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Monitoring of population programmes, focusing on fertility, reproductive health and development

Report of the Secretary-General

Summary

The present report on the monitoring of population programmes, focusing on fertility, reproductive health and development, has been prepared in response to the topic-oriented and prioritized multi-year work programme of the Commission on Population and Development, which was endorsed by the Economic and Social Council in its decision 2009/239. In its decision 2009/101, the Commission decided that fertility, reproductive health and development should be the special theme for the forty-fourth session of the Commission in 2011.

The report reviews the interrelations between fertility, sexual and reproductive health, development and human rights. It examines work in progress, from relevant advances in terms of commitments at different levels, partnerships and experiences and lessons on different programme fronts. In addressing the tasks ahead, the report highlights knowledge of what works and actions still needed to speed up progress and achieve the promise of universal access to sexual and reproductive health, and reaching those left behind.

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I. Introduction

1. The Programme of Action[1] adopted at the International Conference on Population and Development, held in Cairo in 1994, raised awareness of the importance of human rights, gender equality and a broader concept of sexual and reproductive health, sexuality and parenthood on the population and development agenda. Over the 16-year period in which the Programme of Action has been implemented, many successes and advances have been observed. Yet important gaps remain which must receive more international attention, action and funding.

2. The implementation of the Programme of Action is intimately related to global efforts to eradicate poverty and achieve sustainable development. Human rights, sexual and reproductive health and reproductive rights, and gender equality shape population dynamics, which are all-important to development and sustainability. In response to the request of the Commission on Population and Development, the present report examines progress in the implementation of the Programme of Action in areas of fertility, sexual and reproductive health and development. The report comprises eight sections. Section II starts by examining the interrelationships between fertility, sexual and reproductive health, development, including the Millennium Development Goals, and human rights. Section III examines an essential package of services in sexual and reproductive health in relation to the health-care system. Section IV looks at progress in relation to the Millennium Development Goal target of universal access to reproductive health, and reaching those left behind. This is not only a human rights imperative: reducing disparities and reaching the unreached will largely determine the degree to which the Millennium Development Goals — including poverty reduction — will be achieved. It will also play a pivotal role in determining whether world population can stabilize earlier than expected, which would have an enormous impact on environmental sustainability and other challenges.

3. Sections V and VI then examine different aspects of the work in progress, from relevant advances in terms of commitments at different levels, partnerships and experiences on different programme fronts. The report highlights in sections VII and VIII challenges of implementation and actions still needed. Political commitment, capacity-building and reliable and adequate funding are critical to speeding up progress.

4. In doing so, policymakers and funders must target scarce resources to poor and marginalized groups, while addressing the issues underlying their vulnerability. These groups are likely to include the poor, adolescents and youth, migrants and population affected by humanitarian crises, people living in rural areas, ethnic minorities and indigenous populations. Factors related to gender cut across all of these groups, and special attention should be directed to marginalized girls and women. In conclusion, the report points out that the vision of the International Conference on Population and Development, reflected in various goals in the Millennium Development Goals framework, highlights the value of a comprehensive approach to primary health care, and to broad participatory country planning and priority-setting. Special attention must be placed on young people, who represent a large proportion of the marginalized. They are critical to bringing

[1] *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994* (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex.

about the positive changes needed to achieve universal access, stabilize global population growth and accelerate economic development.

II. Fertility, sexual and reproductive health, development and human rights

5. The Programme of Action that emerged from the International Conference on Population and Development placed human rights, equity, choice and individual decision-making at the centre of population and development policies and programmes. Family planning was integrated in a broader definition of sexual and reproductive health, encompassing also maternal and newborn health care; prevention, diagnosis and treatment of sexually transmitted infections (STIs), including HIV; adolescent sexual and reproductive health; the prevention of abortion and the management of the consequences of abortion;[2] cancer screening; and infertility counselling. Access to comprehensive sexuality education is another fundamental component of the Programme of Action.

6. By addressing a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", the International Conference on Population and Development definition of sexual and reproductive health also incorporates the elimination of gender-based violence, harmful practices, coercion or abuse, and gender inequalities. Sexual health — intimately related to reproductive health — implies the ability to express one's sexuality free from risks of STIs, including HIV, unwanted pregnancy, coercion, violence, stigma and discrimination. It entails the capacity to have an informed, satisfying and safe sexual life.

7. Ensuring universal access to sexual and reproductive health, empowering women, men and young people to exercise their right to sexual and reproductive health, and reducing inequities, are fundamental to sustainable development and to ending poverty. This was reaffirmed in 2007, when universal access to reproductive health was added as a second target to Goal 5 of the Millennium Development Goals. Sexual and reproductive health is now part of the political agenda of world leaders and is increasingly recognized in international human rights law.

8. Sexual and reproductive health information and services, in particular family planning, can save many lives and improve the quality of lives of many more while promoting human rights, poverty reduction and development. Having fewer children, with longer intervals between births, is associated with reduced maternal and child mortality, and puts fewer demands on household, community and environmental resources. It enables families to invest more in each child's education, food and health, and enables Governments to shift savings to other social priorities. Furthermore, enabling women to take decisions about whether and when to bear children creates opportunities to pursue education and employment.[3]

9. Lower fertility puts in motion powerful incentives to economic growth. For example, if we account for lower dependency ratio in families and the ability of

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[2] In paragraph 8.25, the Programme of Action states that "in circumstances where abortion is not against the law, such abortion should be safe".

[3] United Nations Population Fund (UNFPA), *Sexual and Reproductive Health for All: reducing poverty, advancing development and protecting human rights* (New York, UNFPA, 2010).

women to seek employment, eliminating unwanted fertility was estimated to raise the incomes of the poor by 10-20 per cent in Honduras and in Colombia.[4] In conditions of extreme poverty, the effect can be equivalent to raising incomes by 20 per cent, an impact similar to or even larger than that of conditional cash transfers.

10. The potential microeconomic and macroeconomic returns resulting from the reduction in fertility, lower dependency ratios and the increasing concentration of the population in productive age groups with the coming of age of large cohorts of young people, are very real. More important, these returns emanate from people, especially women, exercising their rights. Enabling policies (such as employment creation, education and employable skills for new entrants to the labour force) ensure this demographic dividend. The policies required for the demographic dividend to translate into accelerated economic growth consist mostly of investments in human capital and infrastructure, and must be part of any sound development policy.

11. The use of safe and reliable contraceptives is one of the several factors influencing fertility, by allowing women and couples to decide the timing, spacing and number of pregnancies. Access to sexual and reproductive health information and services, and in particular to safe and reliable contraceptives, has increased since the 1960s, and varies by region and by socio-economic characteristics of women and households. Accordingly, starting in the 1960s, dramatic declines in fertility were observed in much of the world, followed by more gradual decreases since 1995. Fertility levels vary among regions and by women and household characteristics.

12. Fertility decline contributes to slowing population growth, but even with declining fertility, the medium variant of the United Nations population projections anticipates that growth will continue at least until 2050.[5] Most of the growth will take place in the developing world, as a result of the combined effects of the large number of women of childbearing age owing to the high fertility of the past (population momentum), declining mortality and remaining high fertility in some parts of the world. Population momentum will be the largest contributing factor, followed by declining mortality and high fertility as the growing population of reproductive age increases the number of births even if couples have only two children. However, important differences exist between regions and countries, for instance, high fertility is still the largest component of growth in sub-Saharan Africa.

13. Addressing high fertility where it prevails continues to be a viable strategy, provided that programme interventions are human rights-based and give women the opportunity to influence the number of children and the spacing between births that they desire. However, in other situations, where population growth is already due almost exclusively to population momentum, it may still be possible to reduce population growth in the short run by delaying childbearing. Increases in the age at marriage, stimulated by the increasing education of women, improving gender equality, and greater female labour-force participation can have significant effects on population growth rates and can foster economic growth.

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[4] United Nations Population Fund, *Population and Poverty Linkages: impacts of population dynamics, reproductive health and gender on poverty* (New York, UNFPA (forthcoming)).

[5] *World Population Prospects: The 2008 Revision* (United Nations publication, Sales No. 10.XIII.2).

14. Integrating sexual and reproductive health, including family planning, adolescent and youth programmes and other International Conference on Population and Development components, into development plans, including poverty reduction strategies, is a smart choice in terms of efficiency and effectiveness. The resulting synergies create promising scenarios in the medium and long term, which are fundamental to achieving the Millennium Development Goals, environmental sustainability, and adaptation and mitigation strategies for climate change.

III. Sexual and reproductive health and the health-care system

15. Sustainable delivery of quality sexual and reproductive health services requires functioning health-care systems. The minimum health-care package must incorporate sexual and reproductive health services at all levels, especially at the primary level. A core package of such services includes: family planning; maternal and newborn care (including quality delivery care and emergency obstetric services); prevention of abortion and management of the consequences of abortion; and STI/HIV prevention and services, including access to male and female condoms, voluntary counselling and testing, the prevention of mother-to-child transmission and antiretroviral therapy, either at the same facilities or by referral.[6] Sexual and reproductive health services should also be available to people living with HIV. This package also addresses gender-based violence and harmful practices.

16. Integrating sexual and reproductive health into primary health care is a key thrust of the International Conference on Population and Development and has multiple benefits. Bringing women and vulnerable groups, including adolescents, into the health-care system provides an opportunity to identify people at risk, offer family planning and HIV prevention information and services, and diagnose and treat other STIs. High-quality commodities and many sexual and reproductive health interventions must be available whenever needed. The ability to meet sexual and reproductive health needs is therefore a signal indicator of the coverage and accessibility of health services overall. In locations where services are limited, mobile units and services at the workplace should be created. Adequate training and compensation for health workers are critical.

17. That said, the health sector alone cannot achieve sexual and reproductive health for all. Sociocultural norms surrounding gender equality, sexuality, reproduction and harmful practices have to be challenged in order to address the roots of poor sexual and reproductive health and to reach people at the community level. This entails strong intersectoral collaboration, community mobilization, and innovative media and communication strategies to provide information and to encourage social, behavioural and cultural norms supportive of gender equality and good health. This also means providing sexuality education to young people and supporting girls and women in developing decision-making and negotiation skills. Furthermore, it is critical to engage men and boys in programmes and initiatives that promote gender equity, equality and women's empowerment.

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[6] United Nations Population Fund, *Making Reproductive Rights and Sexual and Reproductive Health a Reality for All: reproductive rights and sexual and reproductive health framework* (New York, UNFPA, 2008).

IV. The unfulfilled promise of universal access: the challenge of reaching those left behind

18. Starting in the 1960s, dramatic declines in fertility were observed in much of the world, followed by more gradual decreases since 1995.[7] Average fertility in the developing world (including China) was 2.7 children per woman in 2005-2010. In the least developed countries, fertility is estimated at 4.4 children in 2005-2010. Fertility declines have slowed in recent years in many regions. In sub-Saharan Africa, fertility has remained very high, at about five children per woman. Countries with the highest levels, such as Burundi, Mali, the Niger, Sierra Leone and others, also face high child mortality and very low per capita incomes.[8] Several factors influence fertility, such as age, education, residence, marital status, household wealth, age at marriage, the availability and use of contraceptives, and so forth.

19. The use of contraception has increased dramatically since the introduction of oral contraceptives in the 1960s. In 2007, 63 per cent of women around the world (aged 15 to 49) who were married or in union used a method of contraception, versus 55 per cent in 1990.[9] Family planning helped to reduce the rate of unintended pregnancies by 20 per cent in developing countries from 1995 to 2008.[10] Moreover, if the existing need for both modern contraceptives and maternal and newborn health services was met in developing countries, maternal deaths would be reduced by more than two thirds and newborn deaths by more than half. Still, contraceptive use remains low, especially in sub-Saharan Africa, rising from 12 per cent in 1990 to 20 per cent in 2000 to just below 22 per cent in 2007.[9] Disparities have persisted or grown within countries: for example, throughout sub-Saharan Africa, contraceptive prevalence among women living in the wealthiest 20 per cent of households in 2007 is close to four times that of those living in the poorest 20 per cent.[11]

20. An estimated 215 million women aged 15 to 49 and who are married or in union have an unmet need for family planning; this means that they would use contraceptives to prevent or delay pregnancy if they had the proper information and access to services. If data on women who are single were included, the absolute number of women with unmet need would be significantly higher. 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.[11] Unmet need always restricts the exercise of reproductive rights. Yet the interpretation of trends over time may not be straightforward as they reflect changes in supply and demand of contraceptives and are associated with behavioural change. Unmet need varies widely across and within regions. In the least developed countries, an estimated 24 per cent of women of reproductive age who are married or in union have an unmet need for family planning, versus 11 per cent in developing regions overall.[12] In Latin America and

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[7] Department of Economic and Social Affairs, Population Division, 2009.

[8] World Bank, "The World Bank's Reproductive Health Action Plan 2010-2015" (April 2010).

[9] *The Millennium Development Goals Report 2010* (United Nations publication, Sales No. E.10.I.7).

[10] Susheela Singh and others, *Adding It Up: the benefits of investing in family planning and reproductive health* (New York, Guttmacher Institute and UNFPA, 2009).

[11] United Nations Population Fund, *How Universal is Access to Reproductive Health? A review of the evidence* (New York, UNFPA, 2010).

[12] Department of Economic and Social Affairs, 2010, see http://unstats.un.org.unsd/mdg/.

the Caribbean, the level of unmet need ranged from a low of 6-7 per cent in Brazil and Colombia to 38 per cent in Haiti.[13] Unmet need in South and South-East Asia ranged from 5 per cent in Viet Nam to 25 per cent in Cambodia.

21. Data from sub-Saharan Africa also show that contraceptive use is lower 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.[14] Disparities are even wider when measured by household wealth and education. Women with no education have a contraceptive prevalence rate of 10 per cent, compared to 42 per cent for women with a secondary or higher education.

22. A recent review by the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), UNFPA and the World Bank estimates 358,000 maternal deaths worldwide for 2008, a 34 per cent drop from the 546,000 deaths reported in 1990[15] — encouraging, yet insufficient, progress. Developing countries continue to account for 99 per cent of total maternal deaths; 87 per cent of them occur in sub-Saharan Africa and South Asia. In sub-Saharan Africa, 1 in 31 women dies from causes related to pregnancy and childbirth, compared to 1 in 480 in Latin America and the Caribbean and 1 in 3,600 in developed countries.[15] Inequalities are again found within countries: wealthier groups and urban populations have achieved significant progress, while the poor and rural populations still suffer high levels of mortality.

23. The provision of care during pregnancy, one determining factor to reduce maternal mortality, has increased, with the greatest advancements seen in Northern Africa, where the share of women who made at least one antenatal visit during pregnancy increased by 70 per cent, and in Southern Asia and Western Asia, with reported increases of nearly 50 per cent.[3]

24. Unsafe abortion has been estimated to cause about 13 per cent of maternal deaths globally.[16] In some regions, such as Latin America, it is a leading cause of maternal death. In 2003, almost half of all abortions globally were unsafe and nearly all occurred in developing countries.[17] Worldwide, induced abortions decreased from nearly 46 million in 1995 to about 42 million in 2003. The largest drop occurred in Eastern Europe, falling from 90 to 44 abortions per 1,000 women of reproductive age.[18] The decrease corresponded with significant increases in contraceptive use.

25. In 2009, an estimated 33.3 million people worldwide were living with HIV.[19] The number of new infections in 2009 was estimated at 2.6 million, 21 per cent lower than in 1997 — the peak of the epidemic. HIV prevalence is declining among

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[13] Gilda Sedgh and others, "Women with an unmet need for contraception in developing countries and their reasons for not using a method", *Occasional Report*, No. 37. New York, Guttmacher Institute (June 2007); 2005 Demographic and Health Survey for Cambodia.

[14] Davidson R. Gwatkin and others, *Socio-Economic Differences in Health, Nutrition, and Population within Developing Countries: An overview* (Washington, D.C., World Bank, 2007).

[15] World Health Organization, *Trends in Maternal Mortality: 1990 to 2008. Estimates developed by WHO, UNICEF, UNFPA and The World Bank* (Geneva, WHO, 2010).

[16] World Health Organization, *The Global Burden of Disease: 2004 update* (Geneva, WHO, 2008).

[17] Susheela Singh and others, *Abortion Worldwide: A Decade of Uneven Progress* (New York, Guttmacher Institute, 2009).

[18] Gilda Sedgh and others, "Legal abortion worldwide: incidence and recent trends", *Perspectives on Sexual and Reproductive Health*, Vol. 39, No. 4 (New York, Guttmacher Institute, 2007).

[19] Joint United Nations Programme on HIV/AIDS, *Global Report: Report on Global AIDS Epidemic* (Geneva, UNAIDS, 2010).

young people in 16 of the 21 countries most affected by HIV, largely owing to a fall in new infections and shifts in age at first sex, the number of sexual partners and condom use.[20] Sub-Saharan Africa remains the most heavily affected region, accounting for 69 per cent of all new HIV infections in 2009. Tremendous strides have been made in the number of people on antiretroviral therapy, yet prevention efforts need to be strengthened, which entails broader, more comprehensive sexual and reproductive health information and services (see A/64/735).

26. Some progress over the last several years was observed in access by adolescents and youth to sexual and reproductive health information and services. Still, they face steep challenges. The adolescent birth rate in developing countries decreased from 65 in 1990 to 55 in 2000, but has reached a plateau since, remaining at 53 per 1,000 girls in 2007. Sub-Saharan Africa has the highest level of adolescent birth rates and has seen little reduction in the rate.[11] High levels also persist in Latin America, Oceania and Southern and Western Asia. At the same time, disparities in adolescent birth rates are widening. Rates have declined in urban areas in sub-Saharan Africa, but may be on the rise among the poorest, least educated girls.[11] Almost 15 million adolescent girls become mothers every year. Young women are also up to eight times more likely to become infected with HIV than men of the same age in some of the worst affected countries, as their risk is exacerbated by their unequal status.[19]

27. Early childbearing, associated with child marriage, leads to adverse consequences for sexual and reproductive health. While the mean age of marriage has been rising, particularly in parts of Asia and Northern Africa, many women in developing countries still marry at a very young age: about one in four girls aged 15 to 19 in the developing world (excluding China) are married.[17] Child marriage is twice as high in rural areas as in cities.[21] Full consent to marriage has long been recognized as a human right, yet exercising that right is not yet universally guaranteed.

28. Research has revealed that a disproportionate share of public spending on health and education goes to the wealthier sectors of society.[14] As the wealthy see increasing gains in access to sexual and reproductive health, those excluded by poverty, gender, ethnicity, age, residency, lack of education, conflict or other forms of marginalization are often left behind. Data for 24 sub-Saharan African countries show that women living in the wealthiest households and women with secondary or higher levels of education have seen notable progress, while the poorest and least educated have not.

29. Lack of access to sexual and reproductive health aggravates poverty. However, those receiving services quickly transition to lower levels of mortality, morbidity and fertility, and to family structures with lower dependency rates. As a result, they have increased capacity to shift resources from basic consumption to improved education, nutrition and health, as well as savings and capital assets. In contrast, those left behind have a heavier burden of disease and higher levels of mortality along with poor nutrition. They also use higher proportions of their household income for basic subsistence. Their high fertility translates into a large number of

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[20] Joint United Nations Programme on HIV/AIDS (UNAIDS), *Outlook Breaking News*, "Young people are leading the prevention revolution" (Geneva, UNAIDS, 2010).

[21] United Nations Children's Fund, *The State of the World's Children 2009: Maternal and Newborn Health* (United Nations publication, Sales No. E.09.XX.1).

dependent children deprived of education and choices in life, who — in turn — tend to marry and start childbearing early, reproducing a life cycle of deprivation and poverty.

V. Work in progress: commitments and partnerships

30. Political commitment is a key factor in achieving progress in sexual and reproductive health. At all levels, positive changes have been observed in terms of commitments, policies, laws, partnerships and development approaches, promoting a conducive environment for sexual and reproductive health, guiding strategies to expand gains and to address glaring inequities. The present section highlights a few important examples to illustrate progress made from that perspective.

Global level

31. Progress at the global level has been significant. International conferences in the 1990s and their follow-up events advanced understanding of sexual and reproductive health and reproductive rights, clearing the way for stronger implementation. During the last decade, international human rights law and United Nations treaty monitoring bodies, which are legally binding on Governments, have increasingly recognized sexual and reproductive health, particularly in the areas of adolescents' rights, maternal health and family planning.

32. Over the last decade, the centrality of the International Conference on Population and Development in the achievement of the Millennium Development Goals has been recognized in many intergovernmental processes; the addition of Goal 5b on universal access to reproductive health complemented other Goals on different aspects of the Programme of Action, for example, Goal 3 on the promotion of gender equality and the health Millennium Development Goals on maternal mortality (Goal 5), newborn health (Goal 4), and on the prevention of HIV (Goal 6). The United Nations Millennium Project recognized reproductive health among the "Quick Wins/Quick Impact Initiatives" in its primary report.[22] In the outcome document adopted by the High-level Plenary Meeting at the United Nations Summit on the Millennium Development Goals that took place in New York in September 2010, world leaders reconfirmed their commitments to sexual and reproductive health and identified a series of actions to implement, based on lessons learned and good practices for each of the Goals, including for the health-related Goals in an integrated manner (see General Assembly resolution 65/1).

Regional level

33. Important policy statements and commitments have been made at the regional level, especially in Africa. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (better known as the Maputo Protocol) was signed in 2003 and entered into force in 2005. The Protocol condemns and prohibits sexual violence and harmful practices 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

[22] United Nations Millennium Project, *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals* (London and Sterling, Virginia, Earthscan, 2005).

those rights. In 2006, the African Union endorsed the Continental Policy Framework for Sexual and Reproductive Health and Rights in Africa. African ministers of health then developed a document outlining a plan of action, which was endorsed in 2007. This was reaffirmed in July 2010 by the ministers, who also recommended that African countries participate in the Campaign for Accelerated Reduction of Maternal Mortality in Africa, an initiative to hold member countries accountable for action on their pledges.

34. Ministers of health and education from Latin America and the Caribbean committed themselves to investing in comprehensive sexuality education and youth-friendly health services through the Ministerial Declaration on "Preventing through education". The Declaration was adopted in Mexico City in August 2008, in advance of the seventeenth International Conference on AIDS.

Global and regional initiatives and partnerships

35. The Group of Eight (G8) industrialized nations have addressed health as an essential aspect of development since the early 1990s. In 2000, the G8 began establishing the Global Fund to Fight AIDS, Tuberculosis and Malaria; in 2001, they identified the challenge of breaking the cycle of poverty and disease; in 2005, they agreed to boost investment in HIV/AIDS and malaria; and, at the most recent meeting in Muskoka, Ontario, they identified maternal, newborn and child health as a G8 flagship initiative, with family planning as a key component. Providing for Health (P4H), coordinated by France and Germany, was mandated to implement decisions taken at G8 summits to strengthen health systems. In addition, the Group of Twenty (G20) has reaffirmed its commitment to meeting funding pledges for the Millennium Development Goals and ODA, in line with the principles of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action.

36. A joint effort by UNFPA, UNICEF, WHO, the World Bank and UNAIDS is under way to improve maternal and newborn health. The initiative, known as H4+, is helping 49 countries to build capacity in this area and has mobilized an unprecedented number of commitments from countries around the world. Joint programmes in countries, including Bangladesh, Ethiopia, Nigeria and Pakistan helped to lay the groundwork for the Secretary-General's Global Strategy for Women's and Children's Health, launched in September 2010.

37. The Global Strategy is the first blueprint of its kind to intensify and coordinate existing efforts, build new commitments and establish an accountability framework for delivering results. The Strategy was endorsed by Governments, international organizations, philanthropic institutions, civil society, the business community, health workers, professional associations and academic and research institutions, and welcomed by all 192 Member States. The strategy gives the world community an agreed plan that stresses the need for investment, innovation and measurable results, accompanied by over $40 billion in pledges of support.

38. The global Partnership for Maternal, Newborn and Child Health was launched in 2005 to harmonize action in this area. The Partnership provides a forum through which members can combine their strengths and implement solutions that no one partner could achieve alone.

39. The International Health Partnership is scaling up efforts to advance the health-related Millennium Development Goals. The Partnership is strengthening

national processes in 21 countries in Africa and Asia with a focus on revitalizing health systems.

40. The Reproductive Health Supplies Coalition is a global partnership of multilateral and bilateral organizations, private foundations, Governments, civil society, and private-sector representatives dedicated to ensuring that all people in low- and middle-income countries can access and use affordable, high-quality contraceptives and other reproductive health supplies.

41. 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; promoting harmonization and alignment with country processes; and helping to remove health-system bottlenecks.

Private foundation initiatives

42. Increasingly, private foundations have come to support sexual and reproductive health as part of their agenda; for example, in June 2010, the Bill and Melinda Gates Foundation announced a commitment to spend $1.5 billion through 2014 on family planning; health care for pregnant women, newborns and children; and nutrition.

Country level

43. The recent 15-year review of the International Conference on Population and Development has revealed the depth and variety of policy change at the country level:[23] commitment, policies, strategies and plans to enforce reproductive rights, to eliminate gender-based violence, to provide sexuality education to young people, to strengthen access to sexual and reproductive health at the primary health-care level, and so on. Implementation of these commitments and plans in resource-constrained and diverse national contexts remains the most important challenge in moving forward.

VI. Work in progress: programmes on the ground

Improving maternal health

44. Through the Maternal Health Thematic Fund, UNFPA provides support to countries with high levels of maternal mortality and morbidity by addressing obstetric fistula and emergency obstetric and newborn care. For example, with support from H4+ and Columbia University, the Government of Ethiopia carried out an emergency obstetric and newborn care needs assessment to document gaps in the provision, quality and use of sexual and reproductive health services. The findings are being used for policymaking and planning, including the development of a five-year national health-sector plan, comprising an annual core plan and a joint United Nations programme on improving maternal and newborn health, including the training, recruitment and retention of health workers — with encouraging results so far.

45. In 2008, UNFPA and the International Confederation of Midwives launched a joint programme to improve skilled attendance at birth in low-resource settings by

[23] UNFPA, *Looking Back, Moving Forward: The results and recommendations of the ICPD-at-15 review*, 2010.

developing a sustainable midwifery workforce. The programme is now under way in 15 countries, mostly in sub-Saharan Africa, where midwife advisers in country offices work with Governments to address gaps and increase the availability and quality of care provided.

46. In Mongolia, with the support of UNFPA and other partners, improved antenatal care and the promotion of mobile sexual and reproductive health services and outreach activities to reach remote and vulnerable populations have contributed to a drop in the maternal mortality ratio from 79 per 100,000 live births in 2005 to 65 per 100,000 in 2008.[15]

47. In order to address persistently high maternal and neonatal mortality, UNFPA, UNICEF and WHO, with financial support from the Department for International Development of the United Kingdom and the European Union, joined hands with the Government of Bangladesh to implement a comprehensive initiative to improve the utilization of quality maternal and newborn health services, especially among the poor and socially excluded groups. As a result, the number of deliveries in public health facilities has increased, as has the treatment of complicated cases in hospitals.

Expanding access to family planning

48. The UNFPA Global Programme to Enhance Reproductive Health Commodity Security is supporting some 45 countries to increase their contraceptive prevalence rate and reduce the unmet need for family planning. The programme is providing contraceptives and other essential sexual and reproductive health commodities, helping to increase demand, and building national capacity for the management of sexual and reproductive health supplies. For instance in Madagascar, where the unmet need for family planning is 24 per cent, UNFPA has successfully supported the public health distribution system through training, software and supplies to overcome stock-outs or overstocking in health facilities.

49. In Jamaica, UNFPA has been providing support to reduce teenage pregnancies and to ensure pregnant adolescent girls receive the services they need to mitigate the effects of early pregnancy on their educational, economic and social opportunities. Girls are provided access to family planning and receive sexuality education and counselling.

Providing post-abortion care

50. In Argentina, complications from abortions have been the leading cause of maternal death for more than 25 years. The Ministry of Health, with support from UNFPA and UNDP, undertook a project to improve the quality of care for abortion complications, aimed at strengthening the capacity of public hospitals to provide comprehensive care for women with incomplete abortions. The project resulted in reduced waiting times and total time spent in the hospital.[24]

Combating HIV

51. In Zimbabwe, the percentage of those infected between the ages of 15 and 19 fell from 23.7 per cent in 2001 to 14.3 per cent in 2010. In that country, UNFPA, in

[24] United Nations Development Group, *MDG Good Practices*, 2010, available from <www.undg-policynet.org/?q=node/11>, accessed 19 January 2011.

collaboration with other United Nations system agencies and partners, helped to develop a comprehensive condom programme and a massive behavioural change communication effort that touched all parts of the society.

Targeting adolescent girls

52. 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. It has initiated girl-targeted activities in Ethiopia, Guatemala, Liberia and Malawi. In the Amhara region in Ethiopia, for instance, where 48 per cent of rural married women and 28 per cent of urban married women were married before the age of 15, a programme supported by UNFPA was instrumental in increasing the mean age of marriage from 13.5 to 15 through a comprehensive intervention targeted at adolescent girls.

Abandonment of harmful practices

53. The UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting, which started in 2007, works in 17 countries with a high prevalence of the practice. The programme is designed to facilitate grass-roots-level community education programmes and social mobilization campaigns leading to the collective abandonment of the harmful practice. During 2009 alone, such activities have led to the public abandonment of the practice in hundreds of communities in the Gambia, Guinea, Senegal and the Sudan.

Expanding sexuality education

54. Evidence shows that young people want information on sexual and reproductive health, including on HIV. Research also indicates that sexuality education programmes tend to postpone the onset of young people's sexual activity, reduce the number of sexual partners and increase condom use.[25] Since 1993, with UNFPA support, the Government of Colombia has implemented a comprehensive programme that aims to improve young people's knowledge of sexual and reproductive health issues and promote gender equality. More than 2,000 teachers have attended 180 workshops through the programme. Universities are now offering courses on sexuality education, ensuring a supply of trained teachers.

Tapping innovation and new technologies

55. Since the International Conference on Population and Development, contraceptive technology and other reproductive health interventions have progressed, with improvement in and diversification of existing methods and with the development of new ones. These have resulted in more choices for women, higher degrees of safety and efficacy, and additional modes of delivery. Funding for contraceptive research and development, for instance, through the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, remains insufficient, however.

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[25] United Nations Educational, Scientific and Cultural Organization, *International Technical Guidance on Sexuality Education: An evidence-informed approach for schools, teachers and health educators*, Vol. 1 (Paris, UNESCO, 2009).

56. 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 health-care level.[26] Two recently developed vaccines can protect against infection by certain strains of the human papillomavirus, which causes most cervical cancers. Reaching pre-teens and adolescents with this vaccine could bring down rates of cervical cancer, the leading cause of cancer death among women in the least developed countries. Significant advances have, for instance, been made in Georgia on cancer prevention and early detection. In the early 2000s, the Government focused on treatment at advanced stages of the disease. Today, the Georgia Breast Cancer and Cervical Cancer Screening Programme, which began in 2006 with UNFPA support, is offering services to promote early detection and plans to reach national coverage in the coming years.

57. The use of mobile phones in the developing world, where sexual and reproductive health challenges concentrate, can have a far-reaching impact. For example, monitoring and referral of patients by mobile phone could potentially follow women from the start of a pregnancy through the post-partum period. The use of mobile phones can also reduce delays in decision-making and transport during childbirth.[27] With UNFPA support, Mali is developing a mobile health system to monitor maternal and newborn deaths and to track stocks of contraceptives and life-saving medicines in health facilities.

VII. Challenges of programme implementation

58. **Political commitment and good governance**. Sexual and reproductive health for all requires tackling constraints at many levels: in the household and community, within the health-service delivery system, in broader policies and public institutions, and among donors and international organizations. The quality of governance at the national and local levels is crucial, as are the commitment, credibility and capacity to devise and implement sound policies for strengthening health systems and creating an enabling environment that makes universal access possible.

59. **Funding trends**. In recent years, donors have moved away from funding specific projects or disease-specific programmes. Rather, they are providing broader health-sector support aimed at addressing the underlying causes of poverty and supporting health systems overall. Frequently, important aspects of health, such as sexual and reproductive health, have however been neglected in the process. Development assistance for health overall nearly tripled between 2000 and 2008, owing mainly to the rapid increase in the amount of funding for HIV/AIDS, while aid for other sexual and reproductive health services lagged and funding for family planning declined. According to the UNFPA/Netherlands Interdisciplinary Demographic Institute Resource Flows Project, funding for family planning has increased somewhat in recent years, but is still below the 1994 figure.[28] At the same

[26] World Health Organization, *Global Strategy for the Prevention and Control of Sexually Transmitted Infections 2006-2015: Breaking the chain of transmission* (Geneva, WHO, 2007).

[27] *Women Deliver Bulletin* (December 2010).

[28] UNFPA, *Financial Resource Flows for Population Activities*, various years and report of the Secretary-General on the flow of financial resources for assisting in the implementation of the Programme of Action of the International Conference on Population and Development (E/CN.9/2011/5).

time, the number of women of reproductive age has grown substantially, as has the percentage of those who want to prevent or delay pregnancy. The unpredictability of funding from year to year also makes effective planning difficult.[29]

60. **Global financial and economic crisis**. The world's poorest countries are suffering especially from the indirect effects of slow recovery in developed countries and from the associated increase in food prices, since most of them are net food importers. Several donor Governments have fallen behind their aid commitments and the efforts of Governments to reduce budget deficits and public debt are likely to discourage a further increase in development assistance, with negative effects on all areas, including health and other social sectors.[30] The June 2010 pledge by the G8 of $5 billion for maternal, newborn and child health (including sexual and reproductive health) is promising, however.

61. **Weakened health systems and lack of skilled providers**. Sexual and reproductive health care must be embedded in a strong health system. Such a system must be adequately funded, through well-regulated private-public partnerships that are effectively governed, and must have a sufficient number of qualified and trained providers. It must also have insurance and other mechanisms to guarantee health-care coverage for all.[8] In reality, health systems face shortages of funds and personnel, which raise barriers to health care, especially among the poor and marginalized. Many countries, especially in Africa, face serious shortages of health-care staff. An estimated 2.4 million additional doctors, nurses and midwives are needed worldwide.[8]

62. **Persistent gender inequalities and violations of rights**. Every year, girls and women die unnecessarily owing to neglect, discrimination and violence. Millions suffer from intimate partner violence, "honour" crimes and crimes of passion, and a lack of medical attention or adequate nutrition.[31] Gender inequity and a failure to recognize and guarantee women's and girls' rights stall progress in sexual and reproductive health.

63. **Engaging religious leaders and faith-based organizations**. Despite advances in generating the support of religious leaders and faith-based constituencies for the International Conference on Population and Development agenda, pockets of organized opposition to evidence-based sexual and reproductive health programmes remain, which can impede the advancement of sexual and reproductive health and reproductive rights.

64. **Addressing inequities**. Despite considerable advances in the delivery of sexual and reproductive health services, they are very often not reaching the poor, resulting in disproportionately higher rates of sexual and reproductive health morbidity and mortality, and lower access to information and services. The most marginalized and vulnerable are not sufficiently factored into the design, planning and implementation of sexual and reproductive health programmes and policies.

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[29] Giulia Greco and others, "Countdown to 2015: assessment of donor assistance to maternal, newborn, and child health between 2003 and 2006", *The Lancet*, Vol. 371, No. 9620 (April 2008), pp. 1268-1275.

[30] "Swimming against the tide: how developing countries are coping with the global crisis", background paper prepared by World Bank staff for the G20 Finance Ministers and Central Bank Governors Meeting, Horsham, United Kingdom, 13-14 March 2009.

[31] Nicholas Kristof and Sheryl WuDunn, *Half the Sky: turning oppression into opportunity for women worldwide*, New York, Alfred A. Knopf, Random House, 2009.

VIII. What is needed to accelerate progress?

65. Progress on universal access to sexual and reproductive health requires urgent and sustained action at all levels. It calls for adequate funding, firm political commitment, courageous and creative programming, and the involvement of diverse actors, including civil society, faith-based and private sector partners. Key elements of the way forward include the following:

66. **Making sexual and reproductive health and reproductive rights a national priority**. A strong national commitment and funding, a functioning health-care system, integration of sexual and reproductive health into all levels of health care — especially primary health care — and a focus on reaching and serving vulnerable groups are fundamental. Sexual and reproductive health must be incorporated into national development planning mechanisms and translated beyond descriptions in situation analyses, into strategies, outputs and funding. Plans should include indicators such as fertility and maternal mortality rates for the population as a whole and/or specific groups. Process indicators should also be included, such as service use and access, 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.

67. **Using a human rights framework**. A human rights-based approach that promotes gender equality, equity and fairness is essential. Laws and policies should prohibit and sanction harmful practices, gender-based violence and discrimination in accessing health care. Creating an effective policy environment involves also building mechanisms for monitoring and accountability. Affected communities should be active participants in developing laws and policies and in ensuring that they are effectively carried out.

68. **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 must be integrated into other measures aimed at attaining gender equity, women's and girls' rights, universal access to education, and processes that promote democratic, participatory governance. Experience over the last few decades has provided ample evidence of what works. Preventive measures maximize well-being and protect rights, in addition to yielding high returns in terms of cost-savings for the public health system. The most effective approaches should be replicated and scaled up.

69. **Identifying and serving vulnerable groups**. To advance social justice and maximize scarce public resources, efforts should be made to address economic, social and cultural inequities. Regional, national and local contexts vary enormously, requiring reliable population data, analysis and consultation to identify the most vulnerable and excluded. Policymakers and funders should target scarce resources to such groups and address the underlying factors contributing to their vulnerability. Universal health-care coverage is the long-term goal. In the interim, it may be necessary to construct social protection floors for disadvantaged groups and individuals.

70. **Responding to the needs and realities of adolescents**. Policies and programmes should support the comprehensive development of young people through multisectoral approaches, including access to life-skills education and sexuality education; and the promotion of a core package of health and sexual and

reproductive health/HIV services that responds to the needs of young people and the multiple factors that shape sexual behaviour. They should also encourage young people's leadership and participation in all issues that pertain to their lives and affect their future.

71. **Building participatory processes**. Addressing the social and cultural determinants of poor sexual and reproductive health requires the leveraging of community-level resources for girls and women and involving men and boys. Implementation, monitoring and evaluation are most effective when they include all stakeholders and are rooted in community planning and mobilization. Engaging community organizations ensures ownership and the responsiveness of policies and programmes to people's needs and realities.

72. **Strengthening health systems**. Strengthening health systems for equitable, efficient and sustainable delivery of quality sexual and reproductive health services is paramount. 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 and eliminating barriers to access, including legal, cultural and economic obstacles.

73. **Training health-care providers**. Training of providers, including for task-shifting, can help to address shortages of health-care staff. Medical doctors are necessary for managing grave sexual and reproductive health problems. Other health professionals, such as midwives and other cadres, can be trained to handle most aspects of sexual and reproductive health, including deliveries, family planning, post-natal care, STI screening and treatment and the prevention of mother-to-child transmission of HIV.

74. **Maintaining the flow of sexual and reproductive health commodities**. The availability, efficient management and effective distribution of affordable, high-quality commodities, including contraceptives, male and female condoms, medicines and equipment, is key for a performing health system.

75. **Integrating sexual and reproductive health and HIV**. Many sexual and reproductive health problems, including HIV, unmet need for family planning and high maternal mortality, share the same root causes of gender inequity, poverty, exclusion and stigma. And many of the strategies that address those root causes are the same, such as changing sexual behaviours and community norms surrounding gender, sexuality and reproduction; strengthening and improving access to basic health services; tackling taboos around sexuality, and so forth. Therefore, integrating sexual and reproductive health and HIV prevention needs to happen at all levels: policymaking, the health-care system and within communities and households.

76. **Increasing funding while fostering cost-benefits for sexual and reproductive health**. The Millennium Development Goals related to sexual and reproductive health require additional resources that are strategically directed and effectively used, including the following:

(a) *Family planning services*. Immediately providing contraceptive services and commodities to all who want to delay, space or avoid pregnancy would cost $6.7 billion (in 2008 United States dollars) a year: this includes $3.1 billion for serving current users of modern contraceptive methods plus $3.6 billion to fill unmet needs. If the estimated 215 million women with an unmet need for modern

family planning methods were to use contraception, unintended pregnancies in developing countries would drop by 53 million (to 22 million), and 25 million abortions and 7 million miscarriages would be averted;[10]

(b) *Maternal and newborn health care*. The current cost of providing pregnant women and newborns with maternal and newborn care is $8.6 billion per year. 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 a year. As a result, maternal deaths would drop by an estimated 57 per cent. Meeting the unmet need for modern contraceptives would reduce unintended pregnancies, saving $5.1 billion, which could be used to provide care to pregnant women and newborns. Hence the yearly cost of expanding maternal and newborn care to all would increase to only $17.9 billion, versus $23 billion.[10]

77. **Improving planning, monitoring and evaluation**. Better stewardship of available funds requires increased capacity and improved methodologies to guide policymaking and the allocation of resources. These include indicators to measure progress towards universal access to sexual and reproductive health; the gathering of regular and quality data, disaggregated by sex, age, wealth, marital status, residence, and other pertinent characteristics such as ethnicity, for example; and using existing data to plan programmes, monitor developments and adjust strategies as necessary.

78. The Millennium Development Goals are interdependent and are increasingly addressed together; advances in each of the goals foster progress in all the others. Sexual and reproductive health for all is part of that dynamic. Sexual and reproductive health spurs social, economic, political and cultural progress and, in turn, is affected by them. Moreover, it is fundamental to human dignity and wellbeing. This is consistent with the wide-ranging vision of the Programme of Action of the International Conference on Population and Development, which recognizes the importance of expanding education, especially for girls, achieving gender equity, and reducing poverty and hunger. Understanding and addressing the dynamics of population growth is a key aspect of responding to climate change and other environmental harms that threaten our very survival.

79. The International Conference on Population and Development vision recognizes both the immediate and long-term impact of enabling individuals and couples to satisfy their aspirations regarding the timing and spacing of their children. In working towards the goal of universal access to sexual and reproductive health, including to HIV prevention and treatment, many lives will be saved and countless others made better. At a time of scarce resources, investing in sexual and reproductive health is a clear path to resolving a host of development challenges and to breaking the cycle of intergenerational poverty.