per cent, but the average income losses are nearly twice as high for the poorest households.<sup>52</sup>

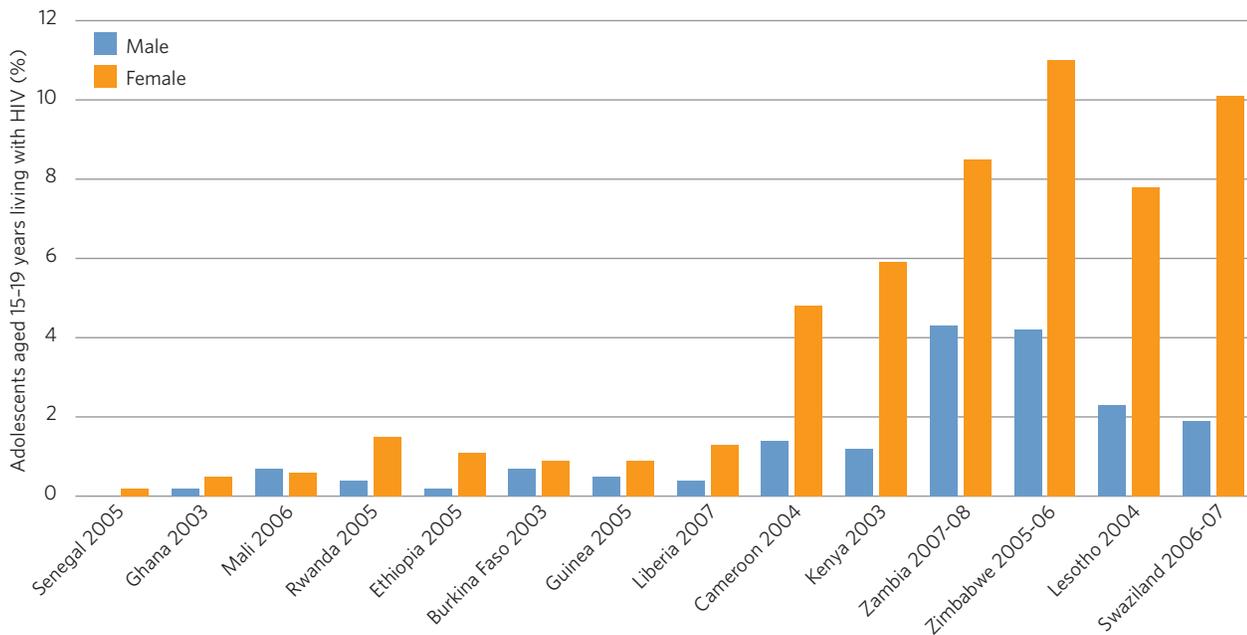
Most HIV transmission is sexual. In countries where infection had previously been spread primarily through injecting drug use, particularly in Eastern Europe and Central Asia, it is now transmitted mainly through sex.<sup>53</sup> And in many countries, sexual transmission between men also accounts for a significant portion of new infections, ranging from 11 per cent to 50 per cent.<sup>54</sup>

### Heightened vulnerability of women and girls

Women and girls are particularly vulnerable to sexually transmitted infections (see Figure 3). HIV prevalence in women has increased steadily since the early 1990s and is most pronounced in sub-Saharan Africa, where women account for more than 60 per cent of people living with the virus.<sup>55</sup> Women’s greater vulnerability to HIV derives from social, cultural and biological factors. The female genital tract is more prone to infection, especially if the woman is young or if she is pregnant, making women more susceptible to infection from unprotected heterosexual sex than men.<sup>56</sup> Biological risk is exacerbated by women’s unequal status in many countries. Stigma, lack of power and cultural barriers to negotiating safe sex and condom use or to leaving a risky relationship, economic or social dependency, and intimate partner violence all compound women’s vulnerability. Women also carry a greater burden of caring for male partners, children and other family members when they become ill.

### FIGURE 3

#### More girls than boys are infected with HIV in high-prevalence countries in sub-Saharan Africa



HIV prevalence among adolescents aged 15–19 years, by sex, selected countries in sub-Saharan Africa, 2001–2008

Source: Statcompiler, Demographic and Health Surveys, accessed 23 August 2010.

Research suggests that HIV infection increases the risk a woman faces from pregnancy or childbirth, affirming the importance of integrated services.<sup>57</sup> Providing reproductive healthcare to HIV-positive women who want to get pregnant and have a child not only ensures that their reproductive rights are respected. It also brings them into the healthcare system and gives them the treatment they need to safeguard their own health and to prevent the transmission of HIV to their babies.

#### Other sexually transmitted infections

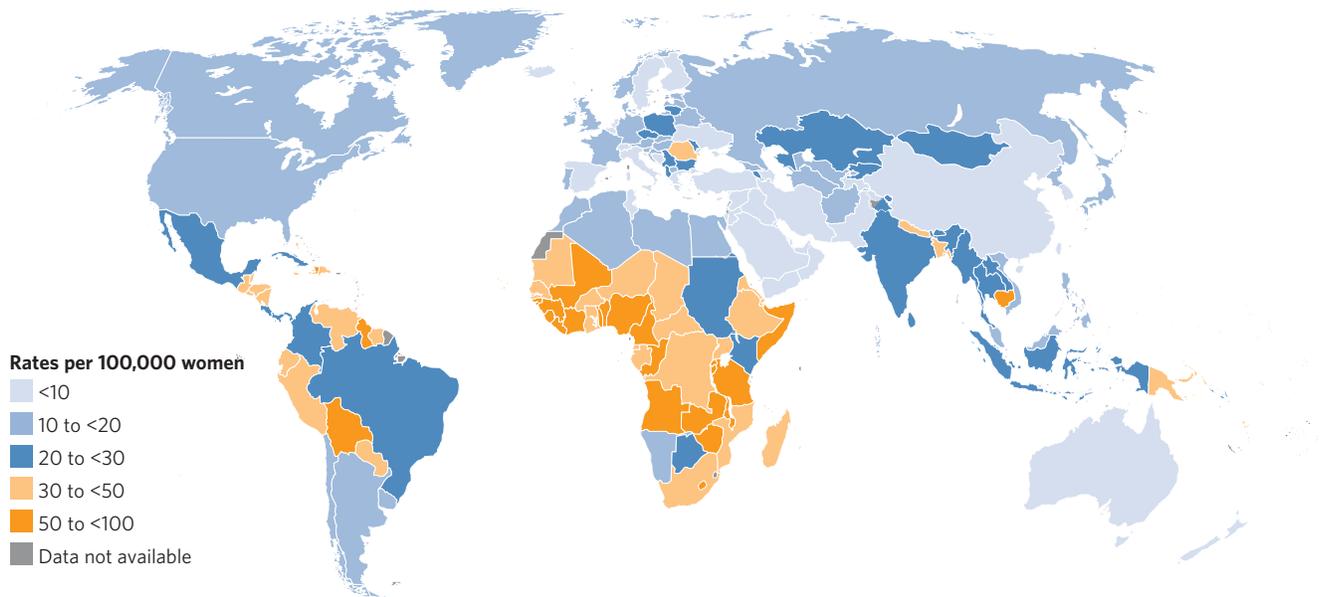
In developing countries, STIs, excluding HIV, are second only to maternal morbidity and mortality as a cause of death, illness and ‘healthy life lost’ among women in their childbearing years. Among the serious health consequences of untreated STIs are cervical cancer, ectopic pregnancy, infertility, pelvic inflammatory disease and miscarriage, in addition to discomfort, distress and shame for millions of women. Studies show that STIs increase the risk of HIV infection by two to five times.<sup>58</sup> The rates of STIs are highest among women in Latin America and sub-Saharan Africa, with about 25 per cent of women having one of four treatable infections at any point in time.<sup>59</sup> The symptoms of

many STIs, particularly chlamydia and trichomonas, are less apparent in women than men, making it less likely that they will be treated. Gonococcal and chlamydial infections that are left untreated will result in pelvic inflammatory disease in up to 40 per cent of cases, one in four of which will lead to infertility. Sexually transmitted infections also increase the likelihood of negative outcomes of pregnancy, including stillbirths, low-birthweight infants, neonatal deaths and congenital syphilis. Syphilis, if untreated, will lead to stillbirth in 25 per cent of cases.<sup>60</sup>

*Studies show that sexually transmitted infections increase the risk of HIV by two to five times*

Certain varieties of the human papillomavirus (HPV) cause an estimated 95 per cent of cervical cancers worldwide.<sup>61</sup> Cervical cancer is yet another indication of global inequities: most of the deaths from cervical cancer are in developing countries, where it is the leading cause of death from cancer (see Figure 4).<sup>62</sup> Women are usually infected when young, but are not aware of the danger because no symptoms appear until it is too late.

**FIGURE 4**  
**Rates of cervical cancer are highest in less developed countries**



Incidence rates of cervical cancer (age-standardized per 100,000 women, all ages), 2004  
**Source:** World Health Organization.

Sexual and reproductive health information and services offer an opportunity to address and reduce vulnerabilities to HIV and other STIs. Bringing women and other vulnerable groups into the healthcare system provides an opportunity to identify people at risk, offer prevention information and services, including prevention of mother-to-child transmission of HIV, and diagnose and treat other STIs.

### Enhancing environmental sustainability

Global environmental problems are largely due to the consumption and production patterns of developed countries; population growth contributes to the impact at the local level. Addressing the global environmental crisis does not have a simple demographic answer. Nonetheless, access to high-quality and rights-based voluntary sexual and reproductive healthcare, including contraception, can help alleviate mounting environmental problems.

Population growth due to high fertility results in increased demand for food and natural resources.<sup>63</sup> Many women and couples say that they would like to prevent or delay pregnan-

cies and have fewer children, but lack access to family planning. Oftentimes they end up with large families, leading to the division of land into smaller and smaller plots. As subsistence farmers struggling to survive, they may see no choice but to clear forests, cultivate steep hillsides and graze their livestock on marginal lands. The result can be erosion, flooding and depletion of the soil, which all contribute to increased poverty, food insecurity and environmental decline. Environmental stress and the struggle for livelihoods in rural areas can also lead people to migrate to urban areas. The rapid growth of urban slums has contributed to deforestation in peripheral areas due to demand for cooking fuel. And large numbers of urban poor live in flood plains, on hillsides and other insecure places, where they are vulnerable to the effects of climate change.<sup>64</sup>

Women disproportionately carry the burdens of environmental degradation and food insecurity. Yet they are often the stewards of the land and its natural resources: they also have knowledge of practices that could help mitigate and adapt to climate change (see Box 5). As improved sexual and reproductive health contributes to women’s empowerment, it can also free women’s time and resources to help prevent environmental degradation and food insecurity.

## Box 5 Women take on the challenge of a changing climate

In responding to natural disasters, women have shown resourcefulness and often taken leadership. Many of the collective efforts of women in recent years will, in fact, reduce the impact of climate change or help communities adapt to resulting hardships. In Malawi, for example, women are joining together in farmers' clubs to share current information about seeds and cultivation techniques that can take advantage of poor soils and erratic rainfall.

At the 14th Conference of the Parties to the United Nations Framework Convention on Climate Change, held in Poznań, Poland, Mazoe Gondwe, the food provider for her family, said, "As a local farmer, I know what I need and I know what works. I grew up in the area and I know how the system is changing." In Bangladesh, very poor and marginalized women living along rivers harvest resources on *chars* (silt islands that appear and quickly disappear with changes in the water levels), using their knowledge of the changing environment to eke out a living. Rural women in Nepal struggling to maintain their agricultural livelihoods after deadly monsoon flooding in 2007 used video technology to communicate their circumstances to local officials. In this way, they enhanced their own capacity to ask for the resources they needed to adapt to the changed environment, thereby participating in policy-making in their communities.

**Source:** United Nations Population Fund: *The State of World Population 2009. Facing a changing world: Women, population and climate*. New York: UNFPA.

# What have we achieved so far?

The last two decades have seen mixed progress in access to sexual and reproductive health and in exercising rights related to sex and reproduction. These gains were achieved despite significant challenges, such as changes in donor financing, economic instability and hardship, opposition from extremist groups, poor governance and more.

One of the most troublesome trends over the last several years has been widening inequities among and within countries. Even as the wealthy have seen gains in reproductive health access, those excluded by poverty, gender, ethnicity, disability, residency status, situations of conflict or other forms of marginalization have often been left behind. Research finds that a disproportionate amount of public spending on health and education goes to wealthier sectors of society.<sup>65</sup> As described below, the poor and marginalized lag behind the better off in important aspects of sexual and reproductive health from all sources, both public and private.

In sub-Saharan Africa,<sup>66</sup> for example, women from the wealthiest households are more than three times as likely as those from the poorest households to give birth with assistance from a skilled provider; in Southern Asia, the rich are five times more likely to have an assisted delivery; and women in the poorest households are at a particular disadvantage compared to those who are better off in Northern Africa and South-Eastern Asia. Data from sub-Saharan Africa also show that use of contraception is significantly lower and the adolescent birth rate higher among women who are poor, uneducated or living in rural areas. Rural women in sub-Saharan Africa have a contraceptive prevalence rate of 17, versus 34 for their urban peers. Disparities are even wider for women grouped by household wealth and education. For women with no education, contraceptive prevalence is 10 per cent, compared

to 42 per cent for those with a secondary or higher education. Women from the poorest 20 per cent of households have a contraceptive prevalence rate of just 10 per cent, versus 38 per cent for those in the highest wealth quintile.

Similarly, advances have been made in reducing the adolescent birth rate, but progress tends to be concentrated among girls who are better off economically, live in urban areas, and have at least a secondary education. The most recent Demographic and Health Surveys show that the birth rate for girls with a secondary or higher education declined from 56 to 48, while among girls with no education, it increased from 193 to 207. (For further discussion on trends and disparities, see *How Universal is Access to Reproductive Health? A review of the evidence*, published by UNFPA in September 2010.)

On a positive note, advances that have been made point the way towards strategies to maintain and expand these gains in the future and to address inequities, as discussed below. Some areas of notable progress include the following:

## Changes in policies, laws and development approaches

### *International policy*

A series of UN conferences in the 1990s advanced international understanding of and commitment to sexual and reproductive health and human rights, as described in Chapter 1. These conferences and subsequent meetings to mark their anniversaries, especially of the ICPD, have changed public discourse around sexual and reproductive health and reproductive rights. Implementation must now be the focus. Other examples of shifts in international policy on the issue follow:

*UN conferences have changed public discourse around reproductive health and rights; implementation must now be the focus*

- In the past decade, international human rights law and UN treaty monitoring bodies have increasingly recognized sexual and reproductive health, particularly the areas of adolescents' rights, maternal health and family planning. Unlike the international agreements of the 1990s, these treaty monitoring bodies are legally binding on governments.
- The United Nations Millennium Project<sup>67</sup> has recognized the importance of sexual and reproductive health in several of its task force reports and included increased access to reproductive health among its 'Quick Wins/Quick Impact Initiatives' in its primary project report.<sup>68</sup> A separate supplementary report expanded on findings and provided additional analyses and recommendations.<sup>69</sup>
- At the World Summit in 2005, as mentioned in Chapter 1, world leaders acknowledged the importance of reproductive health in its own right, and its contribution to other MDGs. By 2007, universal access to reproductive health had been added as a second target to MDG5.
- Changes in development approaches have also contributed to improved progress. For instance, integrating gender, human rights and culture into sexual and reproductive health programmes entails collecting and analysing critical information on why people make the choices they do within a particular social and cultural context and how these choices influence their sexual and reproductive health. This knowledge is being used to inform programming, rather than to impose predefined solutions that overlook the values and beliefs of diverse sectors of the population. Evidence shows that some of the toughest opposition to sexual and reproductive health programmes comes from cultural gatekeepers—religious and otherwise. At the same time, dramatic changes can and do occur when the guardians of cultural norms and practices advocate for such programmes. The integrated approach championed by UNFPA and other UN agencies seeks to identify, understand and build on the responses already developed by communities, while addressing structural



factors such as access to services (for example, cost and availability), policies and legal implications. Agents of cultural change include parliamentarians, government officials, community, religious and traditional leaders, media representatives and civil society organizations, including women's rights NGOs as well as community and faith-based NGOs dealing with human rights, reproductive health and gender issues.

*The approach championed by UNFPA and other UN agencies seeks to identify, understand and build on the responses already developed by communities, while addressing structural factors*

## Regional policies

Work has also been carried out at the regional level:

- The Protocol on the Rights of Women in Africa (better known as the 'Maputo Protocol') to the *African Charter on Human and People's Rights* was signed at the July 2003

session of the African Union in Mozambique and entered into force in November 2005 after ratification by the requisite 15 member states. The protocol condemns and prohibits sexual violence (Articles 3 and 4) and harmful practices (Article 5) and affirms women's right to health, especially reproductive rights. It also obliges governments to provide adequate, affordable and accessible information and services for women to realize those rights (Article 14).<sup>70</sup> Of the 53 member countries of the African Union, 28 had ratified the Protocol as of August 2010.<sup>71</sup>

- In 2006, the heads of state of members of the African Union endorsed the *Continental Policy Framework for Sexual and Reproductive Health and Rights*. Subsequently, in September, African ministers of health developed a document outlining a plan of action, which was then endorsed by national leaders in 2007. It states: "This Maputo Plan of Action for the Operationalisation of the Sexual and Reproductive Health and Rights Continental Policy Framework seeks to take the continent forward towards the goal of universal access to comprehensive sexual and reproductive health services in Africa by 2015." This was reaffirmed by the African Union in July 2010, when it was also recommended that African countries participate in the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA), an initiative to hold member countries accountable for action on their pledges. Leaders also called for broad involvement of key stakeholders and the institutionalization of "an annual CARMMA week in solidarity with the women and children of Africa for the next four years."<sup>72</sup>
- Health and education ministers from Latin America and the Caribbean committed themselves to investing in comprehensive sexuality education and youth-friendly health services through the Mexico City Declaration on Sex Education in Latin America and the Caribbean. The declaration was unanimously adopted in August 2006, in advance of the XVII International AIDS Conference.
- The 5th Asia Pacific Conference on Reproductive and Sexual Health and Rights was held in Beijing in October 2009, bringing together governments, parliamentarians, donors, NGOs, academics and youth organizations. Special attention was given to women's empowerment and young people and to addressing concerns related to migration, climate change and HIV/AIDS treatment, with

emphasis on the prevention of mother-to-child transmission. A parallel regional Youth Forum was also held, which called attention to the need for comprehensive sexuality education and a human rights focus.

## National policies

Among recent achievements at the national level:

- Nepal adopted an interim constitution in 2007, which states that women have "the right to reproductive health and other reproductive matters." This is the first time in the South Asia region that a national constitution has recognized women's reproductive rights as human rights.<sup>73</sup>
- In Ecuador, a new constitution protects the right to make "free, informed, voluntary, and responsible" decisions about sexuality, including sexual orientation and reproduction. It obliges the state to provide sexuality education to young people and sexual and reproductive health services to all. The constitution also includes clauses to prevent violence against women and discrimination based on sexual orientation.<sup>74</sup>
- For many years, Colombia had one of the most restrictive abortion laws in the world. It was ruled unconstitutional in 2006, however, when the Colombian Constitutional Court cited international human rights law and stated that "women's sexual and reproductive rights have finally been recognized as human rights, and, as such, they have become part of constitutional rights, which are the fundamental basis of all democratic states."<sup>75</sup>
- Female genital mutilation/cutting (FGM/C) has been criminalized in 18 African countries—Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Mauritania, Niger, Senegal, South Africa, United Republic of Tanzania and Togo.<sup>76</sup>
- National decisions on conditions regarding abortion remain wide-ranging. Abortion restrictions have been eased in 17 countries since 1997: Benin, Bhutan, Cambodia, Chad, Colombia, Ethiopia, Guinea, Islamic Republic of Iran, Mali, Nepal, Niger, Portugal, Saint Lucia, Swaziland, Switzerland, Thailand and Togo. In contrast, El Salvador, Nicaragua and Poland have made their laws



more restrictive.<sup>77</sup> Liberalization usually paves the way for reducing complications from abortions and resulting morbidities. In South Africa, for example, the incidence of infection resulting from abortion dropped by 52 per cent after the law was liberalized in 1996.<sup>78</sup> In fact, the lowest abortion rates in the world are in Northern and Western Europe, and where reproductive health information and services are more generally accessible and where abortion is widely allowed by law.<sup>79</sup>

Legal measures to address gender violence and harmful practices have also been taken at the country level, as described later in this chapter.

### *Global and regional initiatives and partnerships*

Several donor country and international stakeholder initiatives aimed at strengthening health systems have been launched in recent years, usually in the context of harmonization and alignment in support of country-led processes. Many

of these efforts include attention to sexual and reproductive health, often linked to improvements in maternal and child health. This heightened donor attention to reproductive health in the context of health system strengthening is an encouraging trend, although it poses the challenge of ensuring that the various efforts do not increase reporting burdens and other transaction costs for national governments. These initiatives include the following:

- The International Health Partnership (IHP+) is scaling up efforts to advance the health-related MDGs. Initiated by the United Kingdom, the partnership is helping to strengthen national processes in 21 countries in Africa and Asia (including vulnerable and post-conflict countries), with a particular focus on bolstering health systems.
- Health 4+, a joint effort of UNFPA, the United Nations Children's Fund (UNICEF), WHO, the World Bank and UNAIDS, is supporting 60 countries with the highest rates of maternal and newborn mortality. Through work with governments, national partners and other multilateral agencies, H4+ aims to save the lives and improve the health of women and their newborns through national capacity-building in a variety of areas.
- The Catalytic Initiative to Save a Million Lives, launched in November 2008 by the Government of Canada, aims to improve healthcare for poor mothers and children in Africa and Asia.
- Women Deliver, a broad-based coalition of NGOs, donors and national stakeholders, has advocated for greater attention to women's and children's health, including reproductive health, through two global conferences and the promotion of ministerial-level discussions.
- Deliver Now for Women and Children, initiated by Norway and coordinated by the Partnership for Maternal, Newborn & Child Health, is using advocacy to help eliminate maternal and newborn deaths and improve the health of women and children around the world.
- The World Bank issued a new Reproductive Health Action Plan for 2010-2015 in April 2010. Within the broader framework of health systems strengthening, the plan seeks to help countries address high fertility, including unmet need for contraception, improve pregnancy outcomes and reduce STIs.

- The Group of Eight industrialized nations have addressed health as an essential aspect of development since the early 1990s. At a 2000 meeting in Okinawa, G8 leaders declared that “health is key to prosperity” and started the process to establish the Global Fund for AIDS, Tuberculosis and Malaria; at the 2001 Genoa meeting, they identified the challenge of breaking the vicious cycle of poverty and disease; at the 2005 Gleneagles meeting, they agreed to boost investment in HIV/AIDS, malaria and other diseases; and at the most recent meeting in Muskoka, they identified maternal, newborn and under-five child health as a flagship initiative for the G8. Family planning is recognized as a key component of the initiative.
- Providing for Health (P4H), coordinated by France and Germany, was established and mandated to implement decisions taken by G8 summits to strengthen health systems and to create social health protection mechanisms in developing countries.
- The Group of Twenty has reaffirmed its commitment to meet funding pledges for the MDGs and official development assistance, in line with the principles outlined in the Paris Declaration on Aid Effectiveness<sup>80</sup> and the Accra Agenda for Action.
- The Secretariat Co-Sponsors Working Group on Health Systems Strengthening (of UNAIDS) is working to strategically position HIV/AIDS within efforts to strengthen health systems through coordination, collaboration and the identification of best practices.
- The United Nations Inter-Agency Task Force on Adolescent Girls is fostering collaboration at the country level to enable adolescent girls to claim their rights and to access social services, particularly education, healthcare and employment, and to boost human development overall. The task force is a partnership including UNICEF, the International Labour Organization (ILO), the UN Educational, Scientific and Cultural Organization (UNESCO), the UN Development Fund for Women (UNIFEM), WHO and UNFPA.
- Harmonization for Health in Africa, a regional mechanism involving the African Development Bank, UNAIDS, UNFPA, UNICEF, WHO and the World Bank, is facilitating evidence- and country-based planning, costing and budgeting; alignment with country processes and harmonization; and removal of health system bottlenecks. The initiative is aligned with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action.
- The UN Social Protection Floor Initiative is promoting nationally defined strategies that protect a minimum level of access to essential services and income security for all.
- Health 8 (also known as H8) is supporting global efforts to reach the health-related MDGs. This informal group comprises the principals of eight health organizations—WHO, the Global Alliance for Vaccines & Immunisation (known as GAVI), the Global Fund to Fight AIDS, Tuberculosis and Malaria, The William and Melinda Gates Foundation, UNFPA, UNICEF and the World Bank.
- Also important are the initiatives of private foundations. In June 2010, the Gates Foundation announced a commitment to spend \$1.5 billion through 2014 on family planning; healthcare for pregnant women, newborns, and children; and nutrition.
- In the United States, newly elected President Obama revoked the ‘Global Gag Rule’, thereby allowing NGOs to receive U.S. funding if they use other revenue sources to fund legal abortion services. It also allows these NGOs to provide information, referrals and counselling on safe abortion options and participate in advocacy to improve service access, while maintaining constraints on U.S. funds. On another front, President Obama and Congress worked together to restore funding to UNFPA. They also initiated PEPFAR2 (the President’s Emergency Plan for AIDS Relief), which gives higher priority to integrating action on AIDS with progress on sexual and reproductive health than its predecessor. In 2009, the President announced the Global Health Initiative, which will provide significant additional funds over six years to strengthen health systems, with a particular focus on improving the health of women, newborns and children.<sup>81</sup>
- In May 2010, the UN Secretary-General initiated discussions to launch the Strategy for Women’s and Children’s Health at the time of the High-Level Plenary Meeting of the General Assembly (known as the MDG Summit) in September. This initiative gives high political priority to progress, particularly on MDGs 4 and 5. It recognizes the

need to enhance financing, strengthen policies and improve service delivery to address maternal and child health as a core component of health-system strengthening. It also seeks to improve mutual accountability by better monitoring and evaluating outcomes. The objective is to identify approaches that can foster effective action locally and to scale them up.

## Improvements in maternal health

The 2015 target for maternal mortality is a reduction of three quarters from the 1990 level. To accomplish this will require an annual decrease in maternal mortality of roughly 5.5 per cent worldwide. Yet the current rate of reduction is under 1 per cent globally and a mere 0.1 per cent in sub-Saharan Africa.<sup>82</sup>

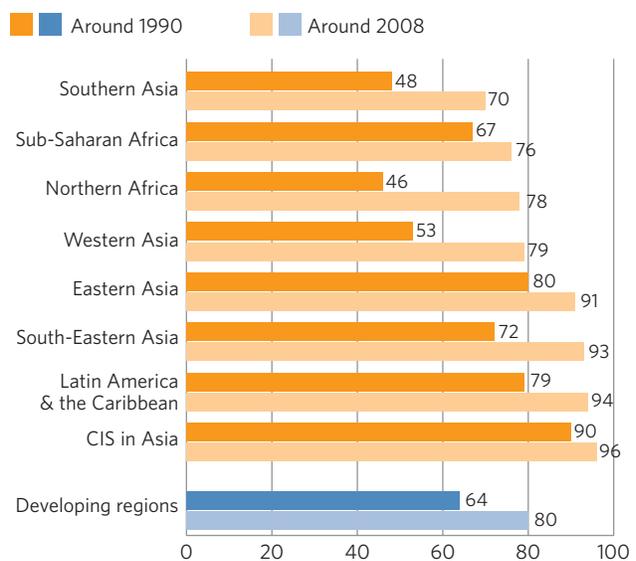
Until recently, studies indicated that maternal mortality was not declining, but rather remaining steady at half a million deaths per year. A new analysis, published by *The Lancet* in April 2010, has suggested that maternal deaths fell from 526,300 in 1980 to 342,900 in 2008.<sup>83</sup> The study found the largest declines in maternal mortality and morbidity in parts of Latin America, North Africa and the Middle East, and South and South-Eastern Asia, with some exceptions. Nonetheless, progress has been uneven, and stark disparities among and within countries persist. One in 22 women in sub-Saharan Africa die from causes related to pregnancy and childbirth, compared to one in 280 in Latin America and the Caribbean and one in 5,900 in developed countries.<sup>84</sup> More than 50 per cent of all maternal deaths are found in only six countries: Afghanistan, the Democratic Republic of the Congo, Ethiopia, India, Nigeria and Pakistan. *The Lancet* reports that in 2008 the highest maternal mortality ratio was in Afghanistan,<sup>85</sup> which was 1,575. This was 394 times higher than in Italy, the country with the lowest ratio of 4. The study also showed that the proportion of maternal deaths that occurred in sub-Saharan Africa as a region had risen dramatically, from about 23 per cent in 1980 to 52 per cent in 2008, due to the high death rate from HIV there and to declines in maternal mortality elsewhere, especially in Asia. While increases in sub-Saharan Africa were partially due to HIV, in Central and West Africa the maternal mortality ratio would have increased even without the HIV epidemic.<sup>86</sup> New United Nations estimates (in a forthcoming publication) differ in the details, but confirm an overall pattern of significant, but insufficient, progress on reducing maternal mortality.

*New United Nations estimates confirm an overall pattern of significant, but insufficient, progress on reducing maternal mortality*

Countries that show decreases in the maternal mortality ratio are also those with falling total fertility rates.<sup>87</sup> This is likely due to the direct effect of fewer pregnancies and births, which would reduce the risk of maternal death and disability, as well as factors that influence both fertility rates and maternal mortality ratios, such as access to sexual and reproductive health services, higher levels of education for women and poverty alleviation.

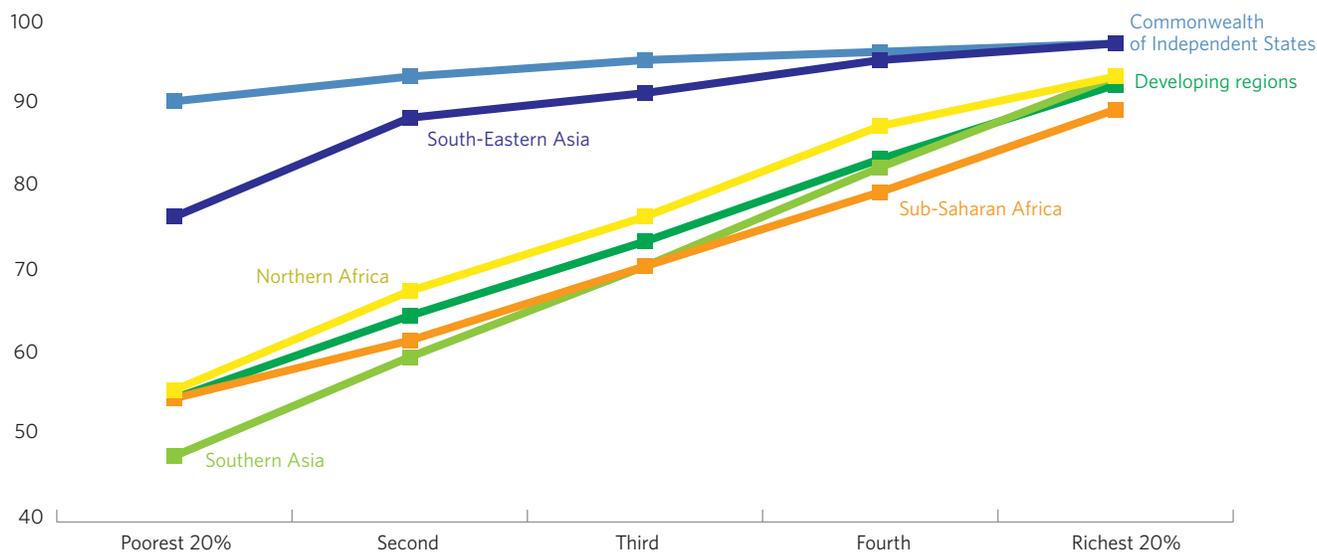
It is clear that widely recognized methods for reducing maternal mortality and morbidity can save thousands of lives and should be more widely implemented. An examination of the programmatic details that have had the greatest impact, and the policy and programme differences between successful and unsuccessful national efforts, is already under way and will intensify. These lifesaving measures involve a full continuum of care, from pre-pregnancy through post-delivery and include: 1) contraceptive services and counselling; 2) quality maternal

**FIGURE 5**  
More women are benefiting from skilled antenatal care



Proportion of women attended at least once during pregnancy by skilled healthcare personnel, around 1990 and around 2008 (Percentage)

Source: United Nations: *Millennium Development Goals Report 2010*.

**FIGURE 6****Substantial differences are found in antenatal care coverage by household wealth**

Proportion of women attended at least once during pregnancy by skilled healthcare personnel, by household wealth quintile (Percentage)

Source: United Nations: Millennium Development Goals Report 2010.

healthcare, including antenatal, assisted delivery and emergency obstetric services, and care for mothers and newborns following delivery; and 3) access to safe abortion services, where not against the law, and reduction of unsafe abortion. Progress towards increasing access to voluntary family planning is discussed further on. Recent advances on the other important strategies follow.

### Provision of antenatal care

Encouraging progress has been made in care during pregnancy. The regions with the greatest increases are Northern Africa, where the share of women who made at least one antenatal visit during pregnancy increased by 70 per cent, and Southern Asia and Western Asia, with reported increases of nearly 50 per cent (see Figure 5). Also promising is the fact that inequities between rural and urban areas have declined, although disparities are still significant. In developing countries, only one third of women living in rural areas make the four antenatal care visits recommended by WHO and UNICEF.<sup>88</sup> The gap between rich and poor is also significant in several regions for both low levels (at least one visit; see Figure 6) and the recommended level of care. In South Asia,

an average across four countries (Bangladesh, India, Nepal and Pakistan) shows that only 13 per cent of women in the poorest fifth of the population make four or more antenatal visits, compared to 65 per cent of the wealthiest women. In the Middle East and Northern Africa, an average across four countries (Egypt, Jordan, Morocco and Yemen) shows that 32 per cent of the poorest women and 74 per cent of the wealthiest women make multiple antenatal visits.<sup>89</sup>

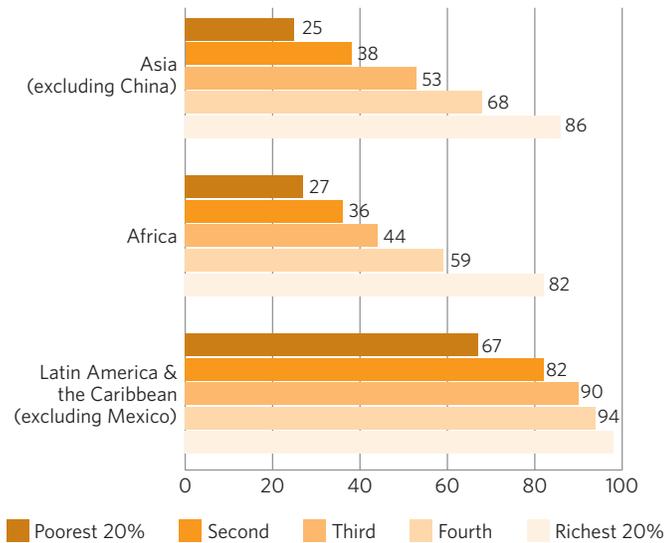
### Attendance by skilled providers

Substantial progress has been made in the proportion of women who are attended by trained health workers during childbirth in developing countries, which rose from 53 per cent in 1990 to 63 per cent in 2008. Progress was especially notable in Northern Africa, with an increase of 74 per cent, and South-Eastern Asia, with an increase of 63 per cent. Southern Asia also expanded coverage significantly, although in both that region and in sub-Saharan Africa fewer than half of deliveries are attended by skilled providers. Also encouraging is the fact that the gap between urban and rural areas is declining almost everywhere. Inequities based on wealth, however, persist (see Figure 7). In sub-Saharan Africa and Southern Asia, where coverage for assisted childbirth is lowest, the gaps between rich and poor are the largest; wealthy women are five times more likely in Southern Asia and three times more likely in sub-Saharan Africa to give birth with a skilled provider present than

*Encouraging progress has been made in antenatal care, although disparities are still significant*

**FIGURE 7**

**The poorest women in all regions are the least likely to deliver their babies in a health facility**



Percentage of delivery in facilities by household wealth, by region, 2008

**Source:** Guttmacher Institute and United Nations Population Fund, 2009: *Adding It Up: The benefits of investing in family planning and reproductive health.*

the poorest women.<sup>90</sup> For example, in Bangladesh in 2004, only 3 per cent of the poorest women were attended during delivery by a trained health worker, versus 39 per cent of the wealthiest fifth of the population. In Chad, during the same year, only 1 per cent of the poorest women gave birth with a trained provider, compared to 51 per cent of the wealthiest women.<sup>91</sup>

*Substantial progress has been made in the proportion of women who are attended by trained health workers during childbirth, though inequities based on wealth persist*

**Lower fertility levels and increasing contraceptive use**

Over the last quarter century, women have started having fewer children in many regions. In most developed countries, fertility levels are now below replacement—that is, the level, adjusted for child mortality, which allows a generation to replace itself in the total population.<sup>92</sup> After dramatic declines since the 1960s, fertility rates in much of the developing world have continued to drop more gradually, from 3.1 in 1995 to 2.7 children in 2005, if China is included.<sup>93</sup> Nonetheless, in the least developed countries, fertility levels are still high, estimated at 4.4 children per woman in 2005-2010.<sup>94</sup> Furthermore, fertility declines have slowed in recent years in many regions. In sub-Saharan Africa, particularly, fertility rates have remained very high at about five children per woman.<sup>95</sup> Countries with the highest fertility levels, such as Burundi, Mali, Niger, Sierra Leone and others, also face high child mortality rates and very low per capita incomes.<sup>96</sup> In other countries, huge disparities in fertility rates reflect social and economic inequities. For example, in some Latin American countries, the wealthiest women have fertility rates comparable to European countries, while the fertility rates of the poorest women resemble those of least developed countries.

**Box 6** Returns on reproductive health programmes in Bangladesh go beyond declining fertility

Research in Bangladesh compared villages that had received door-to-door family planning and maternal and child health programmes from 1977 to 1996 with villages in the same area that had not. Data showed that while significant fertility decline was observed in both areas from 1981 to 1996, fertility in the programme villages was consistently about 15 per cent lower than in the control villages during this period. Researchers also looked at other outcomes affecting well-being, such as women's health, household income and assets, use of preventive health inputs, and the intergenerational effects on the health and education of children. Over the 20 years studied, many of these indicators of well-being had improved significantly, suggesting that returns to reproductive health programmes went well beyond declining fertility.

**Source:** Schultz, T. Paul, and Shareen Joshi. February 2007. *Family Planning as an Investment in Development: Evaluation of a program's consequences in Matlab, Bangladesh.* Discussion Paper No. 951. Yale University Economic Growth Center, and Discussion Paper No 2639, Institute for the Study of Labor.

## Box 7 Women and children are dying for lack of care in the Congo

The following was extracted from a 19 May 2010 column in the *New York Times* by Nicholas Kristof, reporting from the Democratic Republic of the Congo:

*Here in Kinshasa, we met Emilie Lunda, 25, who had nearly died during childbirth a few days earlier. Doctors saved her life, but her baby died. And she is still recuperating in a hospital and doesn't know how she will pay the bill.*

*"I didn't want to get pregnant," Emilie told us here in the Congolese capital. "I was afraid of getting pregnant." But she had never heard of birth control.*

*In rural parts of Congo Republic [known officially as the Congo], the other Congo to the north, we found that even when people had heard of contraception, they often regarded it as unaffordable.*

*[All] the clinics and hospitals we visited in Congo Republic said that they would sell contraceptives only to women who brought their husbands in with them to prove that the husband accepted birth control.*

*Condoms are somewhat easier to obtain, but many men resist them. More broadly, many men seem to feel that more children are a proud sign of more virility.*

*Parents want many children partly because they expect some to die. So mosquito nets, vaccinations and other steps to reduce child mortality also help to create an environment where family planning is more readily accepted.*

*In short, what's needed is a comprehensive approach to assisting men and women alike with family planning—not just a contraceptive dispensary.*

*Romerchinelle Mietala, a 17-year-old girl in Mindouli, Congo Republic, has one baby and told us that she doesn't really want another child for now. But she had never heard of contraceptives and, when we explained, was ambivalent. She worried about her status in the village if she didn't get pregnant again reasonably soon.*

*"If a woman doesn't have a baby every two or three years, people will say she's sterile," she said.*

*Another woman in Mindouli, Christine Kanda, said that she is ready to stop now after eight children—two of which have died. But she doesn't know if her husband will accompany her to the clinic to sign off, and she doesn't know how she would pay the \$1 a month that the hospital charges.*

### Access to contraceptive services, commodities and counselling

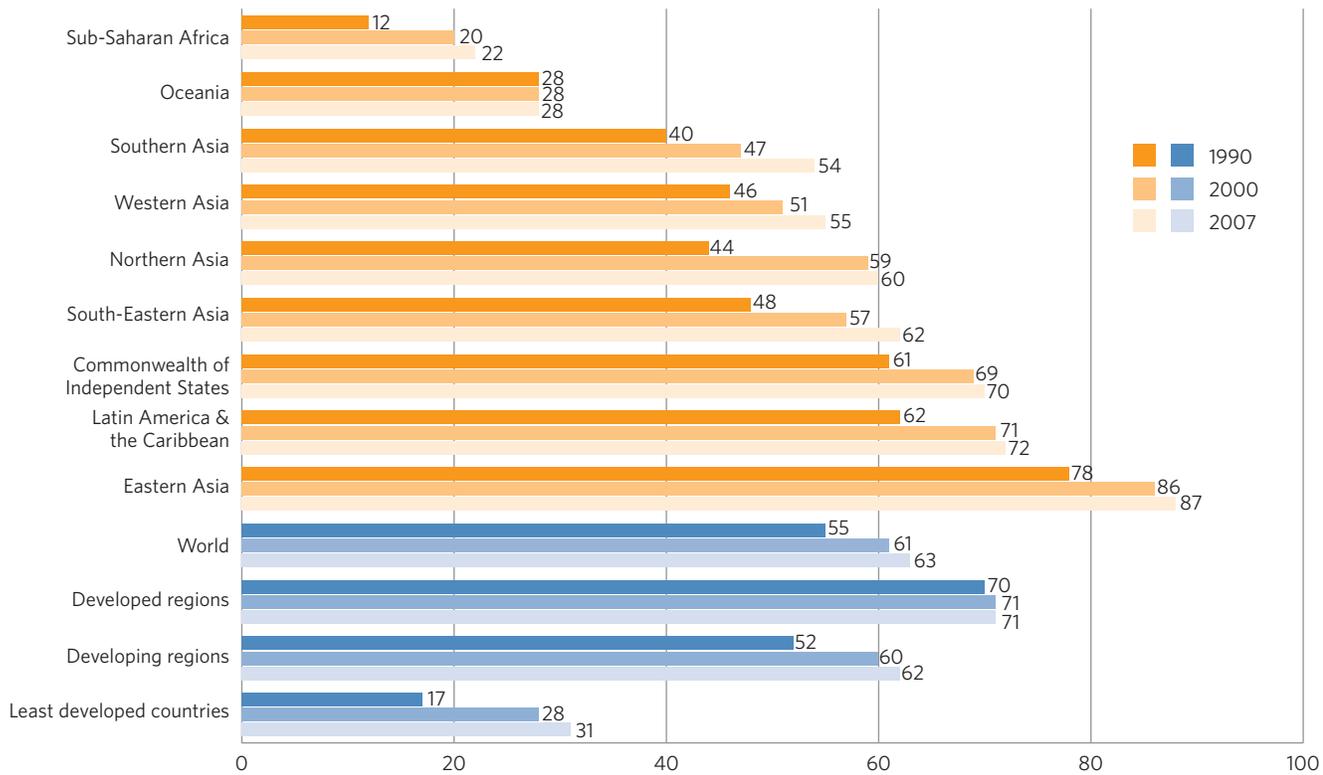
The use of all forms of contraception has increased dramatically since the introduction of oral contraceptives in the 1960s, although growth has slowed in recent years (see Figure 8). In 2007, 63 per cent of women around the world who were married or in union and between the ages of 15 and 49 used modern methods of contraception, versus 55 per cent in 1990.<sup>97</sup> Family planning helped reduce the rate of unintended pregnancies by 20 per cent in developing countries from 1995 to 2008. Moreover, use of modern contraceptives in

2008 alone prevented the deaths of 1.2 million newborns and 230,000 women.<sup>98</sup> Still, contraceptive use remains very low in some countries, especially in sub-Saharan Africa, where it rose from 12 per cent in 1990 to 20 per cent in 2000 and stood at just 22 per cent in 2007.<sup>99</sup>

*Use of modern contraceptives in 2008 alone prevented the deaths of 1.2 million newborns and 230,000 women*

**FIGURE 8**

**Gains in women’s use of contraception have slowed in many regions**



Percentage of women who are using any method of contraception among women aged 15-49 who are married or in union, 1990, 2000 and 2007

Source: Data from the United Nations Population Division.

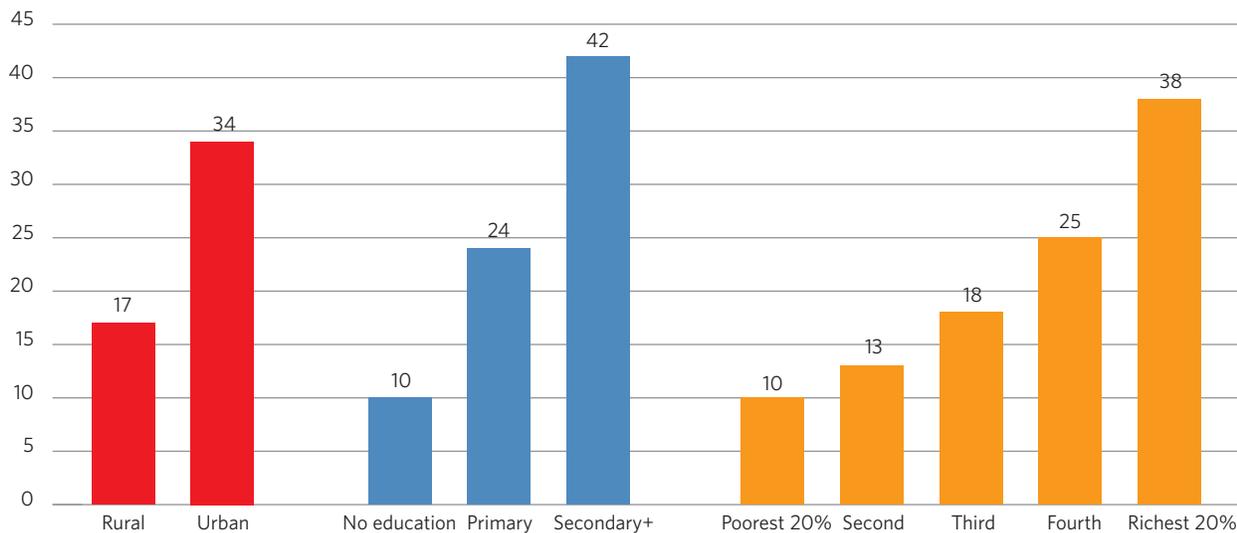
Disparities have persisted or even grown within countries. For example, contraceptive prevalence among women in the wealthiest fifth of households is roughly four times that of the poorest fifth throughout sub-Saharan Africa (see Figure 9). In many countries around the world, the wealthiest women use contraception at twice the rate of poorest quintile, including Bolivia (in 2003), Cambodia (in 2000), Nepal (in 2001), Mozambique (in 2003) and Turkey (in 1998). In some countries, the gap is even greater. In Guatemala (in 1998/1999), for instance, contraceptive prevalence among the richest 20 per cent of women was ten times that of the poorest quintile. In Cameroon (in 2004), the rates were 27.2 compared to 2.4.<sup>100</sup>

**Unmet need for family planning**

Many of the estimated 215 million women who have an unmet need for family planning would use contraceptives to prevent or delay pregnancy if they had the proper informa-

tion and access to effective family planning services. (See description of package of services under ‘Scaling up approaches that work’, below, for more on what constitutes ‘effective’.) In least developed countries, an estimated 24 per cent of women of reproductive age who are married or in union have an unmet need for contraceptive services, versus 11 per cent in developing countries overall.<sup>101</sup> However, a large deal of uncertainty exists about the current level of unmet need: while data are available for many of the countries where unmet need is likely highest, major gaps remain. Furthermore, if data on women who are single are included, unmet need would be significantly higher. Current data show that, globally, the unmet need for family planning has remained almost constant, declining from 13 per cent in 1990 to 11 per cent in 2007.<sup>102</sup>

Unmet need varies widely across and within regions. In a 2007 report, the level of unmet need in Latin America and the Caribbean ranged from a low of 6-7 per cent in Brazil and

**FIGURE 9****Poorer, rural and less educated women have less access to contraceptives in sub-Saharan Africa**

The percentage of women, married or in union, of reproductive age using any method of contraception, by background characteristics, 24 countries in sub-Saharan Africa, 1999-2008

**Source:** United Nations Population Fund, 2010: *How Universal is Access to Reproductive Health? A review of the evidence.*

Colombia to 40 per cent in Haiti, the highest level of unmet need among the 53 countries studied. Unmet need in South and South-Eastern Asia ranged from 5 per cent in Viet Nam to 26 per cent in Cambodia.<sup>103</sup>

Unmet need often declines little or stays intact as a result of the combination of growing demand and weaknesses in the health system. In some countries, more than 40 per cent of women of reproductive age have an unmet need for contraception, a figure that may grow as the population of women of reproductive age expands, and/or as more women express a desire to space pregnancies or have smaller families. In regions with the highest levels on unmet need—South-Central Asia and sub-Saharan Africa—the number of women unable to fulfil their desire for contraception is growing as populations swell. Globally, the number of women of reproductive age will increase from 1.3 billion in 1990 to 2.1 billion in 2050.<sup>104</sup> Rwanda, for example, succeeded in increasing contraceptive prevalence from 10 per cent to 27 per cent between 2005 and 2008, yet unmet need remains high because of growing demand.<sup>105</sup> An exceptionally high 49 per cent of women report not wanting another child,<sup>106</sup> and 36 per cent of women wish to postpone their next birth by at least two years.<sup>107</sup> In general, awareness of contraception has grown over the last few decades among women with an unmet need, but so too have concerns about actual or rumoured health risks of contraceptives.<sup>108</sup>

*In some countries, more than 40 per cent of women of reproductive age have an unmet need for contraception*

### Proportion of demand satisfied

Contraceptive use and unmet need levels together define the total level of demand for family planning (that is, the proportion of women who want to delay or limit their births, rather than have another child within the next two years). The share of total demand being fulfilled by contraceptive use is the ‘proportion of demand satisfied’. This is useful to monitor, since the components are themselves dynamic. Fertility desires may fall due to short-term and long-term changes, such as temporary economic challenges or more lasting shifts in social norms. The ability to access contraceptive services also changes as delivery systems improve or falter.

This method of combining indicators provides the opportunity to look more closely into the dynamics of trends. The basic inequalities in service access suggested by rates of contraceptive prevalence and unmet need are heightened in an analysis of demand satisfied, which offers some conclusions that are relevant for policy-makers and programmers:

## Box 8 Training midwives in Indonesia leads to improvements in maternal and child health

Research in Indonesia found that access to a trained midwife in poor communities improved the health of both women and their babies. In the 1990s, a government programme trained approximately 50,000 midwives, who then went to work in relatively poor and remote communities. The study found that the presence of a midwife in a village was associated in increased body mass for women of reproductive age and higher birthweights for infants.

**Source:** Frankenberg, Elizabeth, and Duncan Thomas. May 2001. 'Women's Health and Pregnancy Outcomes: Do services make a difference?' *Demography*, vol. 38, no. 2, pp. 253-265.

- Although desires regarding family size differ among various subpopulations (and are influenced by place of residence, education and income level), differences in the ability to achieve one's intentions are relatively even larger.
- Once fertility transitions develop,<sup>109</sup> the ability of health systems to meet reproductive health needs becomes more important in predicting outcomes.
- The relatively wealthy (the richest 20 per cent of households) everywhere are almost always able to fulfil their desires regarding contraceptive use. This ability decreases as relative wealth diminishes. Similarly, the youngest cohorts and rural populations are particularly disadvantaged.
- In many countries with data that allow comparisons over time, the disparities in effective service access are increasing, even where there is improvement overall among many groups.

### Addressing unsafe abortion

Unsafe abortion is the cause of at least 13 per cent of maternal deaths globally. In some regions, such as Latin America, it is a leading cause of death among women. In 2003, almost half of all abortions globally were unsafe and nearly all of these were in developing countries.<sup>110</sup> Abortion can be unsafe when performed by unskilled people or when medical emergency services are inadequate.

*In 2003, almost half of all abortions globally were unsafe and nearly all of these were in developing countries*

As discussed previously, several countries have liberalized laws regarding abortion in the last decade. In some cases, the lifting of restrictions has resulted in lowering the incidence of complications, although legal change alone is not sufficient. Reducing complications from unsafe abortion also requires increased access to family planning, including emergency contraception, quality services for abortion care (as allowed by law) and post-abortion care. Between 1995 and 2003, the number of induced abortions worldwide decreased, from nearly 46 million to about 42 million. The largest drop in the abortion rate took place in Eastern Europe, where it fell by roughly half, from 90 to 44 abortions per 1,000 women of reproductive age. The decrease corresponded with significant increases in contraceptive use. (Abortion is generally allowed by law and is safe in Eastern Europe.)<sup>111</sup>

## Progress among adolescents in sexual and reproductive health

### Adolescent pregnancy and childbearing

The world's largest cohort of adolescents faces significant challenges in accessing sexual and reproductive health information and services, despite some progress over the last several years. The adolescent birth rate (the number of births per 1,000 women aged 15 to 19) in developing countries decreased from 65 in 1990 to 55 in 2000. Since 2000, however, the rate has reached a plateau and has remained at 53 per 1,000 in 2007. Sub-Saharan Africa has the highest level (121 births) and has seen little reduction in the rate. High levels also persist in Latin America, the Caribbean, Oceania and much of Southern Asia.<sup>112</sup> Worrying, too, is that disparities in the adolescent birth rate are actually widening. In sub-Saharan Africa, declines have been seen among adolescents in urban areas,<sup>113</sup> while rates may be increasing for the poorest and least educated girls. (For a fuller discussion on trends and disparities, see *How Universal is Access to Reproductive Health? A review of the evidence*, published by UNFPA in September 2010).

### Early marriage

The average age at which people marry has been on the rise, helping to simultaneously bring down fertility rates and bring about improvements in health and educational attainment, particularly in parts of Asia and Northern Africa. That said, many women in developing countries still marry at a very young age: about one in four girls aged 15 to 19 in the

## Box 9 Argentina improves post-abortion care

Complications resulting from abortions have been the leading cause of maternal death in Argentina for more than 25 years. With a maternal mortality rate of 44 for every 100,000 live births, two-and-a-half times the rate in the neighbouring countries of Chile and Uruguay, Argentina is falling short of achieving the goal of cutting maternal mortality by three quarters by 2015. Abortion is severely restricted by law and women are prosecuted. Poor women cannot afford clandestine abortions in private clinics and must resort to abortions under unsafe conditions. They often end up in hospitals with potentially life-threatening complications. Most are young—between 20 and 29 years old—and many are adolescents.

In response, Argentina's Ministry of Health, with support from UNFPA and the United Nations Development Programme (UNDP), undertook a project to improve quality of care for abortion complications, aimed at strengthening the capacity of public hospitals in Argentina to provide comprehensive care for women with incomplete abortions. In the first phase (2007-2008), providers were trained in a comprehensive post-abortion care model. Elements of the training covered pain management, using analgesics before the procedure and anaesthesia during it, as appropriate. The model emphasizes privacy and confidentiality, with a guarantee that women will not be reported to the police. It stresses the provision of other reproductive-healthcare services to women in the hospital for abortion complications, including counselling on and provision of contraceptives.

In a second phase (2009-2010) the project was expanded to additional provinces. It also created links between civil society organizations and public health services in an effort to reduce unwanted pregnancies and unsafe abortions and to build capacity to refer women for appropriate and timely care.

As a result of the project, waiting times and total time spent in the hospital have been reduced. Women are offered sexual and reproductive health information and services, including contraceptive methods and counselling. In each province, one person is responsible for replicating the training, thereby increasing the potential for sustainability and expansion. Now, a clinical history of each woman's sexual and reproductive health is recorded and a national system has been established to collect data on the care women receive.

**Source:** United Nations Development Group. 2010. MDG Good Practice. See: [www.undg-policynet.org/?q=node/11](http://www.undg-policynet.org/?q=node/11), accessed 20 August 2010.

developing world (excluding China) are married.<sup>114</sup> According to UNICEF, in 2007 approximately 36 per cent of women aged 20 to 24 had married before the age of 18, most of them in South Asia and sub-Saharan Africa.<sup>115</sup> Inequities persist. Child marriage, for example, is twice as high in rural areas as in cities.<sup>116</sup> Voluntary choice of a marital partner has long been recognized as a human rights issue, yet exercising this right is not yet universally guaranteed.

*The average age at which people marry has been on the rise, though one in four girls aged 15 to 19 in the developing world (excluding China) are married*

### Sexuality education

Evidence shows that young people want information and education about sexual and reproductive health, including HIV. Studies also find that sexuality education does not promote

early or risky sexual activity. In fact, research confirms that programmes in these areas have a positive impact on young people's initiation into and frequency of sex, the number of sexual partners they have, whether or not they use condoms and other sexual behaviour. A 2008-2009 review commissioned by UNESCO looked at 87 studies (of 85 interventions designed to reduce STIs/HIV and/or unintended pregnancies) from around the world that met defined criteria. The programmes were curriculum-based, either for use in schools, in clinics or in the community. Twenty-nine of the studies were from developing countries, 47 from the United States and 11 from other developed countries. The review examined the impact of these programmes on sexual behaviour that directly affects pregnancy and STI/HIV outcomes. It found that roughly one third of the interventions resulted in delayed sexual initiation (37 per cent), less frequent sexual intercourse (31 per cent), or decreased numbers of sexual partners (44 per cent). The review also ascertained that 40 per cent of the interventions resulted in an increase in the use of condoms or

## Box 10 Mothers and daughters in Viet Nam learn to speak more openly about sex

Like many countries in the developing world, Viet Nam's population is young, with more than half of its 86 million people under the age of 25. The expanding HIV epidemic affects youth disproportionately: more than half of those living with HIV are between the ages of 20 and 29. Viet Nam has one of the highest abortion rates in the world, with an estimated 30 per cent among unmarried women.

Until recently, sexuality education was very limited and attitudes towards sexual and reproductive health and HIV were harshly judgemental. HIV was linked with sex work and drug use, and regarded as a 'social evil'. Parents believe that sexuality education will 'show the deer the way to run'—that is, encourage adolescents to initiate sexual activity.

But attitudes and actions have begun to change, thanks in part to national policies. A national Action Plan for Reproductive Health and HIV/AIDS Prevention seeks to bring comprehensive sexuality education to students in secondary school. In addition, pilot projects are being developed to address gender, sexuality and rights, which can then be documented, replicated and scaled up.

The Creating Connections programme, for example, aims to promote a more open mother-daughter dialogue on sexuality, reproductive health and rights, and gender. The programme was initially piloted by the Women, AIDS and Reproductive Health Centre (WARC) of the Viet Nam Women's Union, working together with an Australian university, a local NGO and supported by a private foundation.<sup>119</sup>

In the project's first phase, clubs for girls and for mothers were established in three provinces. The two sets of clubs work independently on a curriculum that covers the distinction between gender and sex, the biological aspects of sex and reproduction, puberty, STIs, including HIV, contraception and condom use, pleasure and sexual orientation. Three of the sessions stress communication and problem-solving skills, including reducing the risk of gender-based violence and negotiating safer sex.

In addition to acquiring a deeper understanding of all these issues, and skills with which to navigate into adulthood, the girls have started communicating with their mothers, peers and others in a more comfortable and confident way.

The mothers who participated report similar results: "From the second or the third club session, I had a feeling that I need to be close to my daughter, especially during adolescence. I am becoming open and close to her, which leads to her openness."

**Source:** Huynh Thi Hong Ngoc. 23 March 2009. Unpublished Master's thesis.

other contraceptives. The rest of the programmes were found to have no significant impact on these behavioural variables.<sup>117</sup>

*Research confirms that education and information about sexual and reproductive health have a positive impact on young people*

Despite evidence of the effectiveness of these programmes, many young people lack access to the comprehensive sexuality and HIV education that could give them the knowledge, information and tools they need to protect themselves and exercise their reproductive and sexual rights. A study in sub-Saharan

Africa, for example, found large differences in understanding of HIV among all women aged 15 to 19. The percentage of those who said that they knew about methods to avoid infection ranged from 26 per cent in Mozambique to 93 per cent in Rwanda. Among men in the same age group, the range was 40 per cent in Mozambique to 96 per cent in Malawi.<sup>118</sup>

## Addressing gender-based violence and harmful practices

Over the last few decades, women's movements, NGOs, researchers, governments and international organizations have focused increasing attention on gender-based violence. Researchers and activists have worked to expose levels of violence



against women and girls and to bring about change through policies and programmes. Although the *Convention on the Elimination of All Forms of Discrimination against Women* does not specifically refer to violence against women, the Committee on the Elimination of Discrimination against Women (the treaty body created in 1982 to monitor implementation of CEDAW) has emphasized that gender violence is a form of discrimination against women. The Committee frequently calls on States parties to take action on gender violence.

Throughout the 1970s and 1980s, women's organizations lobbied international conferences to recognize violence against women as a human rights violation, culminating in the World Conference on Human Rights in Vienna in 1993. Following the Vienna Conference, the UN General Assembly adopted the Declaration on the Elimination of Violence against Women, and the Commission on Human Rights appointed a Special Rapporteur on violence against women. Since then, many countries have developed policies on the issue, though implementation has lagged. A 2006 UN report found that 89 countries had passed legislation on domestic violence and some had developed national plans of action. At least 104 countries had criminalized marital rape and 90 countries had laws on sexual harassment.<sup>120</sup>

Increasingly, female genital mutilation/cutting is also being recognized as a violation of human rights. As of 2008, 18 of the 28 African countries where FGM/C is widespread had passed laws making it a criminal activity (see above).<sup>121</sup> Of nine Asian and Arab countries where FGM/C is prevalent, two had enacted laws against it. In practice, an encouraging generational trend towards ending FGM/C is evident: the adolescent daughters of women who have undergone the procedure are being cut at a much lower rate than their mothers. This is particularly important in countries where the prevalence among women is higher than 75 per cent. In Egypt and Guinea, for example, where almost all women aged 15 to 49 have experienced FGM/C, only about half of the women indicated that their daughters underwent the procedure.<sup>122</sup>

## Combating HIV

In 2008, some 33.4 million people were living with HIV worldwide, 20 per cent more than in 2000 and approximately

*Many countries have developed policies on violence against women, though implementation has lagged*

three times the number in 1990. The continual growth in the number of people living with the virus results from both new infections and the life-sustaining effect of antiretroviral therapy. The rate at which new infections are occurring globally has slowed. The number of new infections in 2008 was estimated at 2.7 million, 30 per cent lower than the number of new infections in 1996—the peak of the epidemic's growth. Among the countries reporting declines in HIV incidence are Cambodia, the Dominican Republic, Mali, the United Republic of Tanzania and Zimbabwe. One study shows that HIV prevalence is declining among young people aged 15 to 24 in 16 countries, largely due to a fall in new infections. In several high-prevalence countries where evidence suggests that the epidemic is stabilizing, behaviour changes are being seen among adolescents aged 15 to 19 (such as shifts in age at first sex, the number of sexual partners and condom use). Seventeen out of 45 countries with survey-based trend data are starting to show a steady increase in knowledge of HIV prevention among young women.<sup>123</sup>

*The number of new HIV infections in 2008 was estimated at 2.7 million, 30 per cent lower than the number of new infections in 1996*

Sub-Saharan Africa remains the most heavily affected region, accounting for 71 per cent of all new HIV infections in 2008. The epidemic appears to have levelled off in most regions, although high rates of new infections are reflected in rising prevalence in Eastern Europe, Central Asia and other parts of Asia, where epidemics once driven by injecting drug use are increasingly characterized by sexual transmission.

Tremendous strides have been made in the number of people on antiretroviral therapy. As of December 2008, approximately 4 million people in developing countries were receiving the medication, ten times the number five years earlier.<sup>124</sup> Advances in the area of treatment access are estimated to have saved 1.4 million lives since 2004, 1.1 million of them in sub-Saharan Africa. Nonetheless, coverage levels still need to increase.

Despite significant progress, the priority given to prevention remains insufficient. For every two people starting

treatment, five people are newly infected with HIV.<sup>125</sup> Prevention efforts appear to be succeeding in some places. For example, out of five countries with national household surveys in 2008, HIV incidence declined significantly in the Dominican Republic and the United Republic of Tanzania, and dropped among women in Zambia. A decline in new HIV infections among children that same year suggests that expanding coverage of programmes to prevent mother-to-child transmission is making an important difference, rising from 10 per cent of HIV-positive women in 2004 to 45 per cent in 2008.<sup>126</sup>

## Reducing sexually transmitted infections and reproductive cancers

The focus on HIV initially obscured attention to other STIs that cause illness and death, with a disproportionate impact on women and the young. The recognition that the presence of STIs increases the likelihood of HIV transmission has gradually brought greater attention to preventing and treating them.

Successful experience in several countries shows that effective STI prevention and care can be achieved by using a combination of responses, including promotion of safer sex, encouraging the use of health services for diagnosis and treatment; prevention and care at the primary healthcare level; and a case management approach. If the interventions are targeted to vulnerable groups, effectiveness is enhanced.

Progress has also been made in the development of new technologies for preventing and treating STIs, such as a new syphilis test that can be used at the primary healthcare level, thereby allowing for timely treatment. New quick and inexpensive diagnostic tools are also being developed for chlamydia. Moreover, some medicines that are effective for treatment are becoming more affordable.<sup>127</sup>

Two recently developed vaccines can protect against infection by certain strains of the human papillomavirus (HPV), a virus that causes most cervical cancers and the world's most common STI. Reaching pre-teens and adolescents with this vaccine could help to bring down rates of cervical cancer, the leading cause of cancer death among women in developing countries. Achieving this will be challenging, however, since the effort to vaccinate young girls is likely to provoke suspicion and resistance in some countries.

## Box 11 Cancer prevention and early detection are becoming the norm in Georgia

Breast and cervical cancers are the most common forms of cancer among women in Georgia.<sup>128</sup> In the early 2000s, the government focused on treatment at advanced stages of the disease. Today, the Georgia Cervical Cancer Screening Programme is offering services to promote early detection.

The programme began in 2006, when the municipality of Tbilisi, together with UNFPA, launched a pilot project for the prevention and early detection of reproductive tract cancers. Project activities included the development of national guidelines for cervical cancer screening, capacity-building training and seminars, and behaviour change campaigns.

Based on its early success, the programme in Tbilisi expanded in 2008 to cover breast cancer. The following year, the federal government decided to replicate the project at the national level. Since October 2009, the breast cancer screening programme has been operating in four regions of Georgia and the project has been expanded in Tbilisi.

As a result, and thanks to a massive communication campaign, demand for reproductive cancer screening services is growing. The public education effort included a public service announcement on television featuring popular role models, outdoor advertising on public buses and in subway stations, television talk shows, magazine articles, and the widespread distribution of flyers and booklets. More than 18,000 women are screened for cervical cancer and more than 17,000 women are screened for breast cancer each year. The quality of services has also improved significantly. The project was recognized regionally when it received the 'Pearl of Wisdom' award at the Cervical Cancer Prevention Summit in Europe. Regional collaboration has led to the creation of the Black Sea Countries Coalition on Breast and Cervical Cancer Prevention, with the aim of supporting member countries in developing prevention and early detection efforts.

The success of the project is attributed to several factors. First, the government is committed to the programme and has backed that up with the funding necessary to sustain it. In fact, government funding has risen each year, by 34 per cent in 2010 alone. Second, the programme is receiving effective managerial support from UNFPA. In its work, UNFPA emphasizes national capacity development for quality assurance and provision of quality screening services and the collection and analysis of data to identify priorities and inform future planning. An important lesson has been the importance of regional partnerships, which has led to collaboration between Georgian and European institutions and the creation of the Black Sea Coalition on Breast and Cervical Cancers Prevention to further generate political support and maintain government commitment.

**Source:** UNFPA Country Office in Georgia. For more information see: [www.unfpa.org.tr/georgia/index.htm](http://www.unfpa.org.tr/georgia/index.htm), accessed 20 August 2010.

*Reaching pre-teens and adolescents with the HPV vaccine could help bring down rates of cervical cancer, the leading cause of cancer death among women in developing countries*

Recently, research and programmatic attention has highlighted the potential role of reducing sexually transmitted infections among men as a means to reverse the HIV epidemic and other diseases. In particular, research is under way and guidelines are being formulated on the role of male circumcision within comprehensive approaches to HIV prevention.<sup>129</sup> Prevention of female-to-male transmission is the focus of this

work. Less well established, and the subject of active research, is the role of male circumcision in preventing male STIs (a co-factor for HIV transmission) and their transmission.<sup>130</sup> Initial research suggests that male circumcision reduces men's risk of HPV infection.<sup>131</sup> Reduction of sexually transmitted infections in men and women by various means will provide multiple benefits.

## Promoting male involvement

Despite growing recognition that men need to be involved in sexual and reproductive health, both as partners and for their own benefit, progress has been slow. Men are more likely to initiate sex before marriage than women and have multiple partners, so reaching them is critical. Studies show

that communication between women and men improves contraceptive use and outcomes. It is also essential for reducing the transmission of STIs, including HIV. Yet male condom use is still low. The percentage of sexually active boys using condoms is under 50 per cent in most countries, in one account ranging from 50 per cent in Zambia down to 20 per cent in Mali.<sup>132</sup> Few men take full responsibility for preventing unwanted pregnancy. Globally, vasectomy accounts for only 20 per cent of total sterilization.<sup>133</sup> And condoms constitute only about 6 per cent of total modern methods used,<sup>134</sup> pointing to the fact that contraception is still left largely to women.

*Despite growing recognition that men need to be involved in sexual and reproductive health, progress has been slow*

In addition to addressing their own reproductive health needs (including adopting male methods of family planning and preventing the spread of STIs), men can promote and support women's health and empowerment in a variety of ways: for example, by combating gender stereotypes and discrimination, eschewing and reducing gender-based violence and advancing positive attitudes, behaviour and role models. They can discuss with their partners optimal family size and the timing of their children, and treat both male and female children equally. A man can support his partner's access to health services—including contraception, antenatal care, skilled birth attendance and post-partum care—and tend to her nutritional needs as well as those of their children. Men can also become informed about women's health needs and services and help plan for access to emergency obstetric care, should delivery complications develop.

## Using new technologies for the advancement of sexual and reproductive health

### Contraceptive technology

Contraceptive technology has progressed over the past 15 years, with improvements in existing methods, but also the development of new ones. Hormonal contraceptives have been diversified, with a variety of birth control pills (including low-dose pills), patches, injectables and implants; devel-

opments in emergency contraception have advanced; male condoms have been improved and female condoms have become more acceptable and more widely available. These improvements have resulted in more choices for women, higher degrees of safety and efficacy, and additional modes of delivery. Funding for contraceptive research and development, however, is insufficient, and more needs to be done on male methods. Progress has also been made in the treatment of infertility.

### Mobile phones and other communications technologies

Mobile phones are the fastest growing technological commodities in developing countries, and their effectiveness in improving health outcomes has been established in many low- and middle-income countries. Their expanding availability has created opportunities to increase access to health-related information, educate adolescent girls and young married women about birth preparedness, improve the quality of care offered by healthcare providers through checklists, in-service e-learning, and follow-up of people living with HIV. In addition, programme managers can use mobile phones to keep track of supplies that women need, thereby improving logistics systems and ensuring reliable access. Similarly, community health workers, families and individuals can use mobile phones to get information on the availability of supplies at service delivery points. Women and their families, as well as birth attendants, can use mobile phones to obtain information on emergency obstetric first aid that can help stabilize a woman's condition while further care is being accessed, as well as to call for transport (where available) to sites providing emergency obstetric care.

*The effectiveness of using mobile phones to improve health outcomes has been established in many low- and middle-income countries*

The proliferation and use of mobile technologies is also helping to meet the need for effective registration systems in developing countries (to record births and deaths, for example) and to develop reliable methods of collecting data that can be used to monitor progress. For example, such technologies have made it possible to collect, process, analyse and disseminate results in a timely fashion, thereby improving the

monitoring of violence against women and the surveillance of adverse outcomes during delivery, such as obstetric fistula and maternal deaths. Capturing data resulting from large household surveys is now a routine practice,<sup>135</sup> and the effectiveness and reliability of using hand-held computers to conduct verbal autopsies (verbal determination of causes of maternal death) have been established.<sup>136</sup>

Mobile phones are also helping to address another bottleneck in monitoring progress in maternal health, which is the lack

of reliable methods for tracking changes in the short term. It is not feasible to conduct routine weekly or even monthly analyses of trends in maternal deaths, and this has weakened national and global accountability efforts. The use of mobile phones makes possible timely notification of maternal and newborn outcomes, thereby demonstrating progress in the short term and enabling evaluation of maternal-and-child health interventions and policies, as well as evidence-based advocacy efforts.

# What are the obstacles to progress?

As illustrated in the previous chapter, progress is being made in universal access to reproductive health. Nevertheless, those excluded by poverty, gender, ethnicity, disability, residency status, situations of conflict or other forms of marginalization are often left behind. The reasons are not hard to find, but ultimately point to the low status accorded to women and girls, flagging political commitment and inadequate resources. Compounding the problem are weak, overburdened and understaffed health systems. Reaching those hardest to reach with much-needed information and services has likewise proven a formidable challenge. As a result, progress tends to be concentrated among those who are better off economically, have more education and live in urban areas.

## Lack of political commitment

Investing in sexual and reproductive health for all requires tackling constraints at many levels: in the household and community, within the health-service delivery system, at the health-sector level, in broader policies and public institutions, and among donors and international organizations.

The quality of governance at national and local levels is crucial. Good governance means that governments have the commitment, credibility and capacity to devise and implement sound policies, which directly affect the potential for strengthening health systems and for creating an environment that makes universal access to them possible. A recent World Bank paper found that countries with the highest levels of fertility and maternal mortality consistently rank lower in assessments of governance.<sup>137</sup> Conversely, countries that have succeeded in improving maternal health and lowering fertility rates have governments that exhibit leadership and commitment to these issues.



Impeding progress has been the wavering commitment of national governments to sexual and reproductive health and reproductive rights: most government promises have not been followed up with the necessary funding and action. Ministries of health and of finance would benefit from working together more closely to build an understanding of each other's needs and priorities. Country case studies have noted that different institutional perspectives can be better addressed by improved communication and collaboration among different government ministries and agencies, including health expert representation in planning and budgeting bodies.<sup>138</sup>

## Recent trends in funding

### Sector-wide approaches, vertical programming and fewer resources for sexual and reproductive health

In recent years, donors have moved away from funding specific projects or health concerns to providing broader health-sector support. The sustainability of this trend in tight economic circumstances is uncertain, as accountability to taxpayers rises in priority. Notwithstanding this uncertainty, the intention has been to use a structural approach to address underlying causes of poverty and to support strengthening of the health system as a whole. But it also has meant that particular and important aspects of health, such as reproductive health, including family planning, have been neglected in recent years. At the same time that donors have moved away from supporting specific reproductive health programmes, funding for HIV/AIDS has multiplied, especially for treatment, contributing to the lack of integration across health and development concerns.

International aid for reproductive health (excluding HIV/AIDS), in particular for family planning, has, in fact, declined (see Figure 10). Donor assistance covers only a fraction of the cost of reproductive health activities, and less than half of the share pledged at ICPD. While development assistance for health overall nearly tripled between 2000 and 2008, aid

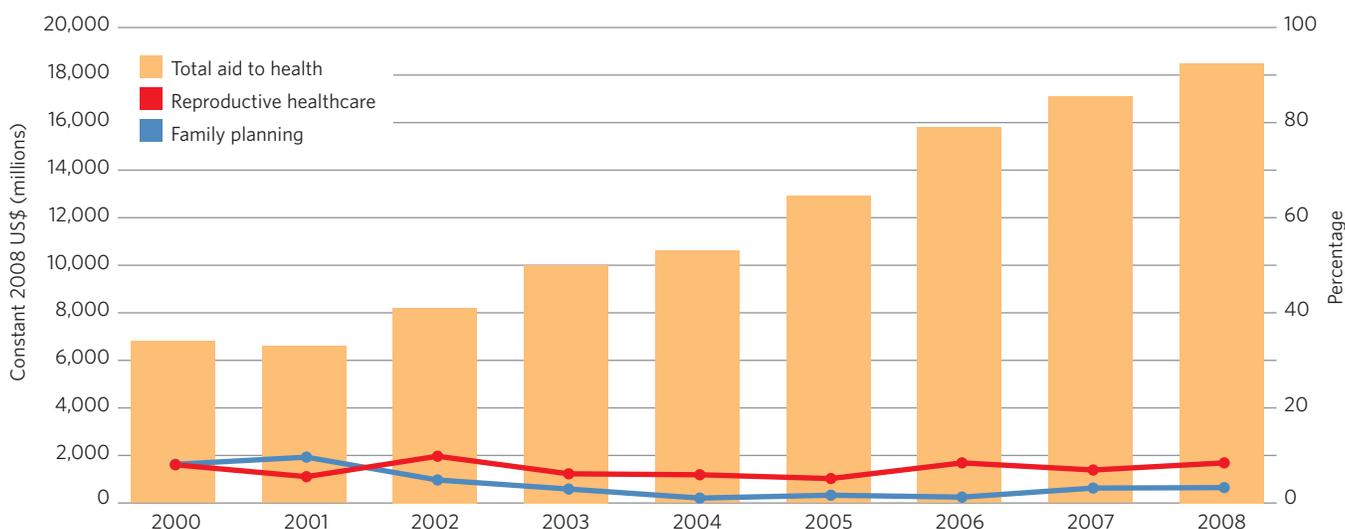
for reproductive health, especially family planning, lagged behind. According to data from UNFPA and the Netherlands Interdisciplinary Demographic Institute, family planning funding reached historic highs of over \$700 million in 1995, 1998 and 2002.<sup>139</sup> Donor investment in this critically important area actually fell to \$394 million in 2006 and has made only a small recovery.<sup>140</sup> At the same time, the total number of women of reproductive age has grown, as has the percentage of those who want to prevent or delay pregnancy. At the World Bank, for example, the share of the health portfolio that goes to reproductive health dropped from 18 per cent in 1995 to 10 per cent in 2007.<sup>141</sup> Furthermore, analysis of reproductive health issues has rarely been incorporated into World Bank poverty assessments.<sup>142</sup>

*Donor investment in the critically important area of family planning fell by nearly half from 2002 to 2006, as the total number of women of reproductive age has grown*

Another challenge, especially for countries highly dependent on foreign assistance, is the unpredictability and inconsistency of funding from year to year, making effective planning

**FIGURE 10**

**Funding for family planning has declined since 2000, while overall aid to health has grown**



Official development assistance to health, total (Constant 2008 US\$ millions) and proportion going to reproductive healthcare and family planning, 2000-2008 (Percentage)

Source: United Nations: *Millennium Development Goals Report 2010*.

## Box 12 Conflict-affected countries are short-changed in aid for sexual and reproductive health

For people living in war-torn areas, a lack of health services, growing poverty and heightened risk of sexual violence are often facts of life. Despite their increased need, a 2009 study found that the amount of official development assistance (ODA) committed to sexual and reproductive health, including HIV, is relatively low in conflict-affected countries.<sup>143</sup> The study, which looked at aid flows between 2003 and 2006, showed that an annual average of \$20.8 billion in total ODA was provided to 18 conflict-affected countries. Of this amount, 2.4 per cent was dedicated to reproductive health. This investment represented an annual average of \$1.30 per person for reproductive health activities, compared to \$2.30 per person in a sample of non-conflict-affected least developed countries. Official development assistance for sexual and reproductive health in these 18 conflict-affected countries was only 4 per cent of total ODA, compared to 9 per cent of ODA going to sexual and reproductive health in comparable countries not at war.

Activities related to HIV and AIDS accounted for nearly half (47 per cent) of all sexual and reproductive health funding in the countries studied. While ODA devoted to HIV prevention and treatment in conflict-affected countries increased by 119 per cent, assistance for other sexual and reproductive health matters declined by 36 per cent over the same period. The study also revealed inequities among conflict-affected countries. For example, Timor-Leste received an average of \$3.20 and Iraq \$2.30 per person per year, compared to Somalia, with an average of \$1.00, and the Democratic Republic of Congo, with only \$.80 per person, despite poorer health indicators.

**Source:** Patel P., et al. 2009. 'Tracking Official Development Assistance for Reproductive Health in Conflict-Affected Countries'. *PLoS Medicine*, vol. 6, no. 6, p. e1000090.

difficult.<sup>144</sup> While the expansion in international partnerships forged in recent years to advance the delivery of health services in developing countries is promising, it also creates new challenges (see above). Efforts are under way to reduce transaction costs and to direct these efforts to better service nationally driven processes, in line with the Paris Principles on Aid Effectiveness.<sup>145</sup> Simplification and harmonization of processes and procedures would increase effectiveness and complement more predictable aid flows.

At the same time, the development of investments for the strengthening of health systems, through the Global Fund to Fight AIDS, Tuberculosis and Malaria, among others, could nonetheless lead to increased support for reproductive health, including family planning, in line with national priorities.

### *The global financial and economic crisis*

The world's poorest countries are especially vulnerable to the consequences of the global economic crisis due to their already fragile social and economic environments. The downturn affects middle-income countries as well because of their greater exposure to the global economy through international

trade.<sup>146</sup> At times of economic crisis, governments cut budgets, thereby reducing investments in health and other social sectors. Evidence shows that the adverse impact on women's health and gender equality further endangers achievement of broader human development goals.

Slowing economic growth, worsening finances (including reductions in national revenue, aid, foreign direct investment and remittances), high levels of poverty and fragile institutional capacity to manage the crisis all contribute to the vulnerability of developing countries. The World Bank has estimated that every 1 per cent decline in developing country growth rates pushes an additional 20 million people into poverty.<sup>147</sup> Of 116 developing countries, 94 experienced decelerating growth in 2009, including 43 of the world's poorest countries.<sup>148</sup> Meanwhile, donors have fallen behind on aid commitments and the probability of increases in the near future appear dim because of continuing economic worries and rising public debt in donor countries. Promising, however, is the June 2010 pledge of a total of \$5 billion to maternal, newborn and child health (including reproductive health) at the G8 meeting, a sign of intensified and focused interest in sexual and reproductive health. Delivering on these promises is vital.

### Box 13 African countries are suffering most from the global economic crisis

The International Monetary Fund (IMF) and the World Bank each have ways to measure a country's vulnerability to the effects of economic crisis. The IMF focuses on trade, foreign direct investment, aid and remittances, while the World Bank analyses the effects of these on poverty and the vulnerability of women and children (for example, by looking at child mortality and gender parity in schooling). Most of the countries identified as most vulnerable by either the IMF or the World Bank in 2009 were in Africa.

UNFPA uses three indicators (adolescent fertility, maternal mortality ratio, and a gender parity index for the literacy rate of those aged 15 to 24) to analyse which countries are most vulnerable in terms of sexual and reproductive health outcomes. When the UNFPA list was cross-referenced with those of the IMF and the World Bank, 12 countries emerge as most vulnerable from a macroeconomic, poverty and UNFPA perspective: Afghanistan, Angola, Burkina Faso, Chad, Democratic Republic of the Congo, Ethiopia, Liberia, Mozambique, Niger, Nigeria, Sierra Leone and Togo.

**Source:** United Nations Population Fund. 9 June 2009. *Financial and Economic Crisis: UNFPA Response*. Unpublished UNFPA document.

### Other effects of the economic crisis

Rapid economic growth in recent years has exacerbated inequalities within and among countries. Now, with the global economic crisis, the slowdown in growth is leading to a deterioration in health and other human development outcomes, from which it will take a long time to recover. The World Bank estimated in 2009 that the current economic crisis was resulting in an increase of about 46 million people living in absolute poverty (that is, on less than \$1.25 per day), due to rising unemployment, deteriorating real wages and dwindling remittance flows.<sup>149</sup> Mounting poverty particularly affects women, who already represent the majority of the world's very poor. WHO, UNICEF, UNFPA and the World Bank estimates show a marked relationship between levels of income and maternal mortality. Economic crisis is also associated with higher infant mortality, notably among girls: countries with a negative shock on GDP of 5.9 per cent or larger in a given year showed increases in infant mortality of 7.4 deaths per 1,000 live-born girls, compared to 1.5 per 1,000 for live-born boys.<sup>150</sup> Women and girls are also more exposed to taking on dangerous employment, engaging in transactional sex (selling or exchanging sex for food or other basic needs) or being trafficked for forced labour or sex work.

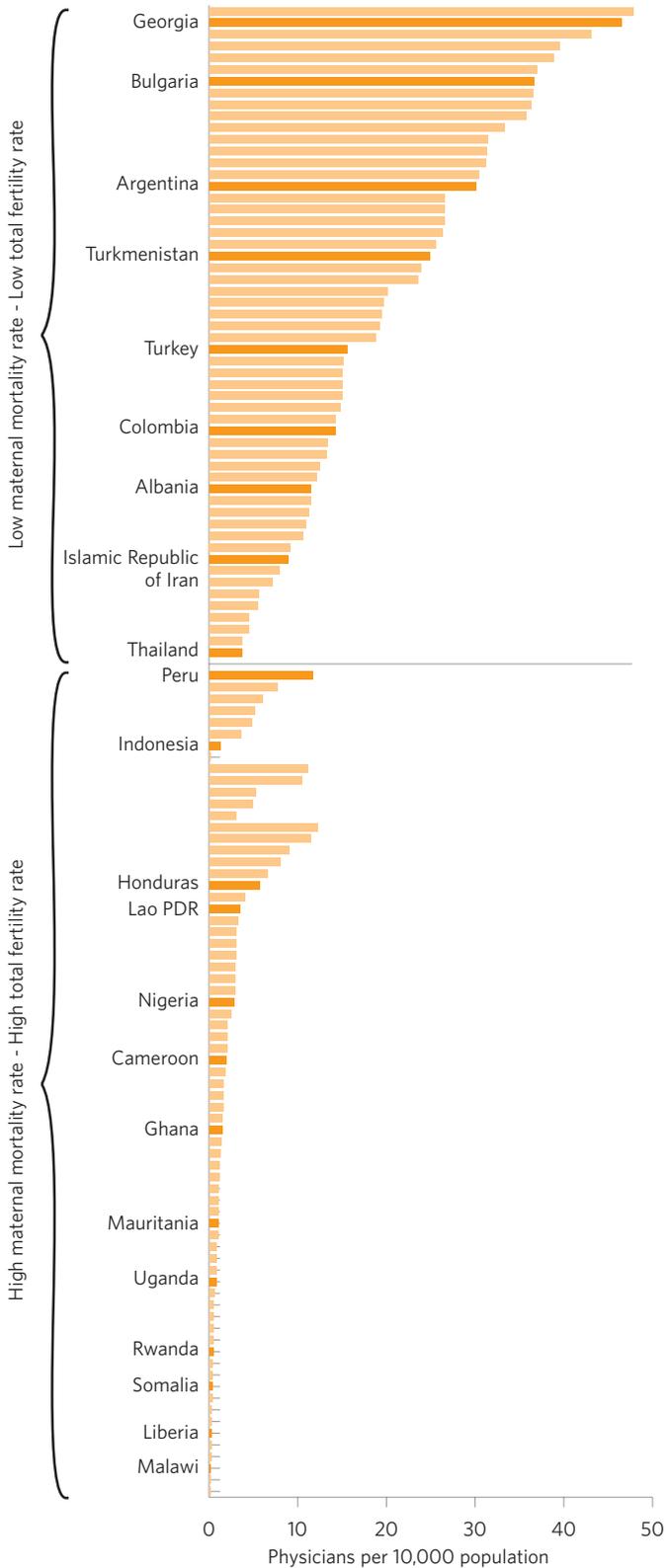
Economic crisis also leads to food shortages and increasing hunger, forcing the poor to use scarce resources to buy food, thus diminishing their ability to pay for reproductive health and other basic health and social services. Unemployment and decreases in family income, combined with reduced subsidies, can make fees for services out of reach. An economic downturn

can also prompt reconsideration of decisions about family life and the maintenance of the household. For example, it can force a couple to delay childbirth or to decide not to have another child altogether. It can also lead to changes in spending patterns for education, healthcare and other basic needs and, more times than not, girls lose out. Though difficult to track or measure, recourse to abortion may also increase as a result of economic constraints. The precise impact would, of course, vary according to local circumstances, including legal restrictions on abortion and cultural norms, along with the availability or lack of programmes that explain and support available choices.

The financial crisis globally has had a wide-reaching impact on sexual and reproductive health, human rights and government activities, often in unexpected ways. There is little doubt that tight economic conditions exacerbate the difficulty in funding national and international programmes. One of many concerns, for example, is that many of the 111 countries expected to have completed national censuses by the end of 2011 may not be able to carry them out as planned. A decline in the availability and quality of census data has serious implications for monitoring population trends, understanding the interrelationships between population and development and, programmatically, for development planning.

*The financial crisis globally has had a wide-reaching impact on sexual and reproductive health, human rights and government activities, often in unexpected ways*

**FIGURE 11**  
**Women’s health and fertility are related to the availability of doctors**



Source: The World’s Bank Reproductive Health Action Plan 2010-2015.

## Weakened health systems and lack of skilled providers

Sexual and reproductive healthcare needs to be embedded within a strong health system. Such a system is adequately funded, relies on well-regulated private-public partnerships, is effectively governed, and has insurance and other mechanisms to ensure healthcare coverage for all. It also has the requisite infrastructure it needs to operate effectively, efficient logistics to ensure a steady supply of commodities, clear guidelines and policies, and sufficient numbers of providers who are well-trained, culturally rooted, and adequately compensated.<sup>151</sup> That said, health systems around the world face shortages of funds and personnel. Structural adjustment processes have often led to cuts in health-sector spending, privatization of services and the introduction of fees into public healthcare. These changes have raised the barriers to healthcare for many, especially the poor and other marginalized groups.

Many countries, especially in Africa, face serious shortages of health staff. An estimated 2.4 million doctors, nurses and midwives are needed worldwide. Predictably, those countries with high levels of maternal mortality and high fertility often have fewer health providers per 10,000 people than countries with lower maternal deaths and fertility (see Figure 11).<sup>152</sup>

## Persistent gender inequality and violations of women’s rights

Slow progress in reducing maternal mortality and in increasing access to reproductive health reflect persistent gender inequity and a failure to recognize and guarantee women’s rights. Every year, girls and women die unnecessary—often cruel—deaths, due to neglect, discrimination and violence. Millions ‘disappear’ as a result of infanticide, intimate partner violence, ‘honour’ crimes, crimes of passion, lack of medical attention or adequate nutrition. In the last 50 years alone, more girls died as a result of these failures or from sex-selective abortion—simply because they were female—than all the men in all the wars of the 20<sup>th</sup> century.<sup>153</sup>

Gender discrimination in communities and families severely restricts women’s access to the sexual and reproductive health information and services they need. They face a myriad of obstacles in daily life and society, including lack of knowledge, fear of social disapproval or opposition from their husband or other family members, and poor treatment by providers if



they are fortunate enough to be able to physically reach health facilities and pay the required fees. Until these various forms of institutional, economic, cultural and social inequity are eliminated, progress towards sexual and reproductive health for all and guaranteeing women's human rights will be stunted.

## Opposition to aspects of sexual and reproductive health

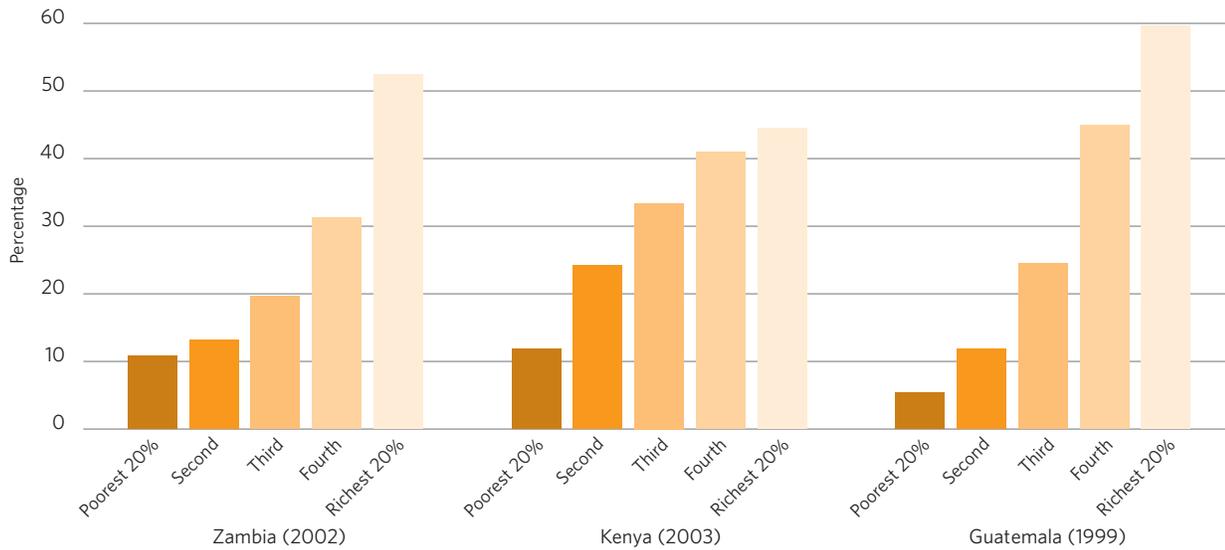
Conservative trends and related backlashes present challenges to advancing sexual and reproductive health and reproductive rights. Women's control over their own sexuality and reproduction can often be perceived as a threat to 'tradition' or to the dominant patriarchal social order. In many instances, religious interpretations are used to justify restrictions on making sexual and reproductive health education and services available, especially sexuality education and services for youth, safe abortion (where not against the law), condom promotion, contraception and other means of prevention. This opposition is often

directed against advocacy efforts, funding streams and policies that support human rights in the areas of sex and reproduction.

*Women's control over their own sexuality and reproduction can often be perceived as a threat to 'tradition' or to the dominant patriarchal social order*

## Growing inequities

One of the most troublesome trends in the last few years has been growing inequities, among and within countries. While global poverty levels have dropped and health outcomes have improved over the last several decades, the gap between rich and poor has widened in many countries. Moreover, research shows that spending on health is not reaching the poor.<sup>154</sup> As the discussion below shows, the poorest sectors of the population suffer disproportionately higher rates of morbidity and mortality related to sexual and reproductive

**FIGURE 12****The wealthy have greater access to family planning than the poor**

Percentage of currently married women (15–49) using a modern family planning method, by household wealth quintile

Source: World Bank: *The World's Bank Reproductive Health Action Plan 2010-2015*.

health, yet often have lower access to much-needed information and services.

An initiative called Countdown to 2015 for Maternal, Newborn and Child Survival has attempted to quantify these inequities by looking at how coverage in four areas of intervention—including family planning and maternal and newborn care—is influenced by wealth. As a group, the countries studied account for 97 per cent of worldwide maternal and child mortality and a predominant share of malnutrition in children. The analysis found huge differences in coverage gaps among countries, ranging from 20 per cent in Peru and Tajikistan to over 70 per cent in Chad and Ethiopia. They also found large disparities within countries, with an average coverage gap of 54 per cent for the poorest sector of the population and 29 per cent for the wealthiest. In India, Peru and the Philippines, for example, the coverage gap was at least three times larger in the poorest than in the wealthiest sectors. Of the four interventions they assessed, the gaps between the poorest and the wealthiest segments of the population were largest for maternal and newborn health. Analyses by intervention found the greatest differences in clinic-based delivery services. Differences in family planning access were intermediate in size among the interventions, below expensive delivery services, but higher than many disparities related to child survival (see Figures 12 and 13).<sup>155</sup>

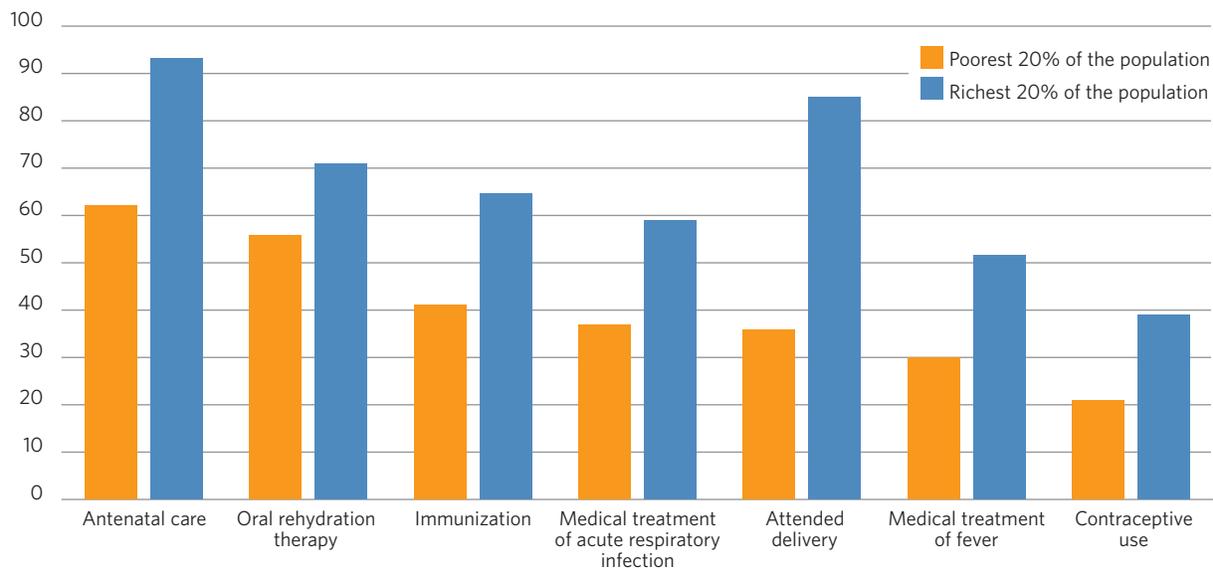
## The scope and complexity of sexual and reproductive health issues

Another challenge is defining and measuring 'success' in sexual and reproductive health. Sexual and reproductive health encompasses a range of issues—a mixture of infectious diseases (such as HIV and other STIs, including HPV), non-infectious illnesses (such as other reproductive tract and breast cancers and complications from pregnancy), disabilities (such as fistula and infertility), and states of being that are not diseases at all (such as voluntary and healthy sexual behaviours, pregnancy and birth outcomes). As pointed out in Chapter 1, good sexual and reproductive health is more than the absence of disease and is affected by diverse factors, such as behavioural, social and cultural contexts. These issues are not fully addressed by bio-medical models. And the complexities can make it difficult to plan, monitor and evaluate sexual and reproductive health programmes and policies.

To some degree, reproductive health has been a victim of its own success in lowering aggregate fertility rates. Some have concluded that population growth is no longer a serious problem. What they fail to recognize is that poor countries and poor people everywhere are still experiencing high unintended fertility rates, which contributes to their persistent poverty. Furthermore, different aspects of sexual and reproductive

**FIGURE 13**

**Disparities in coverage between the wealthy and the poor are proportionally greater for attended delivery and family planning**



Coverage rates among the poorest and wealthiest 20 per cent of the population in low- and middle-income countries (Percentage)

**Source:** World Bank, 2007: *Socio-Economic Differences in Health, Nutrition, and Population within Developing Countries: An Overview*.

**Box 14** Inequities in sexual and reproductive health abound

- Differences in maternal mortality between rural and urban areas and the rich and poor can be striking. In Afghanistan, maternal deaths in the capital city are estimated to be 418 per 100,000 live births, compared to 6,507 per 100,000 in a remote district. In Peru, the average number of poor women who die from causes related to pregnancy and childbirth is more than 800 per 100,000 live births, compared to about 130 per 100,000 for the wealthiest 20 per cent, a sixfold difference.<sup>156</sup>
- In Southern Asia, wealthy women are almost five times as likely as poorer women to give birth with a skilled health provider present.<sup>157</sup>
- Gaps associated with wealth are not only found in access to services, but also in acquiring essential sexual and reproductive health information and knowledge. In four countries of South Asia, for example, only 8.4 per cent of the poorest 20 per cent of women are found to have sufficient knowledge of how HIV is transmitted, compared to 61 per cent of women in the wealthiest fifth of the population.<sup>158</sup>
- A recent population-based study in 57 countries found that cervical cancer screening coverage averages 19 per cent in developing countries, compared to 63 per cent in developed countries. Among developing countries, the disparities are enormous: reaching 1 per cent of women in Bangladesh compared to 73 per cent of women in Brazil. Furthermore, those at highest risk of developing cervical cancer—older and poor women—are least likely to be screened.<sup>159</sup>
- Refugees and displaced persons face particular obstacles in accessing sexual and reproductive healthcare. Impoverishment, fractured family and social networks, and poor living conditions may all reduce refugees' ability to seek or use services and information. Yet conflict-affected countries have received 43 per cent less aid overall than they should have based on their levels of poverty.<sup>160</sup>

health are highlighted by various stakeholders, who bring diverse backgrounds and concerns to the issues. Accordingly, the debates are very rich, but often challenging. Those focusing on rights and community participation may not see the importance of quantifiable measures of success. Others may focus on measureable outcomes, at the expense of rights and participation. Reproductive health and rights, including family planning, have lost ground as other disease-related

issues moved to the forefront. At the same time, the dialogue around mother-and-child health shifted more towards mortality and morbidity and the HIV community focused more on treatment. The full implications of the ICPD concept of reproductive health go way beyond fertility and family planning. True success requires progress across the full continuum of services related to sexuality and reproduction, including neonatal and child health.

# Where do we go from here?

**A**ccelerating progress on sexual and reproductive health for all requires urgent and sustained action by the global community. It calls for adequate funding, firm political commitment, courageous and creative programming, and the involvement of diverse actors, including faith-based, civil society and private sector partners. Fundamental is using a human rights-based approach that promotes equity and fairness; laws and policies should prohibit and sanction harmful practices, gender-based violence and discrimination in accessing healthcare and exercising related rights. The following areas for action, if undertaken seriously over the next five years, would quicken the pace of positive change towards achieving sexual and reproductive health for all and reaching all the MDGs by 2015.

## **Making sexual and reproductive health and rights a national priority**

Achieving universal access to sexual and reproductive health requires national commitment and funding, a functioning healthcare system, integration into all levels of healthcare, especially primary healthcare, and a focus on reaching and serving vulnerable groups. Key elements of this agenda follow.

### *Using a human rights framework for policy and programme development*

Applying a human rights lens demands a focus on equity and non-discrimination, on reaching the most vulnerable, and on building mechanisms for monitoring and accountability. Laws and policies should prohibit and sanction harmful practices, gender-based violence, and discrimination in accessing healthcare and exercising related rights. Passage of laws alone is not sufficient, however; implementa-

tion and monitoring are essential. Affected communities and wider civil society should be active participants in developing laws and policies and ensuring that they are carried out effectively (see more on community consultation and participation below).

### *Integrating sexual and reproductive health into national poverty reduction plans*

If universal access to reproductive health is to become a reality, it must be incorporated into national development planning mechanisms, such as poverty reduction strategy papers (PRSPs). To be meaningful, development plans should include indicators for sexual and reproductive health, such as fertility and maternal mortality rates for the population as a whole and/or for specific groups. Process indicators should also be included, such as service use and access, the proportion of service delivery points that are adequately staffed and have the needed equipment and supplies, and the percentage of service delivery points offering particular sexual and reproductive health services (such as emergency contraception, female condoms, emergency obstetric care, and voluntary counselling and testing for HIV and other STIs) (see more on monitoring below).

### *Taking a multisectoral approach*

If sexual and reproductive health policies and programmes are developed and implemented in isolation, universal access will not be achieved. Rather, they should be integrated with the prevention of HIV and with measures to attain gender equity, women's and girls' rights, universal access to education, and processes that promote democratic, participatory governance.

## Creating a policy framework that includes regulations, norms and guidelines

Creating an effective policy framework for sexual and reproductive health involves the establishment of relevant national laws. Equally important is setting out regulations, norms and guidelines that make implementation of those laws feasible and effective. Also required are human resources with the capacity to develop, administer and enforce the laws and regulations.

## Identifying and serving vulnerable groups

In the interest of advancing social justice and, at the same time, maximizing scarce resources, efforts should be made to address

economic, social and cultural inequities. Regional, national and local contexts vary enormously, requiring analysis and consultation to identify who is most vulnerable and who has been excluded in the past, as well as to understand the reasons for vulnerability and marginalization. Policy-makers and funders should target scarce resources to poor and marginalized groups and address the underlying factors contributing to vulnerability.

These groups are likely to include the poor, youth, migrants and refugees, people living in rural areas, ethnic minorities and indigenous populations, and people of different sexual orientations. Factors of poverty and gender cut across all of these groups, and particular attention should be directed to girls, women and the poor. Addressing vulnerability also means taking compounding circumstances into account.

### Box 15 Girls in Nepal choose their own future

In Nepal, as elsewhere, girls face deeply entrenched discrimination, putting them at risk for early marriage, sexual abuse and unwanted pregnancy.

A programme called Choose a Future enables out-of-school adolescent girls to learn about sexual and reproductive health and to develop confidence and decision-making skills revolving around education, marriage, childbearing, family relations and community involvement. The programme is aimed at the poorest and most marginalized girls. It is premised on the belief that early intervention can give girls and women the confidence to claim their rights.

Through the programme, Nepali girls learned about their bodies as a first step in understanding their health needs and developing the capacity to make health-related requests and decisions. Participants met for two hours, five days a week, over the course of ten weeks. In addition to fostering problem-solving and negotiation skills, the course allowed girls to establish supportive peer relationships and to realize the power of working together to respond to social problems that threatened their well-being.

The course generated a number of positive changes, not only at the individual level, but also in terms of resulting policies and programmes. Following the Choose a Future training sessions, girls spoke out against harmful practices, such as early marriage and *chaupadi*,<sup>161</sup> which were deeply engrained in their culture. In several cases, they were actually able to persuade parents to send their daughters to school, to stop planned early marriages and to encourage older women to use healthcare services. One district reported that gaining accurate information about reproduction led women to stop blaming themselves for not giving birth to male children. The programme also contributed to women's economic empowerment by stimulating the establishment of savings and credit groups, which helped to increase women's decision-making capacity within their families and communities.

The success of Choose a Future in Nepal shows the importance of integrating human rights principles into sexual and reproductive health interventions and to reaching—and helping empower—girls at an early age. As a result of the initial experience, the Department of Women's Development was able to institutionalize the programme and to scale it up to reach girls across the country. The department also made reproductive rights awareness a cross-cutting issue in all efforts involving women.

**Source:** United Nations Population Fund and Harvard School Of Public Health, Program on International Health and Human Rights. 2008. *UNFPA at Work: Six human rights case studies*. New York: UNFPA.

These could include experiences such as gender-based violence, trafficking, forced migration, or living through conflict or natural disasters. In the context of HIV prevention, sex workers, men who have sex with men, injecting drug users and their sexual partners require special attention.

The poor face numerous bottlenecks to accessing and using services. Figure 14 offers a tool that can be used to identify, rectify and monitor key factors that cause inequities. While this tool is linear in design, the constraints encountered by people, especially the poor, when approaching the healthcare system are complex and interrelated. Accordingly, when using a diagnostic tool like this it is important to explore all the dimensions and the interactions among them. The tool recognizes the importance not just of physical access to fully staffed and quality services, but also local acceptability and relevance, organizational effectiveness and accountability. Using such a tool can help to analyse and prioritize constraints that need to be addressed.<sup>162</sup>

### Consulting with communities and building truly participatory processes

Planning, implementing and evaluating sexual and reproductive health programmes and policies are most effective when they are participatory and rooted in the community. This means that the most affected and vulnerable groups are part of the process, which helps to ensure the responsiveness of policies and programmes to people’s needs and realities. Meaningful community participation also contributes to increased sustainability.

**FIGURE 14**  
A number of constraints limit access by the poor to health services



Source: World Bank, 2009: *Attacking Inequality in the Health Sector: A synthesis of evidence and tools*.

### Advocating for universal health coverage and medical insurance for the poor

Universal health coverage must be the long-term goal. In the interim, it is necessary to construct social protection floors for disadvantaged groups and individuals. Regulations and policies that ensure the equitable distribution of healthcare resources should also be put into place.<sup>165</sup> Community-based insurance and savings plans and other risk-pooling measures can help protect poor families from falling deeper into poverty due to out-of-pocket expenses or unexpected healthcare costs.<sup>166</sup> Reducing barriers to access by transferring funds to those in need, offering incentives to health workers, or providing essential services for free can increase the use of healthcare services.

*Universal health coverage must be the long-term goal; in the interim, it is necessary to construct social protection floors for disadvantaged groups and individuals*

### Strengthening health systems

Essential to achieving sexual and reproductive health for all is strengthening healthcare systems for equitable, efficient and sustainable delivery of good quality services. Efforts should be made to build national capacity to carry out planning, implementation and monitoring. A key aspect of this effort is reaching marginalized groups on a priority basis, which necessitates the elimination of all kinds of barriers to access, including financial, legal, economic and cultural obstacles.

Sexual and reproductive healthcare services should be incorporated into the minimum healthcare package at all levels of the national healthcare system, especially at the primary level. In addition, content relevant to sexual and reproductive health ought to be integrated into medical and public health training curricula and programmes.

*Sexual and reproductive healthcare services should be incorporated into the minimum healthcare package at all levels of the national healthcare system, especially at the primary level*

## Box 16 Donors call for better response to the reproductive health needs of those in crisis

A political document known as the Grenada Consensus asserts that more than one third of maternal deaths occur in crisis settings. The consensus was drawn up in Spain in September 2009 by a group of experts, donors and international agencies to identify priorities for action in humanitarian emergencies. While statistics are difficult to verify in such settings, refugees and others affected by armed conflict or natural disasters often face overwhelming challenges, such as sexual violence, the breakdown of social order and lack of services. Growing awareness of the acute needs of refugees and displaced persons has led to the creation of relevant technical guidelines, standards of care and tool kits. Many governments and donors now have policies and guidelines to address HIV and gender-based violence, including sexual violence. What is less clear is whether survivors of such violence are receiving services in emergency situations.<sup>163</sup> The areas that have received too little attention are long-term family planning and emergency obstetric care.<sup>164</sup> The Grenada Consensus calls for humanitarian and development agencies to work together, and with national and local authorities and affected communities, to make sure that sexual and reproductive health services are not neglected during periods of crisis, and that they are integrated into the long-term rebuilding of a health system.

**Source:** Granada Consensus, see: [http://www.who.int/hac/techguidance/pht/reproductive\\_health\\_protracted\\_crises\\_and\\_recovery.pdf](http://www.who.int/hac/techguidance/pht/reproductive_health_protracted_crises_and_recovery.pdf), accessed 19 August 2010.

### *Training healthcare providers*

A serious shortage of healthcare workers is a major barrier. Doctors are necessary for managing grave sexual and reproductive health problems. But other health professionals, such as midwives, can be trained to be proficient in handling most aspects of sexual and reproductive health, including uncomplicated pregnancies and childbirth, family planning, post-natal care, STI screening and treatment, and prevention of mother-to-child transmission of HIV. These health workers can detect sexual and reproductive health risks, such as complications in pregnancy or childbirth or those related to HIV infection, and make the necessary referrals. Recruiting and retaining skilled providers in the area of sexual and reproductive health will require improved compensation and incentive systems, with a greater emphasis on results, while taking care not to repeat the mistakes of the past.<sup>168</sup>

### *Maintaining the flow of reproductive health commodities*

An essential element in achieving universal access to sexual and reproductive health is the availability of affordable, high-quality commodities. These include barrier methods of contraception, such as male and female condoms, which can also reduce transmission of STIs, and STI/HIV test kits and diagnostics, which are critical for successful prevention strategies. Generic drug use and increased efficiency in the logistics of delivery (storage, transportation, planning and distribution) can help keep costs down.<sup>169</sup>

Donor support for sexual and reproductive health commodities has ranged from \$205 million to \$239 million per year since 2003. Total donor support increased by about 11 per cent from 2008 to 2009— from \$214 million to \$239 million. In 2008, 80 per cent of this support was allocated to three types of commodities: male condoms, oral contraceptives and injectables; in 2009, the commodity mix was more diversified. Male condoms led (30 per cent), followed by injectables (22 per cent), oral contraceptives (19 per cent), implants (14 per cent) and female condoms (12 per cent). Donor funding for female condoms more than doubled (from \$18 million in 2008 to \$38 million in 2009), and increases for IUDs and implants were notable.

Sub-Saharan Africa received 72 per cent of total donor funding for reproductive health commodities in 2009 (up 10 per cent from 2008). Asia and the Pacific region received 15 per cent (down 10 per cent from 2008). Latin America and the Caribbean and the Arab States and Eastern Europe received 8 per cent and 4 per cent, respectively. While the regions of Latin America and the Caribbean and the Arab States and Eastern Europe did not see major changes in funding, donor support for sub-Saharan Africa rose significantly (up from \$133 million in 2008 to \$173 million in 2009). Asia and the Pacific, however, experienced a decline (from \$53 million in 2008 to \$37 million in 2009). The United Nations Population Division estimates that the reproductive-age population in developing countries will increase by about 23 per cent between 2000 and 2015. Donor funding would need to

## Box 17 Innovative measures lead to improved reproductive healthcare in Cambodia

Cambodia is recognized for reducing HIV prevalence, but is less known for its innovative work to improve reproductive health-care, especially maternal health. Results of the 2005 Demographic and Health Survey for Cambodia showed that the maternal mortality ratio there was still unacceptably high at 472 per 100,000 live births. Delivery at health facilities was very low at 21.5 per cent and only 44 per cent of births were attended by a skilled provider. Despite the fact that many women would prefer to deliver at a health facility with professional help, serious constraints limit access to such services. On the demand side, they include a lack of money, distance to health facilities, problems with being away from home, and lack of confidence in health staff. On the provider side, the main issues are lack of competent staff, particularly midwives, poor motivation of staff and inadequate supplies and equipment.

Innovative measures to improve maternal health since mid-2007 offer incentives for babies born at public health facilities. This intervention has led to remarkable increases in institutional deliveries, and corresponding decreases in deliveries at home and by inadequately trained traditional birth attendants. The initiative is government-funded.

Reproductive and maternal health indicators in Cambodia saw major improvements from 2006 to 2009: deliveries with skilled birth attendants increased from 36 per cent to 63 per cent; deliveries at health facilities nearly tripled, from 16 per cent to 45 per cent; contraceptive prevalence rose from 22 per cent to 28 per cent; women making one antenatal visit increased from 77 per cent to 100 per cent, and those making at least four visits rose from 23 per cent to 33 per cent. In addition, referrals from the community to health centres and the relationship between skilled birth attendants and the traditional birth attendants all improved.

Cambodia's minister of health subsequently developed an initiative for improving maternal health. The *Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality*, launched in 2010, includes the following core components:

- **Emergency obstetric and newborn care.** This is the principal focus for the government and donor partners.
- **Skilled birth attendance.** Pre- and in-service training for midwives will be improved, with the goal of strengthening the competencies of health staff and the quality of services.
- **Family planning.** Cambodia has seen a recent increase in the use of contraceptives and aims to further increase the contraceptive prevalence rate, reduce unmet need for family planning, expand use of contraceptives by rural and poor women, and ensure a secure supply of reproductive health commodities.
- **Safe abortion:** The aim is to increase coverage and use of safe procedures and improve the quality of services.

The road map also sets out the following components of an enabling environment for reducing maternal mortality:

- **Behaviour change communication campaigns.** The government and donor partners recognize the effectiveness of behaviour change communication campaigns and broader communication efforts in Cambodia, especially in relation to HIV prevention and condom use, and are using these activities to stimulate demand for services, thereby scaling up key interventions.
- **Health equity funds.** These are being established to reduce financial barriers by covering service fees, transport and food costs for poor people accessing health services. This initiative is funded by donors and has led to dramatic increases in the use of services, particularly maternal health services, for the poor.
- **Maternal death surveillance and response.** This newly established system is being used to analyse the problem of maternal mortality and to inform programme implementation and the design of new interventions. It complements audits of maternal deaths, which are performed at the community and facility level.

**Source:** United Nations Development Group. 2010. *MDG Good Practices*. See: <[www.undg-policynet.org/?q=node/11](http://www.undg-policynet.org/?q=node/11)>, accessed 20 August 2010.

almost double to meet projected contraceptive needs in 2015 (estimated at \$408 million).

Of total donor support for reproductive health commodities in 2009, 59 per cent was provided through bilateral funding, 34 per cent was through UNFPA (the Netherlands and the United Kingdom were the major funders), and 7 per cent was channelled through social marketing organizations. The US Agency for International Development continues to be the largest single donor, contributing 37 per cent of total donor support in 2009.<sup>170</sup>

## Scaling up approaches that work

At a time of global economic crisis and scarce resources, the imperative to use resources as efficiently and effectively as possible grows. Fortunately, experience over the last few decades has provided substantial evidence of what works. The most effective approaches should be replicated and scaled up.

As a first step, it makes sense to conduct a country vulnerability analysis that determines essential areas that must be maintained. This includes identifying vulnerable groups and reducing possible barriers to access.

### Box 18 Ecuador's law to guarantee free and friendly services lowers maternal mortality

The global news service Interpress (IPS) circulated a story on 4 May 2010 about the impact of a maternal health law in Ecuador. The following is adapted from their report:<sup>167</sup>

*In 1994, Ecuador passed the Law of Free Maternity and Child Care, which was then codified in 2006 to ensure harmonization with other laws, to reinforce existing regulations and programmes and to provide financial autonomy. The head of institutional development for the Free Maternity programme told IPS that the law "finances medicines, materials, vitamins and minerals, supplies and laboratory tests, for pregnant women, during labour and post-natally, as well as for children up to the age of five."*

*The principle behind Ecuador's law is simple. The first article states that every woman has the right to free, high-quality healthcare during pregnancy, childbirth and the post-partum period, as well as access to sexual and reproductive health programmes. The law also stipulates that a Users' Committee be created in each of the 221 cantons (subdivisions of the country's 24 provinces). So far there are 59 committees.*

*Eulalia Salinas, the secretary of the Latacunga Users' Committee, says that training for these community groups and their supervisory responsibilities over the programme have been the key to its success. The committees have effectively reduced mistreatment of women and discrimination.*

*As a result of the programme, Ecuador has achieved a steep decline in maternal mortality—dropping from 188 deaths per 100,000 live births in the 1970s to 55 per 100,000 for the period 2001-2007, according to internationally recognized statistics. The average maternal mortality ratio in Latin America was 130 deaths per 100,000 live births in 2007.*

*The Saquisilí canton has made the most progress towards 'humanized childbirth'. Mothers can have a person of their choice with them during labour, they can have hot herbal tea before labour starts, and they can choose the birthing position they prefer.*

*Such practices are forbidden in other hospitals, but in Saquisilí they were accepted after pressure from indigenous women, as a mark of respect for their traditional customs.*

*The model, centred on the mother's needs and not those of the doctor or midwife, will be extended throughout the country, and every encouragement will continue to be given for women to deliver in health centres.*

[The Maternity Law also addresses other essential aspects of reproductive health, such as family planning and gynaecological cancer screening. UNFPA is currently supporting User Committees to address an integrated approach to reproductive health.]

## Box 19 Training midwives could help fill the gap in skilled health workers

In September 2008, the International Confederation of Midwives (ICM) and UNFPA launched a new effort to tackle the shortage of trained health providers in developing countries.

The World Health Organization has identified the need for an additional 334,000 midwives globally by 2015. The ICM and the UNFPA have estimated that skilled attendance at delivery, backed up by emergency obstetric care, could reduce the number of women dying in pregnancy and childbirth by up to 90 per cent.

The focus of the new, \$9 million programme is on training midwives, improving midwifery education, developing standards of care, and strengthening national midwifery associations. The programme, funded by the Netherlands and Spain, began in 11 countries with the highest levels of maternal death and disability and the lowest rates of births attended by skilled workers: Benin, Burkina Faso, Burundi, Côte d'Ivoire, Djibouti, Ethiopia, Ghana, Madagascar, Sudan, Uganda and Zambia. The plan is to eventually expand the programme to 30 or more countries.

In June 2010, the original sponsors were joined by several new partners in calling for investments in strengthened midwifery services, including education, regulation and association, as a way to reach MDGs 4, 5 and 6.

**Source:** UNFPA website, see: <[www.unfpa.org/public/lang/en/news/events/pid/5248](http://www.unfpa.org/public/lang/en/news/events/pid/5248)>, accessed 19 August 2010.

*Experience over the last few decades has provided substantial evidence of what works; the most effective approaches should be replicated and scaled up*

Experience has shown that an integrated approach to sexual and reproductive healthcare is most effective. Furthermore, preventive measures have proven to yield high returns in terms of cost-savings for the public health system, in addition to the larger goals of maximizing well-being and protecting rights.

At the primary healthcare level, a core package of sexual and reproductive health services would include:

- Contraceptive counselling, services and supplies to enable girls and women to make fully informed and voluntary choices of the means to delay or prevent unintended pregnancy. A choice of contraceptive methods should be available as well as counselling that supports an individual in making an informed choice. Family planning services should also engage men. Particular effort should be made to offer condoms for dual protection from unwanted pregnancy and STIs, including HIV.
- Care during pregnancy and childbirth, including antenatal care, delivery care by skilled providers, access to emergency obstetric and newborn care, and immediate post-natal care for mothers and newborns. If needed, women should have access to antiretroviral therapy, both for their own health and to prevent the spread of the virus to their newborn.
- Access to safe abortion, where not against the law, including medical or surgical procedures to terminate an unwanted pregnancy (as per paragraph 8.25 of the ICPD Programme of Action). In all situations, regardless of legal restrictions, good quality care for abortion complications and post-abortion counselling ought to be available.
- Prevention, screening and treatment services for STIs and reproductive cancers.
- Voluntary testing and counselling for HIV and referrals for treatment.
- Information, education and counselling regarding sexuality and reproduction.
- Screening for and addressing gender-based violence (including sexual violence), as well as active discouragement of harmful practices.

Particular efforts should be made to reach out to men and to adolescents, ensuring a welcoming environment that is able to meet their needs. In rural areas and other locations where services are limited or difficult for some groups to access, alternative delivery channels should be established, such as mobile units. A very important strategy is partnering with informal or traditional providers in village settings as well as with community-based organizations, including those that are faith-based. In urban and industrial settings, services can also be offered at the workplace with the cooperation of public and private employers.

Special efforts must also be taken to ensure that people in emergency and humanitarian situations have access to a basic reproductive health package.

*Special efforts must be taken to ensure that people in emergency and humanitarian situations have access to a basic reproductive health package*

## Integrating sexual and reproductive health and HIV

Making progress on sexual and reproductive health problems, including HIV, requires an understanding of the root causes they share—gender inequity, poverty, exclusion and stigma. It follows that many of the same strategies can address those root causes, such as changing sexual behaviours; taking into consideration community norms around gender, sexuality and reproduction; supporting girls and women to develop decision-making and negotiating skills; and tackling taboos

### Box 20 Ethiopia relies on evidence-based planning to reduce maternal deaths

Ethiopia is one of six countries that together account for 50 per cent of the world's maternal deaths. To document gaps in the provision, quality and use of reproductive health services, the Government of Ethiopia carried out an Emergency Obstetric and Newborn Care Needs Assessment, with support from UNFPA, UNICEF, WHO, the World Bank and Columbia University. The findings are being used for policy-making and planning, including the development of a five-year national health-sector plan, comprised of an annual core plan and a joint UN programme on improving maternal and newborn health.

The needs assessment was carried out in 2008 in 800 facilities in all of the country's districts. The findings were used to develop evidence-based interventions that include:

- Strengthening maternity healthcare in health centres and district hospitals, including both basic and comprehensive emergency obstetric care
- Developing a human resources strategy to address the severe scarcity of skilled birth attendants through task-shifting and other approaches
- Creating a Master's training programme for health workers in emergency obstetric care, including how to perform Caesarian sections
- Equipping seven midwifery training institutions with materials and supplies
- Training nurses on specific midwifery skills to perform the seven functions of basic emergency obstetric and neonatal care
- Using the assessment fact sheets as baselines for monitoring access to emergency maternal and neonatal services
- Building national capacity to conduct the assessment every five years, to see how coverage and conditions change over time.

The high degree of political commitment, coordination among UN agencies and an outside university, and the use of data for planning and monitoring the upgrading of facilities at the district level have yielded encouraging results. With time, it will be possible to measure the impact on maternal health.

**Source:** United Nations Development Group. 2010. *MDG Good Practices*. See: [www.undg-policy.net.org/?q=node/11](http://www.undg-policy.net.org/?q=node/11), accessed 20 August 2010.

around sexuality. Integration of sexual and reproductive health and HIV prevention needs to happen at all levels—in terms of funding, policy-making, the healthcare system and within communities and households.

At the level of policy-making and funding, development and implementation of policies, strategic plans, and budgets should be closely linked and institutional agencies and mechanisms should be coordinated.

At the health-systems level, key HIV services, such as condom promotion, voluntary counselling and testing, the prevention of mother-to-child transmission, and antiretroviral therapy should be integrated with other sexual and reproductive health services. In some cases, this will mean that HIV services are provided at sexual and reproductive health facilities. Other HIV services, especially treatment, may involve referral mechanisms. At the same time, fundamental services, including family planning, STI prevention and management, maternal and neonatal care, and prevention of and screening for gender-based violence should be incorporated into HIV services. Again, in some situations, the integration will be within one facility and, in others, referrals may be the most appropriate strategy.

At the community level, integration means confronting the social norms and underlying attitudes that hinder progress in sexual and reproductive health and rights. This can entail sexuality education for young people, grassroots and media-based campaigns, and working closely with community and

faith-based organizations to develop programmes that can both change attitudes and build on positive and empowering cultural values, thereby encouraging the use of sexual and reproductive health services.

For many years, the reproductive rights of people living with HIV have been neglected and even denied. Like anyone else, people living with HIV have the right to be sexually active and to choose to bear children or not. This points to the need to integrate sexual and reproductive healthcare into HIV services, including access to contraceptive counselling and commodities, maternal and infant care, and safe abortion (in accordance with national law).

## Engaging community organizations and addressing social norms

Sexual and reproductive health for all will not be achieved by the health sector alone. Indeed, the MDG framework is based on the premise that making progress in one area requires investment in all the others. The ICPD Programme of Action stressed the importance of promoting gender equality, girls' education, poverty reduction and respect for human rights. Addressing the social determinants of poor sexual and reproductive health demands changing social norms and creating resources at the community level for girls and women.<sup>171</sup> This can entail community and media campaigns to provide reproductive and sexual health information, cultivate behaviours that promote health and encourage attitudes that are

### Box 21 Somalia is fighting AIDS by focusing on the gender dimensions of the epidemic

Somalia faces an expanding HIV epidemic, with prevalence levels ranging from 0.6 per cent in the South Central zone and 0.5 per cent in Puntland to 1.4 per cent in Somaliland. The persistent conflict has reduced the possibility of fully understanding the epidemic, and access to reliable data is limited. What is known is that the main route for transmission is sexual, and factors such as displacement, cross border mobility, transport trade and the constant state of emergency tend to increase high-risk behaviour. Somalia has 1.4 million internally displaced persons and the resulting breakdown of social networks and institutions often leads to increased risk of HIV exposure. Public awareness of prevention and modes of transmission are low, and levels of stigma and discrimination high.

In targeting a response, the National AIDS Commission and the United Nations are focusing on the gender dimensions of the epidemic, including gender-based violence and harmful practices, such as female genital mutilation/cutting. They are taking a multisectoral approach to the vulnerability of women and girls, by addressing how the ongoing conflict and instability have exacerbated economic insecurity and disparities in gender relations and created an environment that breeds human rights violations.

**Source:** United Nations Development Group. 2010. *MDG Good Practices*. See: [www.undg-policynet.org/?q=node/11](http://www.undg-policynet.org/?q=node/11), accessed 20 August 2010.

supportive of gender equality. Such campaigns can also serve to reduce public tolerance for gender violence, harmful practices and discrimination towards others on the basis of gender, sexual orientation or HIV status. It also requires working with and supporting community-based initiatives and organizations. Community-based and faith-based groups—especially women’s organizations and other groups that are led by members of the communities most affected—can offer information and build skills. They also can help to deliver services and to encourage the use of them, especially among hard-to-reach populations.

*Addressing the social determinants of poor sexual and reproductive health demands changing social norms and creating resources at the community level for girls and women*

## Responding to the needs and realities of adolescents

### *Expanding comprehensive sexuality education*

A review of sexuality education and HIV prevention efforts, mostly in Africa and Latin America, conducted by the UNAIDS Inter-Agency Task Team on Young People, found that the most effective interventions address multiple factors affecting sexual behaviour, including knowledge, perception of risks, values, attitudes, norms and self-efficacy.<sup>172</sup>

Other research has underscored the importance of gender norms to sexual behaviour and outcomes. For example, conservative attitudes about gender and inequitable power relationships are associated with early sexual initiation, more sexual partners, more frequent intercourse, lower rates of condom and contraceptive use, and higher rates of STIs, including HIV.<sup>173</sup> Some studies have established that young women

### **Box 22** Tanzania tackles reproductive health through a rights-based approach

In the United Republic of Tanzania, as in many places, community members tend to regard sexual and reproductive health not as a human right, but in terms of services the government wants them to use. An assessment undertaken in that country also showed that community participation in planning and implementing services was negligible.

In terms of sexual and reproductive health, the challenges are steep. According to a 2002 census, about three quarters of the population live in rural areas; one in three women are illiterate; and life expectancy is only about 50 years. Total fertility has declined since the early 1990s, but Tanzanian women with no education are still having an average of 6.7 children (compared to those with a secondary education, who have an average of 3.4 children).

The Stronger Voices project, supported by UNFPA and the African Medical Research Foundation, has played a role in changing the situation. The project, carried out from 2001 through 2006, organized workshops in villages throughout the Geita district. Each village organized four groups of 20 people each, composed of women and men of all ages. The goal was not only to help people understand the full range of their reproductive rights, but to empower them to claim them. The project also conducted training for local government officials and health providers.

Individual and group feedback has shown that participants have become more aware of their reproductive rights, more confident, and more motivated to respect the rights of others. Working with providers and municipal health officials has also led to developments in policy and services, such as renovation of facilities, improved equipment, and integration of sexual and reproductive health into local budgets. District staff who participated in the training sessions say they no longer see themselves as benefactors, but as public servants. Moreover, recognition of gender-based violence resulted in a data collection system by which the Ministry of Health can track cases. In short, the Stronger Voices project has fostered the perception of sexual and reproductive health as a human rights issue, encouraging community members, health providers and local authorities to identify concrete mechanisms for accessing and improving services on the basis of community concerns and needs.

**Source:** United Nations Population Fund and Harvard School Of Public Health, Program on International Health and Human Rights. 2008. *UNFPA at Work: Six human rights case studies*. New York: UNFPA.

## Box 23 New guidelines promote an integrative approach to sexuality education

Based on positive experiences of participatory teaching methods for sexuality and HIV education around the world, guidelines were developed by an international working group that go beyond the usual diffusion of information. Rather, they offer activities that engage young people in reflection, critical thinking and discussion, aimed at build self-confidence and problem-solving skills. The *It's All One Curriculum* offers advice on integrating the issues of gender, human rights, sexuality, reproductive and sexual health, and HIV through the following eight modules:

- 1. Sexual rights are human rights:** connecting sexual and emotional well-being with the ability to exercise human rights, such as the right to education, to freedom of expression and to reproductive rights
- 2. Gender:** understanding how gender norms function in society and how they affect sexuality and reproductive health
- 3. Sexuality:** exploring how culture and prevailing gender norms affect sexual attitudes, practices and experiences as well as learning about concerns people often have about their sexual lives
- 4. Interpersonal relationships:** reflecting on relationships and strengthening the ability to communicate
- 5. Communication and decision-making skills:** learning to talk and make decisions about personal issues, such as sexuality, contraception and HIV prevention
- 6. The body, puberty and reproduction:** understanding puberty, the body and reproduction, within a social context
- 7. Sexual and reproductive health (including HIV prevention and contraception):** learning about reproductive-tract infections, sexually transmitted infections, including HIV, contraception and abortion
- 8. Advocating for sexual and reproductive health:** finding ways to promote social changes that will lead to better sexual health and greater justice and equality for all.

**Source:** Haberland, Nicole, and Deborah Rogow, eds. 2009. *It's All One Curriculum: Guidelines and activities for a unified approach to sexuality, gender, HIV, and human rights*. New York: Population Council. See: <[www.popcouncil.org/publications/books/2010\\_ItsAllOne.asp](http://www.popcouncil.org/publications/books/2010_ItsAllOne.asp)>, accessed 19 August 2010.

who had previously experienced sexual coercion are less likely to use condoms and are more likely to have an unintended pregnancy, multiple partners, and/or an STI.<sup>174</sup>

Evaluations of programmes aiming to promote attitudes that are supportive of gender equality, especially among young men, found that they result in less self-reported partner violence and behaviours that place one at risk of HIV.<sup>175</sup> Accordingly, sexuality education programmes ought to address not only taboos around sexuality, but also gender power and norms, and include boys and young men.

Sexuality education strategies should also consider and address the diversity of youth and their needs. Experts underscore the need to reach young people early in their lives, when attitudes are beginning to form. Programmes for younger youth can focus on ideas about equality and gender roles and foster

the development of decision-making and communications skills.<sup>179</sup> Interventions should develop different strategies for speaking to the varied needs of girls and boys, within a specific social and cultural context. Also important is responding to the needs and realities of young people who are not in school, especially girls. In many countries, girls do not routinely attend secondary school. In Senegal, for example, only 9 per cent of girls aged 15 to 19 are in school; in Bangladesh, only 20 per cent and in Kenya only 13 per cent of girls in the same age group are in school.<sup>180</sup>

*Experts underscore the need to reach young people early in their lives, when attitudes are beginning to form*

## Box 24 So what does it mean to be a man?

'Programme H'<sup>176</sup> was developed in 1999 by four Latin American NGOs.<sup>177</sup> The aim is to encourage young men to question traditional gender norms that define what it is to be a man. It does so by fostering change in those norms, so that men: 1) understand relationships as based on respect, equality, and intimacy, not sexual subjugation; 2) believe they should share responsibility for children; 3) assume responsibility for their own (and their partners') reproductive health; and 4) oppose gender violence, including intimate partner violence.

Programme H consists of two parts—a curriculum that includes manuals and a video, and a social marketing campaign for promoting changes in community or social norms. The manuals offer a range of activities, including role plays, brainstorming exercises, discussion sessions and individual sharing on how men are socialized and the benefits of changing attitudes and behaviours. The themes of the manuals include sexual and reproductive health; violence and violence prevention (including gender-based violence); reasons, emotions and mental health, focusing on communication and emotional skills, as well as substance use; fatherhood and care-giving; and HIV/AIDS, including basic information about HIV, condom use, couple communication, STI prevention, counselling and testing and care-giving for people who may be living with HIV.

A wordless cartoon video tells the tale of a young man from early childhood through adolescence to early adulthood. His story includes seeing violence in his home, interacting with his male peers, experiencing social pressures to behave like a 'real man', his first unprotected sexual experience, having an STI and facing an unplanned pregnancy. As a silent cartoon, it cuts across cultures and encourages discussion about how boys are socialized to act.

In addition to the curriculum, Promundo, one of the founding organizations, and its partners developed what they call a 'lifestyle social marketing' process that discovers popular social channels for young men within the cultural context. They then fashion messages—in the form of radio spots, billboards, posters and television series—to make it 'cool' and 'hip' to be a man who respects gender equality.

Promundo also conducted a two-year evaluation study to assess the impact of the programme in a population of 750 young men aged 15 to 24 in Rio de Janeiro, Brazil. They used a methodology that they developed called the GEM (gender equitable behaviours in men) scale to measure men's attitudes about gender. Findings showed that Programme H had a positive impact on attitudes.

**Source:** Adapted from: *Working with Young Men to Promote Gender Equality: An experience in Brazil and Latin America*, by Marcos Nascimento.<sup>178</sup>

## Expanding and strengthening youth-friendly health services

The health sector needs to provide healthcare that meets the needs of young people.<sup>181</sup> The specific approach and services will vary, depending on the context, but key elements are conducting outreach to attract young people, creating an appealing and comfortable environment, and ensuring confidentiality and privacy. Pre-service and in-service training curricula should incorporate content on adolescent health and emphasize the importance of treating young people (and all clients) with understanding and respect.

## Increasing funding for sexual and reproductive health

Despite improvements in some areas, progress towards sexual and reproductive health for all has been unacceptably slow.

Moreover, the gradual advances that have been made are now threatened by the economic crisis. If the MDGs regarding sexual and reproductive health, maternal and newborn mortality and HIV are to be reached, the pace of progress must more than double over the next five years, in a context of scarcer resources.<sup>182</sup> This will require more funding, which is strategically directed and effectively used.

## Family planning services

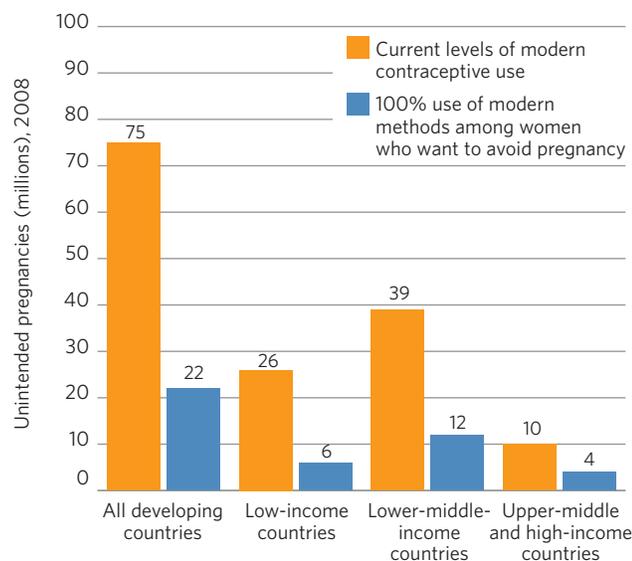
Immediately providing contraceptive services and commodities to all who want them to delay, space or avoid pregnancy would cost \$6.7 billion (in 2008 US dollars) per year: this includes \$3.1 billion for serving current users of modern family planning methods plus \$3.6 billion to fulfil unmet need.<sup>183</sup> If the estimated 215 million people with unmet need for modern family planning methods were to use contracep-

tion, unintended pregnancies in developing countries would drop by 53 million, to 22 million (see Figure 15). It would also result in 25 million fewer abortions and 7 million fewer miscarriages.<sup>184</sup>

UNFPA has projected that each additional \$10 million spent on service delivery and health system overhead costs for family planning could prevent 114,000 unintended pregnancies, 50,000 unplanned births, 48,000 induced abortions, 15,000 spontaneous abortions and over 3,000 infant deaths. Studies show that each dollar invested in contraceptive services would avert between \$1.7 and \$4 in expenditures on maternal and newborn health and up to \$31 in social and other expenses.<sup>185</sup> Condom programming to prevent HIV infection adds to these benefits.

*Each dollar invested in contraceptive services would avert between \$1.7 and \$4 in expenditures on maternal and newborn health and up to \$31 in social and other expenses*

**FIGURE 15**  
**Unintended pregnancies would decline sharply if women with an unmet need for modern contraceptives gained access to them**



Estimated number of unintended pregnancies at 2008 levels of modern contraceptive use and projected levels if unmet need for family planning were met using modern methods, by income groups of developing countries

**Source:** Guttmacher Institute and UNFPA, 2009: *Adding It Up: The benefits of investing in family planning and reproductive health.*

## Maternal and newborn healthcare

The current cost of providing pregnant women and newborns with maternal and newborn care is \$8.6 billion per year (Figure 16). This supports current—though incomplete—levels of coverage. Expanding services so that all women receive the recommended maternal and newborn care would increase costs by \$14.3 billion, to a total of \$23 billion, and would mean that the number of maternal deaths would drop by 57 per cent.

If the unmet need for modern contraceptives were also met, it would reduce unintended pregnancies, thereby saving \$5.1 billion that would otherwise be needed to provide care to pregnant women and newborns. In that case, the cost of expanding maternal and newborn care to all would increase to only \$17.9 billion, instead of \$23 billion.<sup>186</sup>

Meeting the need for both contraceptive services and maternal and newborn care would cost \$24.6 billion a year (see Figure 16), a little more than double the current level of \$11.8 billion. The total represents only \$4.50 per capita and would translate into lives saved and disabilities prevented:

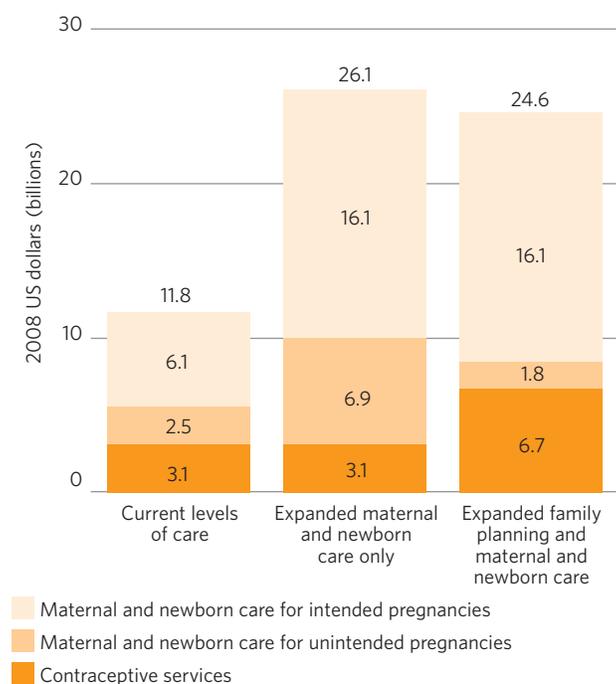
- Unintended pregnancies would decline from 75 million in 2008 to 22 million per year, a drop of more than two thirds (see Figure 15).
- Maternal deaths would be reduced by 70 per cent, a further increase above investments in maternal and newborn health alone.
- Forty-four per cent of newborn deaths would be averted, a decline from 3.5 million to 1.9 million.
- Unsafe abortions would decline by 73 per cent, from 20 million to 5.5 million, assuming abortion laws remain unchanged.
- The number of women needing medical care for complications of unsafe abortion would drop from 8.5 million to 2 million.<sup>187</sup>

This scenario is hypothetical, based on instantaneous achievement of family planning and maternal and newborn health goals. If the elimination of current unmet need were gradually phased in between now and 2015, the figure would come to a similar total, though the benefits would be somewhat delayed. Of course, the total cost of achieving sexual and reproductive health for all would be much greater, since it would and should include costs related to preventing and treating HIV and other STIs, addressing closely related

issues, such as gender-based violence and harmful practices, and conducting relevant policy advocacy, public education and research.<sup>188</sup> But as this report has argued, investing in sexual and reproductive health can create opportunities to address these other important concerns and to reap benefits in multiple areas.

Donors need to work together to analyse the areas of greatest need within specific contexts and to prioritize strategies that focus on vulnerable populations. They should use a mix of funding instruments, again considering the country context, which includes both general and sector support as well as targeted programme support and funding aimed at strengthening civil society.

**FIGURE 16**  
Investments in family planning would help offset the cost of improved maternal and newborn healthcare



Estimated costs of family planning and maternal and newborn care, under different coverage scenarios

**Notes:** Estimates are for 2008 for all developing countries. A small proportion of the cost of care for unintended pregnancies is for post-abortion care. Components may not add up to totals because of rounding. 'Current levels of care' reflect no change in contraceptive use or maternal and newborn care. 'Expanded maternal and newborn care only' reflects 100% coverage with recommended care and no change in contraceptive use. 'Expanded family planning and maternal and newborn care' reflects 100% use of modern methods and 100% coverage with recommended maternal and newborn care.

**Source:** Guttmacher Institute and UNFPA, 2009: *Adding It Up: The benefits of investing in family planning and reproductive health*.

## Improving monitoring and evaluation

### Building capacity and mechanisms to monitor progress

Better stewardship of available funds requires expansion of methodologies that inform policy-making and the allocation of public resources to reach and serve the most vulnerable. This necessitates the monitoring of indicators that measure progress towards sexual and reproductive health for all and strengthening the means to gather new data and/or to use existing data to mark relevant developments and adjust programme strategies.

*Better stewardship of available funds requires expansion of methodologies that inform policy-making*

The definition and use of indicators and data should take into account equity issues. Key to this is disaggregation by sex, age, wealth and marital status.<sup>189</sup> Assessing equity may also require the development of proxies to measure differences in access and use.<sup>190</sup> Also central is recognition of the multidimensional and life-long nature of sexual and reproductive health and reproductive rights, which means looking at important social determinants, as well as outcomes, of sexual and reproductive health. Qualitative evaluations also contribute invaluable information about the effectiveness of programmes as well as equity concerns, such as identifying beneficiaries and barriers to access.

National governments may need technical assistance to strengthen their health information management systems, including the capacity to combine multiple streams of information.<sup>191</sup> It may not be feasible or effective to collect data for all indicators or for the whole population or for all health facilities. Accordingly, each country should find the most relevant indicators for their goals and contexts, and select a sample of households and healthcare facilities that can provide reliable information about access and use, quality of care, and effectiveness of policies and programmes. Existing national surveys can be used or expanded, and service providers trained to collect specific data.<sup>192</sup>

Beyond the process of developing indicators, baselines and benchmarks to track progress is the use of data to improve the quality of services. For example, it is critical for countries with



high maternal mortality to institutionalize audits and reviews of maternal deaths in all health facilities and in communities, so that circumstances that contribute to these deaths can be understood and prevented. Generally, improvements in health management information systems will improve the monitoring of service performance and generate evidence about the coverage and impact of interventions.

Finally, it is essential to build the capacity of affected communities and other civil society organizations to monitor the implementation of policies and programmes as well as budgeting processes.

## Conclusion

The MDGs are interdependent and increasingly are treated together; advances in each of the goals fosters progress in all the others. Sexual and reproductive health for all is part of this dynamic. It spurs social, economic, political and cultural progress and, in turn, is affected by them. Moreover, it is fundamental to

human dignity and welfare. Indeed, interventions in sexual and reproductive health are not only relevant because they contribute to poverty reduction and to economic growth; they are also important objectives in themselves and have been recognized as fundamental human rights. They should therefore be an integral part of any development strategy.<sup>193</sup>

This view is consistent with the wide-ranging vision laid out in the ICPD Programme of Action, which also recognizes the importance of expanding education, especially for girls, achieving gender equity, and reducing poverty and hunger—not only to facilitate access to reproductive health, but because they, too, are fundamental to human development and human rights. And understanding the dynamics of population growth is a key aspect of responding to climate change and other environmental harms, which threaten our very survival. Progress on these diverse goals and implementation strategies requires the kinds of partnerships outlined in Millennium Development Goal 8—developing a global partnership for development.

The ICPD vision, reflected in various goals in the MDG framework, points to the value of a comprehensive approach to primary healthcare, and to full and broadly participatory country planning and priority-setting. It also recognizes both the immediate and long-term impact of enabling individuals and couples to satisfy their desires as to the timing and spacing of their children. A holistic approach towards measurable outcomes in health improvement over the life cycle is at the core of this vision.

At a time of scarce resources and daunting global trials, investing in sexual and reproductive health is a clear and direct path to resolving a host of development challenges and to breaking the cycle of intergenerational poverty. By working towards

the goal of universal access, including to HIV prevention and treatment, we can improve and save millions of lives. At the same time, we can speed progress in other essential aspects of health, human rights and equitable development, and come that much closer to the goals envisioned by the Millennium Development process.

*Investing in sexual and reproductive health is a clear and direct path to resolving a host of development challenges and to breaking the cycle of intergenerational poverty*

# Notes and references

- 1 The definition of reproductive health used here is based on the ICPD Programme of Action.
- 2 The ICPD Programme of Action acknowledges that access to safe abortion services is legally restricted in many countries and calls for access to means of fertility regulation “which are not against the law.” The Key Actions adopted in July 1999, at ICPD+5, went further to say, “In circumstances where abortion is not against the law, such abortion should be safe.” (Paragraph 63.i).
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- 177 Promundo, ECOS and Instituto PAPI in Brazil, and Salud y Género in Mexico.
- 178 Marcos Nascimento is a psychologist with a Master's degree in public health. He coordinates the Gender and Health Programme at Instituto Promundo, a NGO based in Rio de Janeiro, Brazil.
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- 180 Haberland, Nicole, and Deborah Rogow. August 2007. *Sexuality and HIV Education: Time for a paradigm shift*. Brief no. 22. New York: The Population Council.
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- 183 Singh, Susheela, et al. 2009. *Adding It Up: The benefits of investing in family planning and reproductive health*. New York: Guttmacher Institute and United Nations Population Fund. Population growth and increases in demand for services will raise this requirement. The figures presented here are for immediate satisfaction of unmet need. Operationally, scaling up programmes takes time. Additional analyses demonstrate that aggregate family planning costs over the period 2010-2015 would be similar under the immediate and phased scenarios, but the benefits would be achieved at different paces (see: United Nations Population Fund, Technical Division. 2009. *Revised Cost Estimates for the Implementation of the Programme of Action of the International Conference on Population and Development: A methodological report*. New York: UNFPA). New UN estimates of maternal mortality will be released about the time this report is published. Preliminary analyses support the relative magnitudes of impact of increased investment in family planning and maternal and newborn health on outcomes. Some adjustments of exact cost estimates may be required.
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### Acknowledgements:

This report was prepared under the direction of Stan Bernstein and Linda Demers of UNFPA's Technical Division. It was researched and written by Susan Wood and edited by Lois Jensen. The editorial team would like to acknowledge the valuable comments and input of UNFPA's Technical Division, Programme Division, Office of the Executive Director and Regional Offices. Special thanks to Werner Haug, Mona Kaidbey, Kabir Ahmed, Elizabeth Benomar, Henia Dakkak, Sennen Hounton, Katja Iversen, Azza Karam, Josiane Khoury, Jacqueline Mahon, Luz Angela Melo, Mary Otieno, Josephine Sauvarin and Sylvia Wong. Also appreciated were the valuable contributions provided by UNFPA Country Offices in Argentina, Bangladesh, Cambodia, Democratic Republic of the Congo, Ecuador, Ethiopia, Georgia, Indonesia, Nepal, Somalia, United Republic of Tanzania and Viet Nam.

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ISBN: 978-0-89714-979-2

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