
Executive summary

Introduction

Sexual and reproductive health (SRH) was given an international consensus definition at the International Conference on Population and Development (ICPD) in 1994. At its core is the promotion of healthy, voluntary and safe sexual and reproductive choices for individuals and couples, including decisions on family size and timing of marriage, that are fundamental to human well-being. Sexuality and reproduction are vital aspects of personal identity and key to creating fulfilling personal and social relationships within diverse cultural contexts.

SRH does not only involve the reproductive years but emphasizes the need for a life-cycle approach to health. It touches on sensitive, yet important, issues for individuals, couples and communities, such as sexuality, gender discrimination and male/female power relations. Attainment of SRH depends vitally on the protection of reproductive rights, a set of long-standing accepted norms found in various internationally agreed human rights instruments.

The ICPD adopted the goal of ensuring universal access to reproductive health by 2015 as part of its framework for a broad set of development objectives. The Millennium Declaration and the subsequent Millennium Development Goals (MDGs) set priorities closely related to these objectives. Progress towards the MDGs depends on attaining the ICPD reproductive health goals. The leaders of the world ratified that understanding in the 2005 World Summit Outcome Document (UN 2005b).

The current situation

A lack of access to SRH is a major public health concern, especially in developing countries. For example, death and disability due to SRH accounted for 18 percent of the total disease burden globally and 32 percent of the disease burden among women of reproductive age (15–44) in 2001, though there is considerable

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regional variation. Due in large part to the HIV/AIDS crisis, the reproductive health disease burden accounts for about one third of Africa's total disease burden, which is almost double that of most other regions. And death and disability is only a portion of the impact of SRH on the quality of life and the prospects for development. The record of progress in SRH in recent decades is mixed.

Fertility

Although significant declines in fertility have occurred in most regions of the world, these have recently slowed in several countries. In many sub-Saharan African countries the fertility transition remains in its early stages. National level fertility declines also disguise significant variations within countries. Poor and rural populations often have the least access to family planning information and services, and thus the highest fertility rates.

Adolescent reproductive health

Adolescents, currently about 20 percent of the world's population, have special reproductive health concerns and face risks related to early sexual experience, marriage and fertility. A rise in the age of marriage globally has contributed to declines in adolescent fertility. However, up to 50 percent of women in some countries still marry or enter a union by age 18, with this figure rising to 70 percent by age 20. The proportion of young women married or in union by age 20 is closely linked to adolescent fertility and exposure to reproductive health risks.

Family planning

Contraceptive use accounts for a substantial portion of the variation in observed fertility rates (others include age of marriage, abortion rates, postpartum amenorrhea and abstinence, and occurrence of marital separations). Although there have been dramatic increases in the use of family planning services, unmet need for family planning remains very high in low-prevalence regions. While contraceptive use among adolescents has been on the rise, data from 94 national surveys taken over the past decade demonstrate that the unmet need of adolescents is over two times higher than that of the general population in these countries. In this age group, unmet need for family planning is predominantly a desire to delay pregnancy. Addressing these preferences could reduce exposure to reproductive risks and empower young women in education, employment and social participation.

Men are involved in reproductive health efforts as advocates for needed services, as supporters of their partner's needs and as recipients of services for their health and well-being. The majority of men aged 20–24 report having had sexual intercourse before their 20th birthday, with a substantial proportion having had sex before their 15th birthday. A large proportion of married men aged 25–39, particularly in sub-Saharan Africa, say that they have not discussed family planning with their partners. Yet, men in many settings are more likely

Unsafe abortions contribute to 13 per cent of maternal deaths, about 68,000 per year

to approve of contraceptive use than their partners realize, and thus lack of communication leads to lost opportunities to cooperate on attaining preferences. In most countries a majority of men have only one sexual partner in any given year but a significant minority of married men has extramarital partners. Condom use is higher among unmarried men than married men as within marriage this is associated with unfaithfulness and mistrust of the spouse.

Maternal health

Some 529,000 women die each year in delivery and pregnancy – the overwhelming majority in developing countries. While women in industrialized countries face a 1 in 2,800 chance of dying in pregnancy or delivery, the risk in developing regions is 1 in 61. In sub-Saharan Africa it is as high as 1 in 16. This lifetime risk of death reflects both pregnancy rates and the quality of delivery care associated with each pregnancy. Maternal deaths occur from both direct and indirect complications. Direct complications account for 80 percent of maternal deaths and include hemorrhage, sepsis, hypertensive disorders from pregnancy, abortion complications and obstructed labor. Indirect complications vary from region to region and include malaria and AIDS. Moreover, it has been estimated that for every woman who dies, approximately 30 more suffer injuries, infection and disabilities in pregnancy or childbirth. These disabilities include obstetric fistula.

Unsafe abortions contribute to 13 percent of maternal deaths, about 68,000 per year. Abortion-related complications contribute to a relatively large share of maternal deaths in Latin America and the Caribbean (where legal restrictions on abortion are common) and to a lesser degree in Asia and Africa. The case fatality rate for abortions, however, is highest in Africa.

Increases in the proportion of births assisted by a skilled birth attendant have been dramatic in Southern Asia, Eastern Asia and the Pacific and (from higher initial levels) in Latin America and the Caribbean. Sub-Saharan Africa lags behind other world regions with only 41 percent of births assisted by a skilled attendant. This contributes to the high maternal mortality on the continent.

HIV/AIDS and STIs

The HIV/AIDS pandemic constitutes a major threat to development in affected countries. The virus is spreading through different populations at varying rates, and prevalence rates among adults range from a fraction of a percent to well over 30 percent. In sub-Saharan Africa and parts of the Caribbean, the epidemic is clearly established in the general population and is largely spread through heterosexual contact. Whatever the main means of transmission, however, it is almost always the poor and the marginalized that are at greatest risk of exposure. More than half the men and women in most countries worldwide lack comprehensive and correct knowledge on how to prevent HIV transmission.

Gender-based violence is a significant public health problem that affects millions of women worldwide

The prevalence of curable and incurable STIs, including HIV/AIDS, is higher in sub-Saharan Africa and in Latin America and the Caribbean than in other regions. In some parts of the developing world, men may be prepared to use condoms but are unable to obtain them, especially young men and those with limited resources or living in rural areas.

Gender-based violence

Gender-based violence is a significant public health problem that affects millions of women worldwide. Abused women have been found to be more than twice as likely as non-abused to have poor health, including reproductive health, and both physical and mental problems. These women also have an increased risk of contracting an STI, including HIV/AIDS.

Why hasn't SRH been given higher priority?

The importance of SRH to the attainment of international development goals has not been adequately translated into action frameworks and monitoring mechanisms at international, regional and national levels. Advances have been hindered by the complexity of the concept. Different components of SRH fall within the province of different sectoral ministries, challenging coordinated national responses. Many national planners learned development economics before the recent analytical advances on the effect of age structures on poverty reduction. SRH issues have also been distributed among various MDGs (maternal health, child mortality, gender equality, HIV/AIDS) and family planning has been excluded from the Goals, reducing priority attention.

The diverse justifications for the importance of attaining SRH relate to public health, human rights, moral priorities, instrumental concerns related to basic development goals (including linkages and relationships) and institutional analyses. However, different groups and constituencies focus on different elements of this complex of concerns, complicating resolution and political mobilization. Operational planning often takes place in settings that do not welcome or encourage the resolution of these contending vocabularies and priorities. Matters related to sex and reproduction are sensitive – enmeshed in issues of culture and ideology of social institutions and personal identities. In many countries, various cultural groups have different understandings and positions on SRH (and on associated service provision). Public discussion and attention may be limited so political divisions can be avoided or because there is stigma attached. SRH has only become a fit topic for international discussion and consensus within the last 10–15 years.

The targeted time frame for the MDGs also diverts attention from the SRH agenda. The targets and indicators in key areas such as gender equality are defined consistent with what can be measured and with change in short time periods, not in the longer time horizons needed for cultural change and demographic shifts. Further, issues related to women have been accorded low

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priority. Gender disparities in education have not been achieved on time. Maternal mortality has not been given appropriate priority and investment.

Priority-setting approaches in the area of health have slighted SRH concerns. A disease-oriented approach to health priority setting has not recognized the importance of preventing unintended pregnancies. The consequences of these extend beyond the direct individual disability concerns to social participation, familial health and complex empowerment issues. Returns to investments in SRH are, therefore, difficult to assess and often omitted from policy dialogues.

The historical record of progress in SRH, particularly in the expansion of contraceptive use and the overall reduction in fertility, has diverted concern from continued investment needs. The assumption of continuing progress along historical paths has reduced the expenditures needed to attain it. Changing demographic concerns (e.g., the reductions in fertility and increased pace of population ageing) in major donor countries have also undercut some support for developing country initiatives. With donor development assistance policies moving towards direct budget support without earmarks for specific programs, areas like women's health can be neglected. Vertical pipelines for specific initiatives (e.g., HIV/AIDS) can give priority to some interventions but harm health system capacity building.

Within developing countries, health sector reform, often including decentralized priority setting, increases the information and advocacy burden for inclusion of SRH concerns. Central functions (like operating logistic systems and service quality control) require high-level commitment and a supportive policy and regulatory framework.

The international discussion on SRH emphasizes an outcome-oriented public health approach but people react to multiple dimensions. Strong passions and intensive debates continue on a range of issues: abortion, adolescent SRH and even family planning. These issues elicit renewed discussion at every relevant intergovernmental conference. Donor policies can advance or stifle discussion and reproductive health program development.

An example of the difficulties in addressing SRH concerns comes from the response to HIV/AIDS. Despite the dominant role of sexual transmission in its spread, it is classified with communicable diseases (tuberculosis and malaria) in the MDG framework. A historical separation of STIs (including HIV/AIDS) and other reproductive health issues (including family planning) has only recently started to be addressed in policy, programs and funding priorities.

The impact of universal access to SRH on attainment of the MDGs

Apart from being important in and of itself, ensuring universal access to sexual and reproductive health and rights is instrumentally important for achieving many of the MDGs. The achievement of the MDGs is influenced by population dynamics such as population growth, fertility and mortality levels, age

Population trends affect the course of and prospects for poverty reduction

structure and rural–urban distribution. Each developing country has its own unique combination of demographic factors that affect the prospects for progress toward the MDGs.

Creating economic development is connected to increasing productivity and investments in areas such as education, nutrition and health. Population momentum joined with declining fertility rates provides a unique chance to spur economic development as the work force increases and the dependency burden of society decreases. However, this requires policies that create jobs for the growing work force. The young age dependency burden in the least developed countries and regions creates expanding demands for resources to and investment in education, nutrition and health just to keep pace with population growth. The projected declines in birth rates, should adequate resources help realize them, will allow greater investment in quality improvements.

Until the HIV/AIDS epidemic, mortality levels were expected to continue to decline in all regions. However, this tendency has been reversed in countries where HIV/AIDS is most prevalent, especially in sub-Saharan Africa. Life expectancy at birth is lower in the developing regions than in the more developed regions but it is projected to increase in both less and least developing countries. This is dependent on successful implementation of HIV/AIDS prevention and treatment programs and on other health interventions. Migration, both internal and international, also conditions the prospect for progress towards the MDGs.

Goal 1: Eradicating extreme poverty and hunger

Population trends affect the course of and prospects for poverty reduction. Diverse and changing population dynamics have had dramatic impacts in several world regions. Sub-Saharan Africa remains in a poverty trap where demographic factors – high fertility, high infant and child mortality, and excess adult mortality (including that due to HIV/AIDS) – play significant roles. Eastern Asia, on the other hand, has seen dramatic declines in the number of persons living in income poverty. Recent analyses suggest that 25–40 percent of economic growth is attributable to the effects of decreased mortality (health affects productivity) and declining fertility (allowing a deepening of human capital investment). At the societal level there is a remarkable one-time opportunity when the proportion of the population of labor-force age (15–60) is large relative to the more ‘dependent’ younger and older populations. This demographic bonus, though, is not guaranteed. It is an opportunity and a challenge that depends on the right priorities, policies and strategies.

When institutions exist that permit the accelerated flow of information throughout a society it is possible to have wide dissemination of information about the benefits of smaller families, accurate feedback of the returns to investments in children and quicker recognition of the increased chances of children surviving, which reduces old age support motivations for persistent

There is a strong incentive for larger families to keep children, especially girls, at home and out of school

high fertility. However, the largest difference between rich and poor families is not in their desired or ideal family sizes but in their ability to implement their preferences. Access to services for the poor can be adversely affected by clinic placement, hours of service and user fees. The demographic bonus therefore operates not just on a macroeconomic level but also at the micro levels of the community and family. High levels of fertility contribute directly to poverty, reducing women's opportunities, diluting expenditure on children's education and health, precluding savings and increasing vulnerability and insecurity.

SRH programs can help improve the nutritional status of women and their children and advance progress on the hunger and maternal and child health targets. Supplemental feeding programs for pregnant women, improving women's knowledge of the nutritional requirements of themselves and their children and increasing women's power to negotiate access to needed nutrition must be part of a multi-intervention strategy. Closely spaced pregnancies and the associated high fertility levels place women at an increased risk of anemia and other conditions of absolute and relative malnutrition.

Progress in alleviating hunger also requires targeted inputs to improve agricultural productivity. Community level cooperative action can ensure implementation of soil improvement, improved water management and other components of an integrated approach to agricultural productivity. However, rapid population growth fueled by high fertility desires and/or poor implementation of preferred family sizes can lead to the sub-division of land holdings, which can reduce the benefits of productivity-enhancing interventions.

Goal 2: Achieve universal primary education

SRH impacts various levels of education in similar and overlapping ways. For example, girls may be pulled out of school to care for siblings at any time during their education. This is more likely as family size increases. Pregnancy-related dropouts, too, may occur at any level of education, including the primary level.

Many empirical studies have found that a child's school attendance is negatively associated with the number of siblings with whom the child lives. There is a strong incentive for larger families to keep children, especially girls, at home and out of school. There is also evidence from these studies that the gender gap in education may be explained by parental preference for sending boys to school when a family has limited resources. Gender disparities in education, then, should decrease with falling family sizes. Yet, the estimated effects are often relatively small in size compared to other factors: Parental schooling accounts for a substantial proportion of the increase in rates.

As States increasingly subsidize education, the impact of parental resources on younger children's school enrolment becomes less important. However, educational *attainment* has been found to be linked to family size, as older children are increasingly likely to be pulled out of school due to costs

Involving men in SRH is crucial to promoting gender equality and to increasing men's reproductive health

of schooling and their increasing ability to contribute to household responsibilities. Greater investments in children's welfare, including schooling, often occur in households where mothers have greater control over spending.

Adolescents and youth in developing countries are having sexual encounters at an early age. The increased gap between onset of menses and marriage also increases exposure to pregnancy risk. A growth in the percentage of girls attending school after puberty inevitably leads to a rise in the risk of pregnancy among students. There is a high cost associated with becoming known to be pregnant while still in school. A pregnant schoolgirl often has to choose between dropping out or undergoing an abortion that is typically illegal, and therefore likely to be unsafe. Boys who are involved in girls' pregnancies do not face these same risks. Reductions in pregnancy-related drop-outs would make a large enough difference to warrant policy attention, with payoffs that are likely to be greatest, in countries that have begun to address gender discrimination and in those at intermediate levels of socio-economic development. Early marriage is also associated with teen pregnancy. Married young girls, compared to their unmarried counterparts, have limited social networks, are less mobile, have less income-generating opportunities, face heightened exposure to health risks and have higher levels of overall fertility.

Goal 3: Promote gender equality and empower women

Ensuring universal access to sexual and reproductive health and rights is essential for achieving gender equality. Involving men in SRH is crucial to promoting gender equality and to increasing men's reproductive health.

Guaranteeing SRH and rights is important to ensure that girls and women lead longer and healthier lives, and has strong and direct impacts on their well-being. SRH services work to promote voluntary, safe and healthy sexual and reproductive choices. To do this, they must go beyond simply making available family planning information and services and include such activities as combating gender-based violence, sexual coercion and female genital cutting (FGC).

Gender-based violence, in particular, has a profound impact on the well-being of women. It takes many forms: coerced sex in marriage and dating relationships, rape by strangers, systematic rape during armed conflict, sexual harassment, sexual abuse of children, forced prostitution and sex trafficking, child marriage and violent acts against the sexual integrity of a woman (such as FGC or virginity inspections). Sexual violence is associated with significant emotional trauma and long-term mental health problems.

Sex trafficking is a growing problem. Some 800,000 people are trafficked across borders each year, and 80 percent of them are women and girls who are bought and sold worldwide mostly for commercial sex. This figure does not include the substantial number of women and girls who are trafficked within their own country.

Children born to very young mothers are at an increased risk of suffering complications

It is estimated that between 100 and 140 million women and girls, most of them in Africa, the Arab States and Asia, have undergone FGC. This rite of passage may cause hemorrhaging, infection and even death, and exposes young girls to serious and lasting physical and emotional trauma. Long-term chronic health risks include constant urinary tract infections, reproductive tract infections and more severe menstrual pain. Finally, the ability to experience pleasure from sexual encounters is largely destroyed.

Early marriage takes many different forms and has many different causes, including age-old traditions, protecting girls from unintended and out-of-wedlock pregnancies or building ties between families or communities. However, marriage of girls by coercion or before they are old enough to give full and free consent is not only harmful to their health and well-being; but it also violates their human rights, as elaborated in the Universal Declaration of Human Rights and other human rights instruments.

Allowing a woman to satisfy her desire for spacing or limiting children enables her to better balance household responsibilities (including childrearing) with activities outside the home, including economic, political and educational activities. One of the most dramatic transformations in development over the past 30 years has been women's increasing role in the labor force, greatly catalyzed by their ability to control their fertility and thus to shape their careers over their lifecycle.

Goal 4: Reduce child mortality

Maternal behavior and fertility are important determinants of child health and survival. Children born to very young mothers are at an increased risk of suffering complications. Similarly, children born too closely together are also at an increased risk of ill health. Where modern contraceptive prevalence is below 10 percent, the average infant mortality is 100 deaths per 1,000 live births. Where prevalence is 10–29 percent, infant mortality is 79 per 1,000; and where it is over 30 percent, it is 52 per 1,000.

Children born to teen mothers are twice as likely to die during their first year of life as those born to women in their 20s and 30s. Young teen mothers are at higher risk of experiencing serious complications because their bodies often have not yet fully matured. They are also much more likely to have poorer nutritional habits and are less likely to seek adequate antenatal and post-partum care, leading to higher rates of low birth weight, malnutrition and poor health outcomes in their children.

Birth spacing is an important lifesaving measure for both mothers and children. Compared with babies born less than two years after a previous birth, children spaced three or four years apart are more likely to survive to age five. In less developed countries, if no births occurred within 36 months of a preceding birth the infant mortality rate would drop by 24 percent and the under-five-mortality rate would drop by 35 percent. In total numbers this would

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annually amount to 3 million children under age five, or roughly 30 percent of total child mortality. Furthermore, a minimum of three years birth spacing is also important for enhancing the child's cognitive and social development.

Women who have closely spaced births are more likely to discontinue breastfeeding too early, thereby increasing the risk of infant mortality. Breastfeeding protects babies and infants from infectious and chronic diseases – including both diarrheal and acute respiratory diseases – and helps them to recover more quickly from illness. Intensive demand feeding also provides protection against pregnancy immediately after a birth by delaying the return of menses. The promotion of exclusive breastfeeding is an important global priority for increasing the health of infants. An HIV-positive mother may reduce the risk of postnatal HIV-transmission when she exclusively breastfeeds her child as compared to giving mixed feeding.

Goal 5: Improve maternal health

Each year more than half a million women die of preventable complications of pregnancy and childbirth. Making access to SRH more widespread could decrease childbirth- and pregnancy-related mortality and morbidity. That women die of preventable causes during childbirth is a tragedy. This tragedy is compounded when the pregnancy was not even intended. Moreover, as the Task Force on Child Health and Maternal Health asserts, improving maternal health requires policies and interventions that go beyond simply reducing maternal mortality.

About 201 million women have an unmet need for modern contraception – making it more likely that they will experience high-risk or unintended pregnancies and thus complications in pregnancy, during childbirth or from an unsafe abortion. Among married women of childbearing age, demand for birth spacing represented 33–75 percent of demand for family planning services. Younger women especially want to delay their next pregnancy and have longer birth intervals. Some are also interested in delaying their first birth despite the common assumption that women want to have their first child right after marriage. The failure to help women fulfil their spacing desires derives from socio-cultural constraints on women's status and on other restrictions on access to health services.

Comprehensive basic and emergency obstetric care is essential to maternal mortality reduction. Although there has been progress over the past decade, only about 70 percent of births in developing countries are preceded by even a single antenatal care visit. Anemia during pregnancy and childbearing increases the risks of maternal mortality and morbidity and also adversely affects infant health by increasing odds for prematurity and low birth weight. Reductions in delays to providing emergency care (in the decision to seek it, in arriving at a facility and in receiving care on arrival) can dramatically improve survival outcomes. Post-partum care, often less available than antenatal care, contributes

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to the health and survival of the newborn and provides an opportunity for family planning counseling.

High rates of unintended pregnancies are associated with higher incidences of abortion, and specifically unsafe abortions, which further place women at risk of death and disability. Young women are particularly impacted, as two out of every three unsafe abortions are experienced by 15–30-year-olds and 14 percent by women under the age of 20. Legal abortion, however, does not guarantee safety in places where providers are not trained or barriers prohibit broad access to services. Evidence points to a strong correlation between abortion laws and policies, safer abortion and reduced maternal mortality.

Lack of use of or access to contraceptives is a major cause of unwanted pregnancy: More than half of all women in the developing world are at risk because they are using a traditional method with high failure rates, they are using a reversible method that requires regular supplies, or they are using no method at all. Correct and consistent use of contraception and access to emergency contraception can significantly reduce recourse to abortion and improve maternal health overall.

Goal 6: Combat HIV/AIDS, malaria and other diseases

Addressing SRH needs and combating AIDS, malaria and other diseases require essential medicines to be available throughout a country. Globally, 80 percent of HIV cases are transmitted sexually. Only one in five people at risk of contracting HIV have access to even basic prevention services, which could prevent 29 million of the 45 million new infections projected to occur in this decade. Testing, counseling, treatment and care reach an even smaller proportion of those affected.

Correct and consistent use of condoms – which has been found to reduce HIV incidence by 80 percent – is a key component of any national prevention strategy used to reduce sexual exposure to HIV. Other components include delaying sexual initiation, abstinence and reducing the number of sexual partners. However, there is still a wide gap in condom availability in many developing countries, and large-scale investments will need to be made in education and awareness programs that promote and de-stigmatize condom use among both men and women.

Underlying power dynamics between women and men in many developing countries also prevent women from accessing condoms and then insisting on their use. Unprotected sex with a non-monogamous husband greatly increases a woman's likelihood of being exposed to HIV. An important step in addressing such power dynamics is to ensure that there is universal access to sexual and reproductive health and rights, and that family planning services actively target men in their programs. SRH services include counseling (for both women and men) to reduce exposure to risky sexual behavior that may increase a person's chances of contracting HIV (or transmitting it to others).

Expanded SRH services can provide an integrated package of services including counseling on HIV transmission and prevention, psychological and social support, and antiretroviral treatment for HIV-positive mothers

In 2003, an estimated 630,000 infants worldwide became infected with HIV during their mother's pregnancy, labor or delivery, or as a result of breastfeeding. Many of these infections could have been avoided by ensuring mothers' access to a regimen to prevent mother-to-child transmission. Expanded SRH services can provide an integrated package of services including counseling on HIV transmission and prevention, psychological and social support, and antiretroviral treatment for HIV-positive mothers. Voluntary contraceptive services to help HIV-positive women prevent unwanted pregnancies should be a central component of cost-effective national prevention strategies.

Prevention and treatment of STIs, while important in their own right, are also essential components of strategies to reduce HIV transmission. Women are more likely to suffer complications from STIs as they are more often asymptomatic and are less likely to seek treatment even when experiencing symptoms. Women with STIs are also more likely to experience stigmatization, infertility, and even abuse and abandonment.

Pregnancy reduces women's immunity to malaria, which can then lead to adverse health outcomes, and even death, for the mother as well as increased risks of stillbirth or low birth weight and its related complications for the infant. HIV-positive women experience higher frequency and density of parasitemia, and women who are co-infected have more anemia and more adverse birth outcomes than women infected with either malaria or HIV alone. Ensuring universal access to SRH services would help ensure that pregnant women at risk of malaria receive effective treatment.

Goal 7: Ensure environmental sustainability

The past century of population growth has put increasing pressure on natural resources as the scale of human needs and activities has expanded. Population growth, among other factors, has led to cropland expansion, intensified farming, housing sprawl and overuse of water and forests.

Population growth is an indirect driver of environmental degradation. It is part of a complex dynamic that includes poverty, inequality, levels of consumption and policy and market failures. Populations living in countries with scarce natural resources and the fewest resources to invest in health, education and family planning are growing more rapidly than the world population as a whole, putting even greater pressure on these often biologically fragile zones.

Environmental sustainability must be a result of biological conservation programs, technological advancement and a broad human development effort. Development priorities need to include investments in education and health, including SRH, to break vicious cycles of population growth and environmental vulnerability.

The world's urban population is estimated to grow from 2.1 billion in 2000 to 5 billion in 2030. Slowing the growth of new slums and improving the lives of slum dwellers require urgent action. The urban poor require SRH

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services within an accessible and functioning health system. While the fertility rate of rural women is generally higher than that of urban women, poor urban women have significantly higher fertility rates than non-poor urban women. The unmet need for contraception among the urban poor is also higher than among the urban non-poor, though lower than that of people in rural areas. Maternal mortality is generally higher in rural areas than in urban areas.

Both rural and poor urban populations lack access to modern health institutions. However, while rural populations are most affected by proximity of service, urban populations face other factors, including transport costs and user fees. Many improvements are needed for slum dwellers and the urban poor to increase their SRH outcomes. HIV/AIDS is a major health concern in cities and some risks are heightened there. Adolescents may also face greater challenges to leading healthy sexual lives.

Goal 8: Global partnerships

The International Conference on Population and Development (ICPD) was the first international conference to estimate the resources needed to achieve the agreed action plan. The resource estimates included four components: family planning; reproductive health; STIs and HIV/AIDS; and basic research, data and population and development analysis. Each component should be integrated into basic national programs for population and reproductive health.

It is important to recognize that the Programme of Action estimates did not include all the issues brought up at the conference, and that additional resources are still needed for other objectives and goals (later incorporated in the MDGs) like the improvement of women's status and empowerment and the strengthening of primary healthcare systems

However, the resources mobilized from donors are not even living up to the funding targets that were agreed at the ICPD. Although funding for population activities is increasing, this is largely due to a higher resource flow towards HIV/AIDS activities. Unfortunately, this has happened at the expense of other areas within population assistance. Family planning has received less and less attention since the ICPD, and its funding as a share of total population assistance dropped from 56 percent in 1995 to 13 percent in 2003.

Donor countries vary in how much of official development assistance (ODA) they contribute to population activities. In 2003, only five countries gave more than the 4 percent of ODA to population activities (as agreed at ICPD). Population activities in developing countries also receive external assistance from supporters other than donor countries. Development banks, especially the World Bank, foundations and non-governmental organizations (NGOs) contribute important resources. Out-of-pocket expenses contribute a large amount of the total domestic financial resources. Even though domestic expenditures are increasing, many developing countries (and particularly the poorest countries) require adequate ODA. Within the time frame for the

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MDGs they cannot reach a level of sustainable domestic funding anywhere near two thirds of the costs for population activities.

Providing access to reproductive health drugs and supplies is crucial to the achievement of the MDGs and to the improvement of health in developing countries. Reproductive health commodity security is about ensuring a secure supply and choice of commodities such as contraceptives (including condoms), maternal health supplies and those needed for HIV/AIDS and other STI treatment and prevention. These commodities need to be provided to rural and urban populations, rich and poor, young and old, and both women and men. It is crucial that national capacity is developed in order to secure sustainable forecasting, logistics, financing, procurement, warehousing, stock monitoring, distribution of commodities, and training and management of human resources.

What needs to be done

The incorporation of SRH into national strategies to attain the MDGs and into international and regional programs has been recommended by the world's leaders in the 2005 World Summit Outcome Document (UN 2005b) and in health sector recommendations at the World Health Assembly.

Political will for action and the close monitoring of progress can accelerate advances. Political will should be shown by both high-level commitments that legitimate priorities and the mobilization of community support.

Task 1: Integrating SRH analyses and investments into national poverty reduction strategies

National development planning must be based on MDGs needs assessments that include population and SRH concerns. Such analyses need to diagnose the current situation and the projected dynamics of key population groups receiving priority interventions in order to orient investments to reach coverage targets and reflect their expected returns.

To date, these issues have not been adequately incorporated in planning exercises, and existing national population or SRH strategies have not been appropriately referenced. Yet, investments in voluntary family planning programs, for example, would reduce the total resource requirements for progress on the health-related MDGs and provide additional benefits.

The selection of indicators to monitor progress on SRH at national, regional and global levels can help focus action priorities.

Task 2: Integrating SRH services into strengthened health systems

Family planning programs started as vertically organized systems with distinct donor funding guarantees. This provided some advantages and disadvantages. The ICPD placed all SRH services – including family planning – within the regular health system. Countries subsequently changed their programs to

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increase the integration of these services into the primary healthcare system. A systematic framework for approaching integration is needed to guide program design and monitor operations.

Attention to a person-centered continuum of care over a lifecycle and to service interventions is proposed as a guiding framework. Effective information and referral systems, and well-equipped and functioning component service delivery units, are essential to ensuring this standard of care.

Past experience with service integration points to the need for more management expertise. Monitoring and evaluation and accountability burdens increase with service completeness and complexity. Appropriate attention must be given to SRH, the retention and strengthening of specialized capabilities and the improvement of logistics and procurement systems. SRH interventions can be allocated to different actors both within and outside the clinical health system.

Effective integration requires giving priority to meeting client needs, client-focused information, realistic and specific planning and monitoring, and flexible management of motivated and competent staff in strong health systems. SRH issues pose special challenges since needs over the life cycle and among different populations vary greatly, and services at different levels of the health system need to be provided and linked.

The effective integration of SRH delivery with HIV/AIDS prevention, treatment and care systems is a requirement for accelerated progress on the full range of SRH concerns.

Task 3: Systematically collecting data

Effective management of integrated health service delivery, including SRH components, requires investments in service and results-oriented databases. Such system development has been challenging in many settings. Beyond health management information needs, there has been a lack of basic information that stakeholders can use to ensure accountability related to a variety of population and SRH concerns. These include reproductive health and education within the socio-cultural context for sexual and reproductive behavior; population dynamics and youth needs; urbanization and migration; deteriorating rural and agricultural conditions; poverty pockets; gender roles and relationships and belief systems; and gender-disaggregated data to provide a more accurate picture of women's economic contributions to society, including their management roles and their unpaid labor in the family and in the informal sector.

Strategic interventions to improve data for decision-making and accountability include the definition of a basic package of health information needs, negotiation of effective accountability mechanisms between donors and national authorities, formalized linkages between government agencies and national stakeholders (NGOs and national research institutions) and

The quality of SRH care leads to greater acceptance of contraceptives and other SRH services and lower rates of discontinuation

investments in improving the technical capacity of those involved. Such developments should attend to the specific needs at national, regional and district levels.

Task 4: Acting on the Reproductive Health Quick Impact Initiative

The UN Millennium Project has identified key interventions to accelerate progress towards achieving the MDGs as a whole that can produce results within relatively short time frames. The Reproductive Health Quick Impact Initiative has two components: (1) improving access to reproductive health information and services, including family planning, and (2) closing the funding gap for commodities, supplies and logistics.

Knowledge about family planning is now fairly widespread, but important misconceptions and information gaps remain about this and other SRH issues. These are particularly pronounced among young people and include lack of knowledge about the transmission of HIV/AIDS.

Reasons for non-use of services are various and context-specific. Solutions must be tailored to national circumstances as there are no 'one size fits all' methodologies. In addition to addressing unmet need for family planning, the quality of care needs to be improved. This includes attention to providing a range of choice of methods, meeting information needs, availability of technically competent staff and equipped facilities, adequacy and sensitivity of client-provider relations, continuity-encouraging follow up, and provision of an integrated constellation of services. The quality of SRH care leads to greater acceptance of contraceptives and other SRH services and lower rates of discontinuation. The increased use of community-based health workers providing a range of service modules will require extensive training and backstopping to ensure quality.

Contraceptive demand is projected to increase dramatically within the MDG time frame as a result of population growth, the current backlog of unaddressed needs and decreasing family size preferences. The Asia-Pacific region will require the largest share of resources for contraceptives, drugs and medical supplies. But the largest increase – 161 percent – is projected to be in Africa.

The Reproductive Health Supplies Coalition has been working to improve information exchange on availability and needs, strengthen supply systems, foster country ownership and national political and financial commitment for reproductive health supplies, improve coordination between international suppliers and country supply managers and expand the markets for private-sector provision to appropriate population segments. This effort needs to improve national capacity and to address emergency responses to stock-outs and other supply crises. Allocation of national funds remains an important signal that countries can send that might encourage further donor responses. A coordinated effort to increase resources from national and international sources is required, with significant allocations to strengthening national institutions.

Young women and men are underserved in development planning

Such efforts should include improved feedback from local actors (governmental and non-governmental) on evolving demand and on supply quality and dependability.

The effective incorporation of SRH commodities into national Essential Drugs and Medicine delivery systems must be realized. Multiple and ill-coordinated logistic management systems reduce efficiency and effectiveness. Existing management tools can provide technical support to such national delivery efforts.

Improving access to and usage of family planning services should include programmatic attention to key life events at which demand and receptivity is high. These include services to be offered post-abortion, post-partum, post-infection (by an STI, including HIV/AIDS), post-child death and post-puberty/initiation).

Task 5: Meeting the needs of special populations

Since the needs of different population groups vary – both in the risks they face and the programs required to reach them – special attention to targeted service development has increased. Sub-groups include such populations as unmarried youth, the poor, rural populations, and post-partum and post-abortion women.

Adolescents

Young women and men are underserved in development planning. Sectoral institutional frameworks tend not to be organized around age categories and do not offer an integrated approach to the needs of the young. Surveys of the health information and service needs, including SRH, of youth show their reluctance to use clinics or to address sex and reproduction. Comprehensive and holistic approaches must be developed that are sensitive and youth-friendly. Normative frameworks on client rights are particularly important for reassuring youth.

The diversity of situation of adolescent populations must be taken into consideration, with special population groups among adolescents requiring priority attention in program planning. This includes those living in situations of risk and young mothers. Detailed data is needed on the situation of young people, married and unmarried, particularly in the area of SRH.

Humanitarian situations

A humanitarian crisis – whether it is due to conflict or natural disaster – poses an extreme challenge to the achievement of the MDGs. Structures and systems break down, making people much more vulnerable and increasing the need for protection and service provision. Of the 34 poorest countries that are farthest away from achieving the MDGs, 22 countries are in or just emerging from conflict.

To implement the various recommended actions, effective multisectoral programming efforts are critical

The SRH situation during conflict and natural disasters increases the likelihood of unwanted pregnancy, maternal and infant death, and the transmission of STIs including HIV/AIDS. The sudden loss of medical support, as well as the trauma and malnutrition that often follow an emergency, means that pregnant women face a greater risk of maternal morbidity and mortality. The spread of STIs including HIV/AIDS increases because an emergency breaks up stable relationships; disrupts social norms on sexual behavior; and coerces women as well as young girls and boys to exchange sex for food, shelter and income. Gender-based violence also increases. Operational guidelines on reproductive health in emergency situations have been developed and must be implemented.

Men

Men play a crucial role in reproductive health both as clients, partners and agents of change. Donors can support operational research to advance these contributions and countries can give it priority. Gender-equitable programs to involve men should address power relations, and positive and supportive definitions of masculinity should be reinforced to improve the situation of both women and men. Reproductive health strategies should make male involvement a key program strategy. Outreach to men is a vital component for meaningful scaling up of SRH programs. Program staff will need reorientation to address male involvement.

Requirements for effective action

Political commitment

High-level political commitment can signal the importance of SRH progress to the population as a whole and to implementing bureaucracies. Dramatic change is possible on accelerated time scales when national governments mobilize to meet voluntary choices.

Effective coordination

To implement the various recommended actions, effective multisectoral programming efforts are critical. Coordinating mechanisms and institutions can mobilize stakeholders for the design, implementation and monitoring of programs involving diverse actors.

Community participation and cultural sensitivity

Consistent with this vision is recognition of the vital role of community inputs to development planning. Services can be better adapted to local conditions when staff are equipped with methods and guidelines to evaluate their own performance and supplement their evaluations with inputs from service beneficiaries.

In order to make reproductive health programs successful, it is crucial to take into account the local context, including structure and culture. Partnering

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with local groups such as faith-based organizations and individuals from within the community is therefore a crucial step in a successful program that seeks to promote human rights and healthier lives.

Resources for programs

Additional information on detailed intervention costs that have become available in the decade since the ICPD have led to new estimates of resource needs for SRH. These estimates include: (a) detailed disaggregated direct service delivery cost estimates for family planning and other basic maternal and reproductive health services (including safe delivery, emergency obstetric care, neonatal survival/infant mortality interventions and a broad range of HIV/AIDS prevention efforts); (b) overhead costs (e.g., maintenance, power, basic facility supplies, support staff); and (c) system improvement costs related to management, improved monitoring and evaluation and capacity for research and evaluation needs.

Preliminary estimates of additional capital and human resource requirements for attaining the targeted service coverage are also available. Better estimates of these needs will come from ‘bottom-up’ MDG needs assessments carried out by individual countries. UN Millennium Project analyses demonstrate that most low-income countries need to substantially increase capital investments to strengthen health systems and scale up service coverage to meet the MDGs. It is clear that resource requirements for the basic SRH package will be significantly higher than estimated over a decade ago. By 2015 the required annual costs will be about US\$14 billion more than originally anticipated, reaching US\$36 billion. The magnitude and share of required HIV/AIDS prevention investments are substantial.

Additional analyses apply this new methodology to a scenario projecting family planning needs, population dynamics and maternal, newborn and child health services based on the satisfaction of current unmet need for family planning. These analyses reflect the larger savings in other reproductive health services gained by higher investments to eliminate unmet need for family planning preferences. Savings from family planning investments increase over time as smaller birth cohorts reduce other service needs and can finance system improvements.

Both the 1993 and the current resource projections omit supportive investments in other sectors (including investments for women’s empowerment). The current SRH estimates are also based only on direct service costs and added health system costs and do not include the required information, education and behaviour-change communication and community-based interventions. Further work is needed to elaborate these needs.

The expansion of family planning, maternal health and HIV/AIDS prevention efforts depends on the mobilization of political will, institutional capacity and technical and financial resources. However, a significant number

of countries identify shortfalls in international assistance as having a negative effect on their programs. Greatly increased support, both financial and technical, to national programs will be required to reach the ICPD goal of universal access to reproductive health and attain the MDGs.