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WORKING GROUP ON SEXUAL AND REPRODUCTIVE HEALTH

a.

Sexual and Reproductive Health and Rights: *Agreements and Disagreements*

A BACKGROUND DOCUMENT

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Introduction: Purpose and Scope of the Background Paper

The purpose of this *background paper* is to present research based evidence on issues in the field of Sexual and Reproductive Health and Rights (SRHR). It serves as a database for a shorter *policy brief* prepared by ENRECA Health – Danish Research Network on International Health. The background paper and policy brief are intended as an introduction for DANIDA staff, parliamentary members, and others who want to strengthen the evidence base which they use for their own work on programme, policy and advocacy.

The paper has been discussed in the ENRECA Sexual and Reproductive Health working group in a process over several months during 2010-11.¹ It should be seen as a first edition of a paper attempting to cover a broad and complex issue, and subsequent editions will hopefully both sharpen the focus, correct any mistakes and keep it up to date in this rapidly changing field.

Evidence evolves over time and its interpretations vary. Therefore, this background paper refers to 'conventional wisdom,' including academic literature, international consensus documents (e.g. the Millennium Development Goals – MDGs), but also to uncertainties, data gaps and divergent views.

The focus will be primarily on the 6 billion people living in low and middle-income countries (L/MIC), with reference to the 1 billion living in high-income countries (HIC) mostly to give perspective.

Sexual and Reproductive Health and Rights (SRHR) are essential preconditions for gender equity, and conversely, gender equity has a strong bearing on the SRHR of women (Glasier, et al. 2006; WHO 2008a). This is richly recognized in both conventions (CEDAW) and women's conferences (UNIFEM 2011). Thus, both SRHR and gender equality strategies are incomplete without recognition of these links, and this background paper attempts to detail some of them.

What is SRHR? The Concept and the Actors

Actors: There are numerous actors involved in SRHR. At the international level, one United Nations (UN) agency has the issue at the core of its mandate, namely the UN Population Fund (UNFPA). UNFPA is primarily mandated to advocate for policies and initiating and funding programmes. UNFPA relies on the World Health Organization (WHO), as a specialized technical agency, to develop the evidence base and to propose guidelines, e.g. through its Department of Reproductive Health and Research, but WHO is not primarily operational. Other UN agencies include the United Nations Children's Fund (UNICEF) (particularly as SRHR relates to children through their mothers), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and its ten co-sponsors which deal with HIV/AIDS. The UN Population and Statistical Divisions are mandated to assemble data and research related to population, including indicators related to monitoring of the Millennium Development Goals and to the follow up to international conferences on population (see below). UNAIDS, together with WHO, are mandated to monitor progress on HIV/AIDS.

Bilateral donors have also played an active role, including in the creation of UNFPA in 1969, when the topic was seen as too controversial for existing support through bilateral donors or UN agencies.

This is also a field where international civil society historically has had a defining role, again a reflection of the controversial nature of the topic. There are numerous NGOs dealing with SRHR, with the largest being the International Planned Parenthood Federation (IPPF), which has played a strong role both in advocacy and operational activities for many decades. Numerous NGOs dealing with women's rights have also played a central role, not least in the International Conference on Population and Development (ICPD) in 1994 (Corréa 1997). At the time such involvement was unusual for UN conferences, but it has contributed to a greater involvement of civil society in subsequent UN conferences on other topics.

Additionally, a large group of actors hold opposing views. For example, a number of US based NGOs and legislators have influenced US policy, but are also funding and supporting opposition to ICPD, and to family planning, in other countries, including Europe (PPFA 2011).

Concept: The term 'SRHR' has evolved since the 1980s, both in terms of our understanding and agreement regarding the concepts, problems, goals, and strategies for fulfilling the goals.

The term 'Reproductive Health' originated in the late 1980s, as an unofficial working definition used to describe a broad, life course health approach, beyond vertical programmes for example addressing only family planning.² However, in recognition of its sensitivity, at the time, the term was not presented to official international fora such as WHO governing bodies (Singh 2009).

In September 1994 UNFPA convened the International Conference on Population and Development³ (commonly referred to as 'ICPD' or the 'Cairo Conference'). At this conference, the term was presented, and on 13 September the 179 states in attendance adopted the ICPD Programme of Action by consensus.

The ICPD Programme of Action provides a definition of reproductive health:

“Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases” (UN 1994b: 7.2).

However, this adopted text did not spell the end of controversy about the concept:

- b. whether reproductive health should be part of subsequent international agreements, e.g. the Millennium Development Goals
- c. whether reproductive health includes abortion
- d. what focus should be given to sexual health within SRHR
- e. the notion of rights, in particular sexual rights

Re a): The Millennium Summit in 2000 produced the Millennium Declaration, but did not produce quantitative goals. That task was delegated to an Inter-Agency Expert Group (IAEG). The IAEG developed the Millennium Development Goals, with targets and indicators, in early 2001, as a monitoring framework for the Declaration. The framework picked up all but one quantitative targets from the ICPD, such as those referring to maternal health and mortality (MDG5), child and infant mortality (MDG4) as well as the indicator of 'contraceptive prevalence rate', somewhat illogically placed under MDG6 (dealing with AIDS, TB and malaria). However, the one target which it left out was the one dealing with reproductive health.

At the 2005 Summit, which reviewed progress on the MDGs, the UN Secretary-General, in his report on the "Work of the Organization," submitted a recommendation to include four additional targets, including Target 5B: 'Achieve, by 2015, universal access to reproductive health'. This report was noted by the 61st UN General Assembly, October 2006.⁴

The 2007 UN General Assembly adopted the report. Yet, there was still resistance to any specification of precise targets or indicators. Target 5B, and its 4 attendant indicators, became indisputably effective for the UN system only after 15 January 2008 (see Annex 2 and 3). UNFPA instantly took note of this change (UNFPA 2008). However, it has taken time for the concept to be fully internalized by UN organizations. For example, a WHO Executive Board report on progress toward the health MDGs in January 2008 made no mention of Target 5B, and several UN organizations had not included it in their official websites as of April 2009 (Gillespie 2009). Many reproductive health stakeholders see this delayed recognition as devastating for progress, reducing financial and political support, and diverting attention to other areas.

Re b): Abortion is central to much of the controversy. A large number of delegations at ICPD provided their support only on the condition of a number of 'footnotes', many of them specifying that the delegation concerned lent its support on condition that it did not imply support for abortion (e.g. the Vatican and several Catholic countries inserted such reservations).

The discussion has at times become rather cryptic. Thus, as mentioned above, the ICPD Programme of Action (PoA) specified several quantified, time bound targets, with one of them being was '*...the provision of universal access to reproductive health services, including family planning and sexual health...*' by 2015.⁵

The term 'reproductive health services' has been the topic of vigorous opposition in international fora, as some national delegations have understood it to be a code word for abortion.

As noted above in the ICPD definition of reproductive health, it does refer to ... *the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law... (our highlighting)*. Some interpret this to include abortion, but it must be noted that the wording specifies that the methods should not be against the law (of the country concerned), and thus is not interpreted to include a universal right to abortion by legal specialists (nor do they interpret that there is a universal agreement that personhood begins at conception).

The antecedents of this understanding are difficult to trace, but include histories of national discourse, e.g. in the United States⁶. Although there is no precise definition of the terms, some delegations prefer the term 'reproductive health care,' on the understanding that it does not include abortion. The discussion comes up in UN fora and in Europe.⁷

The discussion is at times rather meaningless. To avoid it, many stakeholders prefer the term 'reproductive health,' and indeed that is the term utilized in the MDGs.

Some of the disagreement may be over what is included in 'abortion' – provision of abortion services, or only post abortion care (e.g. treating women who have already had an abortion and are in need of medical care). More stakeholders would agree with lifesaving post abortion care than with provision of abortion. For even more detail on this convoluted discussion, see the chapter below on abortion.

Re c): Sexual health until recently has received little attention, either in terms of conceptual clarification, epidemiology or suggested operational solutions. Yet, as noted above, it is an integral part of the ICPD definition of reproductive health.

A WHO definition from 2002 expands on the ICPD definition: “*Sexual health is a state of physical, emotional, mental, and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health needs a positive and respectful approach to sexuality and sexual relationships, and the possibility of having pleasurable and safe sexual experiences that are free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all individuals must be respected, protected, and satisfied.*” However, WHO also specified at the time that this was not an official expression of WHO technical consensus, let alone international consensus (see Annex 4) (Glasier, et al. 2006).

In recent years, there is increasing discussion (see below under priority Area 5), but there is not policy consensus at governmental level.

Much of this discussion suggests that sexual health should in fact be the umbrella concept, with reproductive health as a component, given the fact that sexual health is a lifelong issue, also outside the reproductive age. It might be seen as criticising the lack of logic in the MDGs, where MDG5 originally (2001) dealt only with maternal health, where reproductive health was added only in 2008, despite opposition. There is still no explicit reference to sexual health or rights in MDG5.

Re d): A strong emphasis was placed on rights, especially women’s rights, throughout the ICPD PoA. A particular point of contention has been sexual rights (Glasier, et al. 2006).

Following up on ICPD, at the Beijing Women’s Conference of 1995, the ‘rights’ were further specified to include women’s rights to decide on issues related to their own sexuality.⁸ However, the term ‘SRHR’ did not appear in the adopted texts, although several delegations, especially from Nordic countries, mentioned it in their speeches both at ICPD and follow up conferences.⁹

The concept of ‘sexual rights’ remains contested. As mentioned above, the Beijing Platform for Action relates it to women’s sexuality, other sources relate it to different sexual orientations, others debate issues such as the sexual rights of HIV discordant couples. As yet, it is neither defined, agreed, nor specified in terms of issues or possible response at the policy level. Particularly the issue of sexual orientation remains divisive. However, as mentioned below, there is a great deal of recent discussion which may result in official recognition (see Annex 4) (Glasier, et al. 2006).

Thus, whereas the terms ‘reproductive health’ and to some extent ‘reproductive rights’ have a relatively solid base in international consensus, ‘sexuality’ in general and ‘sexual rights’ in particular, especially the issue of sexual orientation, are not well established in consensus documents (Cook, et al. 2003; Cook and Fathalla 1996). NGOs such as IPPF use the term SRHR, UNFPA refers to sexual and reproductive health and reproductive rights, WHO usually (but not consistently) refers only to sexual and reproductive health. A number of countries, including Denmark, use the inclusive health and rights term SRHR widely.

As will be noted from the above, SRHR can be controversial, even at the conceptual level. Depending on the situation, and in particular at country level, the most productive approach may at times be pragmatic, addressing programmatic priorities rather than discussing the conceptual content. Annex 6 gives UNFPA’s listing of programmatic priorities.

Another such programmatic framework, citing five priority areas, is WHO’s first reproductive health strategy from 2004, which details five priority programmatic areas from ICPD PoA (WHO 2004d). Although it does not reflect all recent developments, we will use that strategy to structure the discussion.

In summary:

- f. SRHR and gender are closely related. Relevant strategies need to recognize this.

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- g. Since 2008 there has been international consensus on the idea that Reproductive Health is part of the MDGs. Although the consensus is recent, it is a great step forward. Vigilance is in order to ensure that it is not eroded again, in view of some signs of growing conservatism.
- h. The term Reproductive Health is less comprehensive than foreseen in 1994, or than implied in the term 'Sexual and Reproductive Health and Rights' (SRHR). Certain aspects, in particular sexual health and rights, are yet to be adopted in international consensus documents. In some contexts, it may be important to continue clarification, but in others it may be more productive to focus on programmatic priorities.

Situation and Response – Progress Over the Last Decades

The following section outlines the epidemiology (trends, determinants and consequences), policy/programme response and progress, as well as remaining gaps, in particular research priorities. The five priority areas, as outlined in the ICPD from 1994, and structured as per the WHO strategy from 2004, are:

1. Improving antenatal, delivery, postpartum and newborn care
2. Providing high quality services for family planning, including infertility services
3. Eliminating unsafe abortion
4. Combating sexually transmitted infections, including HIV, RTIs, cervical cancers and other gynaecological morbidities promoting sexual health

Overall, the estimate is that reproductive ill health (all five areas) contributes 32% of the burden of disease for women, and 10% for men, in the reproductive age group (PAHO 2007).

Epidemiology: In 1985, attention was drawn to the fact that the ‘maternal and child health programmes’ within primary health programmes (PHC) so far had limited focus on the ‘maternal’ aspect (Rosenfield and Maine 1985).

One challenge was the absence of reliable data, and this remains a major problem in establishing epidemiology and progress (Graham, et al. 2008; Yazbeck 2007). This is both because the population numbers involved to arrive at comparable estimates are very large (the ratio is measured per 100 000 live births) and because the attribution of death to maternal causes can be complicated.

Beginning in 1996, UN organizations sponsored the development of estimates for maternal mortality¹⁰ for each country for 1990, 1995, 2000, 2005 and 2008, gradually expanding the scientific range of experts involved and the methods used. The most recent estimates from WHO, UNFPA, UNICEF and World Bank are that the global number of deaths was 576 300 in 1990 and 358 900 in 2008 (Hill, et al. 2007; WHO 2001b; WHO 2010c; WHO and UNFPA 2004; WHO and UNICEF 1996; WHO, et al. 2007). This translates into estimates of a maternal mortality ratio (MMR),¹¹ which has decreased from around 400/100 000 to around 260/100 000 live births,¹² given that the birth cohort over the period has stayed rather constant at 130-140 million live births per year (UN 2008). Other estimates give similar numbers: 526 000 deaths for 1980, around 440 000 for 1990, and 343 000 for 2008, and suggest that, absent HIV, it would have been 281 500 for 2008 (Hogan, et al. 2010).

Although this represents progress, it is only half the MDG target of a 75% reduction between 1990 and 2015.

Furthermore, all estimates confirm that there is great disparity:

- The vast majority of maternal deaths (99%) occur in L/MICs (where 85% of the world population lives)
- There is great variation within countries (e.g. around 800/100 000 for the poorest quintile, 100/100 000 for the richest in Peru in 2000) (Chowdhury, et al. 2007)
- As well as among countries (e.g. a lifetime risk of maternal death at around 1 in 16 for Niger, and 1 in approximately 11 400 for Sweden).

MDG5 refers to maternal health, that is, not only mortality. Indeed, maternal mortality constitutes only a part of overall maternal health, and is therefore sometimes referred to as the ‘tip of the iceberg’. Estimates are that, for every woman who dies, 10-30 times as many women suffer serious injury or illness as a result of pregnancy (UN 2009)¹³, including obstetric fistula,¹⁴ uterine prolapse¹⁵ and other morbidities and disabilities (Glasier, et al. 2006; Scherf, et al. 2002; WHO 2004d).

Another reason to see maternal deaths as the tip of the iceberg is that the health of mothers is inextricably related to the development of the foetus, and the health of children. Thus, it may be useful to see

the 'total iceberg' of pregnancy outcomes. Globally, WHO estimates that each year approximately 210 million pregnancies occur, about 80 million of them unintended (WHO 2004e). About 135 million result in live births (UN 2008). Out of the remainder, about 3 million result in still births (Cousens, et al. 2011; Di Mario, et al. 2007; Goldenberg, et al. 2010; Lawn, et al. 2005a; McClure, et al. 2009; Stanton, et al. 2006)¹⁶ around 30 million result in miscarriages, and 42 million in induced abortions (WHO 2004e).

As implied in the ICPD definition of reproductive health, and further specified in the WHO strategy, priority area 1 includes the health of the newborn, that is, children up to 28 days of age. The last decade has seen an increased recognition of the close association between newborn (neonatal) deaths¹⁷ and maternal health.

Thus, overall mortality to children under 5 has decreased over the last few decades – from an estimated 12.5 million in 1990 to 8.8 million in 2008 (Black, et al. 2010; UNICEF 2010; You, et al. 2010). This constitutes a substantial decrease, by a third, with the notable exception of sub-Saharan Africa, where the numbers have increased from 4 million in 1990 to 4.4 million in 2008 (UN 2010a).

However, most of this progress has been in older children. The younger the age group, the less progress. Neonatal mortality is stagnating, and by 2008 was estimated at 4 million. That is, 41% of all under five mortality occurs in the 28 days of life, with 99% of deaths occurring in L/MICs. Further focus is now placed on early neonatal deaths, which occur in the first week, and even more specifically, to the intrapartum period – within the first 24 hours of life – where estimates are that up to 2 million children die (UNFPA 2011b).¹⁸

The issue of stillbirths until recently received limited attention in either international agreements or research. Recent studies indicate that here again there is great disparity, with about 98% occurring in L/MICs, and concentrated in the intrapartum period. Thus, one review estimates that there are at least 2.65 million stillbirths annually [2.08-3.79], 98% in low and middle income countries. Numbers vary from 2 per 1000 total births in Finland to more than 40 per 1000 total births in Nigeria. Of the total stillbirths, it is estimated that 1.10 million [0.82-1.97] occur in the intrapartum period, that is, associated with poor delivery care (Lawn, et al. 2011).

With respect to the *determinants* of maternal deaths,¹⁹ estimates vary slightly, but all point to about 80% of deaths being due to direct obstetric conditions, that is, particularly events which take place during childbirth. Estimates from the latest MDG report, which in turn are based on WHO estimates are that: haemorrhage accounts for 35%, hypertension 18%, sepsis 8%, abortion and miscarriage 9%, other direct causes such as obstructed labour, complications of anaesthesia or Caesarian section, and ectopic pregnancy lead to 11%. Indirect causes such as malaria, HIV/AIDS, and heart disease result in 18% of deaths (UN 2010a).²⁰ However, these estimates will presumably change with the new estimates for both total maternal deaths (358 900) and abortion related deaths (47 000). Those estimates would yield 13% of maternal deaths due to (unsafe) abortion.

The direct obstetric conditions at times develop rapidly and with little warning – e.g. untreated severe haemorrhage can lead to death in the span of a few hours, yet it is not possible to predict with any certainty which pregnancy will lead to haemorrhage. Complications are quite common and occur in both rich and poor countries: WHO estimates around 42% of all pregnancies in rich or poor countries experience complications, and that 15% are potentially life threatening in the absence of emergency obstetric care (Kamrul Islam and Gerdtham 2006).

The determinants that lead to these obstetric conditions are first of all poor obstetric care. In sum, efforts to deal with complications in pregnancy and childbirth, particularly emergency obstetric care, could prevent some 74% of maternal deaths (Wagstaff and Claeson 2004).

When examining the direct causes of newborn deaths, most are due to infections (36%), preterm birth (28%), and asphyxia (23%) (Lawn, et al. 2005b). Most of these are in turn linked to the conditions which also determine maternal death and morbidity, namely poor obstetric care. For example, asphyxia is linked to obstructed labour (Black, et al. 2010).

Thus, Emergency Obstetric Care (EmOC), including Caesarian section, may be even more important for neonates than for women, and some refer to it as 'EmNOC.' Although much of this care is highly dependent on sophisticated medical care, there is also a growing body of evidence that much can be

achieved by 'low-tech' methods such as 'kangaroo' care, meaning simply that low birth weight neonates are placed on a mother's abdomen, to ensure contact and warmth (Conde-Agudelo, et al. 2011).

Similarly, stillbirths are closely related to antenatal and obstetric care. One usually refers to 'fresh' stillbirth (that is, where the foetus has recently died, generally induced by poor obstetric care) and 'macerated' (where the foetus has died some time before delivery, often caused by poor health of the woman during pregnancy, e.g. malaria).

In sum, efforts to deal with complications in pregnancy and childbirth, particularly emergency obstetrical care, could prevent some 74% of maternal deaths (Wagstaff and Claeson 2004). In particular, care in the intrapartum period is critical.

The literature on contextual factors is rather limited, but for example refers to factors related to education, income, and health systems of countries (Alvarez, et al. 2009).

The *consequences* of maternal death and disability, apart from the effect on the woman herself, are well documented, e.g. a significant body of research indicates that a mother's death or disability raises the risk that her newborn or other children will die before age five (Ronsmans and Graham 2006). There are also studies showing the economic effect (see chapter on cost of investing, and not investing).

Response: The first 'Safe Motherhood' conference was called in 1987, inspired by the growing concern about maternal mortality as mentioned above. Building on the Primary Health Care approach, with its emphasis on community level response, the recommendation was to undertake large scale training of traditional birth attendants (TBAs).

However, by the next Safe Motherhood conference in 1997, there was growing acknowledgement that this training had no measurable effect on maternal mortality ratio, with the reason given that TBAs could not handle the direct obstetric causes of mortality as mentioned above (Sibley and Armbruster 1997; Walraven and Weeks 1999). In other words, maternal deaths were not as predictable, preventable, or easily treatable as previously thought. WHO no longer recommended training TBAs.

On the other hand, some countries had seen great progress, including Egypt, Romania, Bangladesh and China, for example Sri Lanka and Malaysia achieved a fifty percent reduction of the MMR within a decade. Attention focused on the reasons for that improvement. The consensus developed up until the 'Women Deliver' conference in 2007 that three strategies were needed: family planning (both to avoid early, late, and closely spaced births, but also to avoid unintended pregnancies which are more likely to result in unsafe abortion), birth attendance by skilled personnel,²¹ and access to EmOC care where complications arose. In particular, the model of the 'three delays' – delay in making the decision to seek care, delay in reaching care, and delay in medical decision and quality care, threw light on the central role of the time factor and access to emergency obstetric care (Thaddeus and Maine 1994).

The MDGs in their present form build on this understanding, and include indicators on family planning and the presence of a skilled attendant at birth.²² Despite progress, around half of all births (60 million) in L/MICs still occur without a skilled birth attendant, many attended by a TBA, or with no attendant.

The issue is receiving increased attention. An international conference on midwifery was convened 19-23 June 2011 by the International Confederation of Midwives, where UNFPA will present the report 'The State of the World's Midwifery' on behalf of UN agencies (UNFPA 2011b).

Although the 'conventional wisdom' is now clear about the strategies which we need to adopt in order to improve maternal and neonatal health, many studies on the effectiveness of various interventions remain methodologically weak (Miller, et al. 2003). This includes both studies examining the effectiveness of training of TBAs, but also of Skilled Birth Attendants (SBAs) and EmOC.

Antenatal care is another MDG5B indicator. The role of antenatal care has been downplayed in recent years as an intervention for reducing maternal mortality (ibid.). As mentioned above, this is because the majority of complications arising during child birth, and the resulting maternal deaths, cannot be predicted on the basis of identifying 'high risk' pregnancies (Alexander and Keirse 1989; McDonagh 1996; Rooks and Winikoff 1990; Rooks, et al. 1989; Sibley, et al. 2002; Smith, et al. 1997; The Kasongo Project Team 1984; UNFPA 2002; WHO, et al. 1997).

Nevertheless, there is evidence that antenatal care may improve perinatal health and survival, and that it represents an opportunity to deliver interventions that may improve maternal health in the perinatal period, including the likelihood that women will seek post natal care (Villar 2000). WHO has developed a guideline for focused (goal oriented and based on a reduced number of clinic attendance) antenatal care which to some extent is implemented in health systems in low income countries. However, the quality of service rendered and the potential of the program is insufficiently documented (Villar and Bergsjø 2002; WHO 2003a), and a recently updated Cochrane review indicates that there is an increase in perinatal mortality associated with such focused packages of antenatal care (Dowswell, et al. 2010). WHO is now planning a revision of its guidelines in 2012 (WHO 2011e).

Antenatal care may for example include interventions which target anaemia, such as nutrition, vitamin (and iron) supplementation and malaria/worm treatment. Many women in developing countries are anaemic, and anaemia increases the risk of dying from Post Partum Haemorrhage up to four times (Brabin, et al. 2001; Høj, et al. 2005; Rush 2000). Yet, there is as yet little evidence to clearly demonstrate the linkage between antenatal care and maternal deaths.

There is no MDG indicator on EmOC, partially in recognition of the difficulties of measurement. As for other areas of reproductive health, the indications are that EmOC is very unequally distributed, e.g. in Bolivia in 2003 the proportion of births delivered by Caesarean section varied between 3% for the lowest wealth quintile to 45% for the highest (Ronsmans, et al. 2006).

There is general agreement that these are only partial indicators – child, and in particular perinatal (Richardus, et al. 1998) and maternal, health are particularly sensitive to overall health system functioning – UNFPA and WHO refer to MMR as ‘the litmus test of health systems’, and note that continuity of care, which is important for health systems in general, is absolutely essential for maternal and child health.

Furthermore, as noted above, SRHR in general, and MMR in particular, are closely related to extremely diverse contextual and social factors. To name two examples: women’s empowerment, e.g. increased education is associated with improved SRHR indicators. Distance from health services, mountainous topography and poor transport possibilities are negatively associated with maternal health outcomes (WHO 2008a). Studies e.g. from Sri Lanka, which saw spectacular progress starting in the 1930s, have shown the close relationship with not only health services, but the broader social environment, not least women’s education (Fernando, et al. 2003; Fernando 2005; Perera 1993; Seneviratne and Rajapaksa 2000).

Clear and widely accepted guidelines exist for the kind of care which should be available. The standard is that there should be one basic obstetric care health facility per 125 000 population, which can perform six *basic emergency care* functions addressing the top causes of maternal death, and one *comprehensive emergency care* facility per 500 000 population, which in addition can perform the additional functions which require sterile conditions necessary for surgery or blood transfusion.²³

Also, much literature notes the obvious point that utilization and impact of services depends not only on the availability of services, but also their quality, both with respect to SRHR, and health in general (Das 2011; Harvey, et al. 2007; UNFPA 2011b).

A major remaining issue is that the services required for emergency care are relatively sophisticated. Equitable and ready access, financial, social or geographical, is a challenge, in particular, ‘bridging the outreach gap’ to far flung communities.

Several strategies are being considered to overcome this challenge of the outreach gap. One is the issue of reconsidering the role of TBAs. Some observers have taken issue with the studies which show that they have little effect on maternal mortality. They note that studies lack a clear description of the effect of the surrounding environment, including whether the traditional birth attendants had full backing of and access to the formal health system. To date there is little evidence that TBAs can improve maternal mortality, but there is a small but important evidence base which indicates that TBAs can have a positive effect in reducing maternal morbidity, as well as perinatal mortality and morbidity, especially if part of an overall community outreach package, integrated in the health system. Evidence is as yet insufficient to draw clear conclusions, but several countries are beginning to examine what roles TBAs could play (Advisory Group on Community Action, et al. 2008; Jokhio, et al. 2005; Kumar, et al. 2008; Lassi, et al.

2010; Manandhar, et al. 2004; Morrison, et al. 2005; Pyone 2010; Rowen, et al. 2011; Sibley, et al. 2007; Sibley and Sipe 2004).²⁴ They note the importance of continuity of care and the cultural role of TBAs (Bhutta, et al. 2008; Kruske and Barclay 2004; van Roosmalen, et al. 2005).

The 2011 UNFPA report on midwifery notes: “*Often trained in a period of months, CHWs (ed: Community Health Workers) do have a role to play in strengthening maternal and newborn services by performing some of the essential outreach tasks in the continuum of care. They can, among other things, keep records, promote family planning, urge pregnant women to give birth in a health facility, encourage exclusive breastfeeding and newborn care during home visits, and encourage birth registration. Where outreach services in the community are supervised by and connected to the primary health care centre there is evidence of increased referrals to health facilities and reduced illness and deaths in newborns*” (UNFPA 2011b).

Another approach to health personnel is ‘task shifting’ – in particular allowing lower level trained staff (e.g. non-physician clinicians such as assistant medical officers or midwives) to undertake Caesarean sections.

Yet other strategies deal with drugs. For example, one way to control postpartum haemorrhage (PPH)²⁵ is to administer a hormonal drug that induces uterine contractions. Until recently, the drug of choice has been oxytocin. However, oxytocin is not heat stable, and needs to be administered parenterally (intramuscular). This makes community level utilization more difficult.

Recently, the prostaglandin drug misoprostone has gained attention as an alternative, since it is heat stable, and can be administered sublingually (orally) or as a suppository. Several studies conclude that it reduces severe PPH, and propose it as an alternative first line treatment, where oxytocin is not feasible (Høj, et al. 2005; Winikoff, et al. 2010).

However, to date, there is no final agreement that it is equally effective, or if so, at which stage of childbirth or the post-partum period. There is also lack of agreement about whether it may have effects that would make it less suitable for community level utilization (Hofmeyr, et al. 2009). WHO proposes that a SBA may administer it where oxytocin is not available, but is cautious about recommending wide spread utilization, and discourages advance (prophylactic) community distribution by untrained staff. WHO also recommends more research, and suggests that the results of an on-going large-scale study in Pakistan may bring clearer evidence.

Overall, this is one of the most discussed and researched drugs for reproductive health in recent years. Some observers have criticized the WHO position, seeing it as a compromise due to outside political pressure, since misoprostol can also be used as an abortifacient (see also discussion under abortion chapter below). However, WHO notes the great amount of uncertainty surrounding effectiveness and safety (Potts, et al. 2010; WHO 2009; WHO 2010a).

Although it is not yet part of ‘conventional wisdom’, evidence is accumulating that integrated, community based programmes can have good effect.

For example, in recent years Ghana has instituted improved community level health outreach including maternal and child health, and family planning services. Within a two-year period, deaths of children under the age of five declined from 224 to 100 per thousand, contraceptive prevalence increased and average family size dropped from 5.2 to 4 children per woman. This community-based approach is now being expanded throughout Ghana (Phillips, et al. 2006).

Rwanda provides another striking example. In 1992, Rwanda’s under five mortality rate (U5MR) was estimated at 150/1000, MMR around 800/100 000, CPR at 13% and total fertility rate (TFR) at around 7 children per woman.²⁶ After the genocide, rates saw regression, with U5MR rising to 196, MMR over 1000, TFR staying at 7, and CPR dropping to 4%. In 2007, President Kagame, donors, and the NGO community came together to mount a national comprehensive community-based health initiative. In roughly two years, contraceptive prevalence rose from 10% to 27%. TFR declined to 5.5, MMR fell to 750 and U5MR to 103 (Solo 2008). This is of course very short term developments, and more studies are needed to determine longer term sustainability.

Despite a rapidly growing body of evidence and stated agreement on strategy, there are still many uncertainties and unexplored areas, with major shifts happening with each new conference (Miller, et al. 2003).

Given the particularly high level of disparity, maternal health is also increasingly being presented as a human rights concern, e.g. in the Human Rights Council in June 2009 (UN 2009). There are also several cases where women as individuals or groups have legally challenged the state, in the case of maternal death, and where they have won their cases.²⁷

- In summary:
- Recent estimates indicate improvements in maternal mortality: from a total of 576 300 deaths in 1990 to 358 900 in 2008 (corresponding to MMRs of about 400 and 260/100 000). However, this is still only half way to reaching the MDG target of 75% reduction. Moreover, MMR remains the MDG health indicator with the most disparity, by a factor of several hundred between the countries with the highest and lowest ratios.
- In addition to deaths, 10-30 times as many women suffer serious and/or long lasting morbidity.
- Maternal health is important for the health of women, but also for their children. Especially neonatal mortality (and still birth rates) are closely linked to EmOC, and lack of progress is linked to insufficient progress in providing such care. Estimates are that there are 2.6 million still births, and around 4 million deaths to children in the first 28 days of life.
- Thus, maternal deaths are often referred to as only being 'the tip of the iceberg'.
- 'Conventional wisdom' regarding the best strategies for addressing the problem is clear: access to family planning, SBA and EmOC would save about 75% of deaths.
- Yet, close to 50% of all births take place without such care, and a third of all pregnancies are unintended.
- Attention to maternal health has increased dramatically in the last 2-3 years, including that is now framed as a human rights concern.
- The evidence base is still weak. Some of the areas requiring further research are
 - How to improve the quality of SBA and EmOC (not only the quantity).
 - The effects of antenatal care on maternal and neonatal health.
 - The effectiveness and safety of misoprostol.
 - Other outreach strategies – e.g. the role of TBAs and community involvement, not only on physical but also psycho-social wellbeing. Any pilot projects should be rigorously monitored, and form part of national health systems and referral mechanisms.
 - Better understanding of the contextual factors – both health system and beyond, including transport and cost issues.
 - Further documentation of the integrated community programmes of countries such as Ghana and Rwanda, to determine lessons learned and longer term sustainability.
-

Epidemiology: The contraceptive prevalence rate (CPR)²⁸ in developing regions rose from less than 10% in 1960 to about 52% in 1990, and 60% in 2000.²⁹ In the same period, the average number of births per woman (TFR) decreased from about six to three (UN 2004b). In the last decade, contraceptive prevalence has risen more slowly, and is estimated at around 62% in 2007 (UN 2010a; UN 2010b; UN 2010c). In the same period TFR decreased from 2.9 to 2.7.

Progress is particularly slow in sub-Saharan Africa, where the level in 1990 was 12%, in 2000 20% and in 2007 22%. Levels in many countries remain at 10-20%, and there is evidence that the levels are stagnating (Ojakaa 2008b). As is the case for other areas of reproductive health, disparity is great: 10% of the poorest quintile of women use contraception and this has not changed over the last decade, whereas 38% of women from the richest quintile are using contraception, and this has increased (modestly) from 34% (UN 2010a). The number of births remains close to 5 for sub-Saharan Africa (Cleland, et al. 2006; UN 2011d).

'Unmet need' for contraception is defined as the number of women who are currently married or unmarried and sexually active, are able to become pregnant and want to stop childbearing or to wait at least two years before having a child, or another child. (Singh et al, 2009b). The most recent estimate is around 215 million globally (UNFPA 2009a). Of those, over a third still uses traditional,³⁰ less effective methods. The definition is not consistently used – in particular whether utilization of traditional contraception is included. The UN (and therefore the MDG monitoring site) and WHO at times exclude those who use traditional methods from 'unmet need', and therefore arrive at lower figures (e.g. in 2011 WHO referred to 110 million with unmet need (Ashford 2003; Bulatao 1998; Dixon-Mueller and Germain 1992; Dixon-mueller and Germain 1994; Ross and Winfrey 2002; UNFPA 2009a; WHO 2004d; WHO 2005c; WHO 2011d).³¹

However, there is increasing utilization of the statistic of 215 million.

Methods have a wide range of effectiveness, as seen from the following WHO estimates.

Table 1: Contraceptive failure rates and estimated number of unintended pregnancies, 2007

Contraceptive method	Number of contraceptive users ^a	Estimated failure rate (typical use) ^b	Number of women with accidental pregnancies (typical use)
	000s	%	000s
Female sterilization	232564	0.50	1163
Male sterilization	32078	0.15	48
Injectables	42389	0.30	127
IUD	162680	0.80	1301
Pill	100816	5.00	5041
Male condom	69884	14.00	9784
Vaginal barrier	2291	20.00	458
Periodic abstinence	37806	25.00	9452
Withdrawal	32078	19.00	6095
Total	712586	4.70	33469

a. Based on the estimated number of women aged 15-49 years, married or in union in 2007 and the percentage using specific contraceptive method.

b. Trussell (1998), estimates are based on US data.

Source: (WHO 2011d).

These rates might be compared to the risk of pregnancy if no method is used, which is estimated at about 85% after one year for women under 35 (Leridon 2010).

In sum, the proportion of women who become pregnant after a year of typical use is

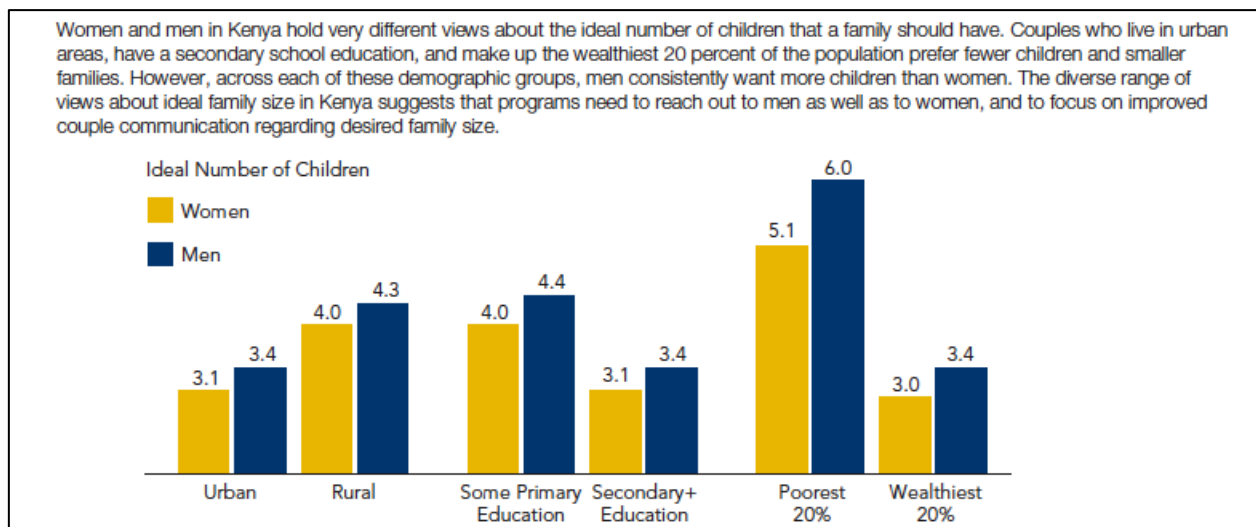
- 0.15%-20% for modern methods
- 19-25% for traditional methods
- 85% for no method

The term 'unmet need' is composite and requires disaggregation. As described in many demographic and health surveys, the reasons for non-use include lack of access to contraception, but also fear of side effects (some well-founded) fear of becoming temporarily infertile (again with some reason) and fear of husband or community disapproval. Therefore, although it is a useful term, it should not simply be translated as lack of physical access (Casterline and Sinding 2000; Hyttel and Tellier 2010). UNFPA estimates that meeting current unmet need and keeping pace with population growth, will lead to an increase in the number of contraceptive users of over 30 per cent during the next 15 years (UNFPA 2010).

Here again there is great variation among and within countries. Low income countries are disproportionately affected. Sub-Saharan Africa and South Central Asia together account for 59 per cent of women with unmet need. In low income countries, 54 per cent of women who want to avoid pregnancy don't have access to contraceptives, compared with 20 per cent in better-off developing countries (UNFPA 2009a)

Disparity within countries is also striking. In Asia and Latin America, unmet need in the poorest quintile of the population is twice as high as in the wealthiest quintile. In sub-Saharan Africa, the association between wealth quintile and unmet need is weaker, partially because levels are uniformly high (Cleland, et al. 2006). Countries such as Uganda and Lao People's Republic have the highest levels of unmet need (both around 40%), and overall sub-Saharan Africa has the highest levels of unmet need, where it is one in four women aged 15 to 49 (DHS 2010; UN 2010a).

With respect to the number of children that families want, and the proportion of children that are unwanted, sub-Saharan Africa is the highest on both: desired family size is 4.4 children per woman, whereas outside sub-Saharan Africa, the number of children desired averages 2.1. In Southern and East Africa, the proportion of births that are unwanted is 20 percent; in Middle and West Africa just over 10% is in this category (Westoff 2009).



Source: (KNBS and ICF Macro 2010).

If one looks at 'met need' worldwide, that is, the number of unwanted pregnancies which are averted by contraception, the use of contraceptives annually averts an estimated 230 million births, or 1.7 times the global number of live births (Liu, et al. 2008).

Determinants of contraceptive use are classically divided into the answer to three questions:

- Are people aware that family planning is possible?
- Do they desire to use it themselves?
- Are they able to access contraception, which they consider adequate? (Bongaarts and Potter 1983).

There is ample evidence that family planning, women's education, income levels, birth rates, and child death rates are closely correlated. For example, within a richer and more educated country women generally have lower birth rates, higher use of contraception, lower levels of unmet need, and their

children have lower mortality rates, although the correlation is weaker where birth rates are high, especially in sub-Saharan Africa.

However, there is great debate about the direction of causality. The 'child survival' school of thought argues that tackling under-five mortality or infant mortality is a sufficient precondition for higher contraceptive prevalence levels and thereby lower fertility. If parents wish to achieve a certain family size, they need to know with a certain level of certainty that their children will survive. This 'child survival hypothesis' is widely quoted in the public health community. Indeed, there is evidence that few if any developing countries have seen major reductions in birth rates without a previous reduction in infant mortality (Schoumaker, et al. 2006).³²

Other scholars dispute this view, or nuance it. As per the classical model mentioned above, fertility declines only if people are both aware of family planning, desire to use it, and have the means to do so. Recent evidence shows that, in Africa, many countries experience stagnating birth rates despite declining child mortality – in the absence of high quality family planning programmes the decrease in child mortality apparently has little effect (Bongaarts 2008). In the 1950s, Uganda, Burkina Faso, Chad, and Niger had birth and child mortality rates similar to India, Bangladesh, Vietnam and Indonesia. However, in the Asian countries both improved health and family planning programmes were initiated quite early, in the 1960s, contraceptive rates increased, and both birth rates and death rates started to decrease in the 1970s. In the African countries, only general health programmes, with little focus on family planning, were introduced. This was particularly true of countries with legal systems modelled on that of France, where contraception was illegal. Child death rates improved, but there was neither little increase in family planning nor decrease in birth rates (Bongaarts and Sinding 2009; Shapiro and Gebreselassie 2008).

Although it is hard to document, increases in contraceptive use seem to reach a tipping point after which they spread widely and regular use becomes normative – that is, once the 'early adopters' who are usually the more wealthy and educated, adopt family planning, it spreads to other parts of the population.

Thus, as was inferred in the ICPD, relationships between contraceptive use and socioeconomic change are complex and multidirectional. A decrease in death rates may be a necessary, but not sufficient, precondition for increases in family planning – (high quality) family planning programmes are also necessary. The discussion should be irrelevant if one accepts that family planning is a human right (see below) and should be provided no matter what the causality.

Whereas determinants of contraceptive use may be a topic of debate, the consequences of contraceptive use are clear, at least in the scientific literature: family planning brings major health benefits, for children as well as for women. The age and parity of the woman, and the timing and spacing of the pregnancies, all have an effect on maternal and child mortality and morbidity.

With respect to health effects for women, age at the time of pregnancy plays a critical role. MMR for women under the age of 15, and under 18, has been found to be 5 and 2 times higher than for women 20-29. In this regard, there seems to have been limited progress: global rates of teenage pregnancy (estimated on the basis of births per 1000 women aged 15-19) decreased from 1990 to 2000 (from 124 to 119), but has since then increased (to 121 in 2007).

For parity, MMR is highest at extremes of parity. For example in Bangladesh it was found that MMR was up to five times higher for the first birth than for births 2-4, and then rose again for the 5th and subsequent births to 3-4 times higher than the lowest rates (Chen, et al. 1974). This finding may be compounded by the fact that 80% of Bangladeshi women are married by the age of 18, so many of the primipara are also very young (DaVanzo, et al. 2004; Majoko, et al. 2004). Studies in many countries show that lower fertility levels contribute to lower MMR (Chowdhury, et al. 2009).

For spacing, evidence from 52 DHS surveys indicates that MMR levels are 2.5 times higher if spacing between delivery and next pregnancy is less than 6 months; the lowest levels occur with spacing 24-48 months, and after that they rise slightly (Conde-Agudelo, et al. 2007; Razzaque, et al. 2005).

Unintended pregnancy constitutes a particular problem. In 2000, about 90% of global abortion-related and 20% of obstetric-related mortality and morbidity – or a total of 32% of maternal deaths – could have been averted by use of effective contraception by women wishing to postpone or cease further childbearing,

partially because a large portion of the unsafe abortions could have been averted (Collumbien, et al. 2004; UNFPA 2009a).

With respect to health effects for children, levels of early neonatal (first week), neonatal (first month), infant (first year) and under 5 child mortality are all impacted by spacing. Evidence from 52 DHS surveys indicates that child mortality continues to decrease with longer spacing (Rutstein 2005). Other findings of studies in both rich and poor countries show that conceptions taking place within 18 months of a previous live birth are at greater risk of foetal death, low birth weight, prematurity, and being of small size for gestational age (Conde-Agudelo, et al. 2006; Zhu 2005). The mechanisms underlying this association are thought to include postpartum nutritional depletion, especially folate deficiency (Rutstein 2005; Smits and Essed 2001). Conservative estimates assume 10% of child deaths could be averted by averting interbirth intervals of less than 2 years (Black, et al. 2003; Conde-Agudelo and Belizan 2000; DaVanzo, et al. 2004), and that an estimated 640 000 neonatal deaths could be avoided by meeting unmet need for family planning (UNFPA 2009a). Other studies are even more dramatic, estimating up to 35% of child deaths could be averted by family planning (Rutstein 2005).

Infertility receives little attention in international literature.³³ A distinction should be made between *core infertility* (primary, before reproductive age) and *acquired infertility* (secondary), with the latter more dependent on life cycle events, e.g. trauma or reproductive tract infections. WHO estimates that about 3-5% of couples in the developing world experience primary infertility, but at times areas of Africa have experienced up to 30-40% secondary infertility (Frank 1983). Various untreated infections (RTIs) with resultant fallopian tube occlusion represent a key factor determining acquired infertility (Cates, et al. 1985; Frank 1983). Unsafe, repeat abortions may also have an effect (for more details see the chapter on abortion). Finally, as the age of child bearing increases, the expectation is that more women will experience increasing levels of infertility (Pison 2010).

Response: As late as the 1960s, family planning was illegal in many parts of the world. For example, in France it was illegal in the period 1922-1967, and in some states of the US it was illegal until 1965. In other cases, family planning was imposed on women – e.g. in the period 1929-67, in Denmark the State implemented 11 000 sterilizations, some of them coerced (Ritzau 2010). This approach, often based on ‘eugenics’ principles, was utilized in many countries.³⁴

The first time an international consensus document referred to family planning as a right was in the Tehran Human Rights Conference in 1968: that *parents* had the right to have *information* about family planning. This was expanded and made legally binding in the Convention on the Elimination of all kinds of Discrimination Against Women (CEDAW) in 1979, which stated that: “...*the right of couples and individuals to freely and responsibly decide the timing number and spacing of their children and to have the information and means to do so...*” (UN 1979). This right is reiterated in the ICPD, and as noted above, since 2007 the MDGs include universal access to reproductive health by 2015 as a target (5B), with ‘Contraceptive Prevalence Rate’ and ‘Unmet Need’ as indicators. This also makes family planning one of the most clearly human rights based MDG targets or indicators.

Family planning programmes have had very varied results over time. Overall, the upsurge in family planning programmes in the period 1960 onwards clearly had tremendous effect, with rising levels of contraception use. Particularly programmes in Asia and Latin America had such effect. Many went from negligible contraceptive use to rates of 60-80%, with birth rates falling from 6 children per woman to 2.1, and great reductions in child mortality, within the space of 15-35 years.

In sub-Saharan Africa however, overall effect has been limited. Francophone African countries generally retained the above mentioned pro-natalis, anti-family planning law of France well beyond the time when it was repealed in France. Several countries experienced increases in contraceptive use, and fertility decline up until the 1990s, followed by stagnation. Scholars point to many reasons, including lack of political will and financing, as well as increases in infant mortality. Yet, there are many examples of great impact within a short period.

One example is Kenya, which had the highest birth rate in the world in 1978 with over 8 children per woman. Then the government instituted a well-supported family planning programme, and in the period 1977-1989 contraceptive prevalence increased, with birth rates dropping to around 4. However, in the

period 1991-2003, both the programme, the CPR, and the infant mortality stagnated, and births increased to around 5 per woman (Crichton 2008; Ojaka 2008a; Schoumaker 2009).

Another example is Ghana. Ghana and Kenya were some of the first sub-Saharan countries to adopt a population policy in the late 1960s; Ghana did so right after conducting its first post-colonial census.³⁵ As in Kenya, progress in Ghana was limited in the first decades of the programme. However, as mentioned above a recent emphasis on an integrated community level programme seems to be having results on many indicators, including family planning, with Rwanda providing another striking example.

The conclusion at this point would seem to be that family planning programmes can be highly successful in terms of meeting unmet need, and that it takes a strong combination of political will, financing, as well as programme organization including at the community level, with a broad approach also addressing other health issues.

In summary:

- Contraceptive use has increased dramatically, from around 10% in 1960, to 60% in 2000. Since then the increase has stagnated, and was estimated at 62% in 2007.
- There is still great disparity – poor, rural, uneducated women have lower use, and higher levels of unintended births.
- About 215 million women (one quarter of the women concerned) have an ‘unmet need for family planning.’ This number is likely to increase, unless efforts are accelerated.
- In order to meet this need appropriately, it is important to disaggregate the overall number, also taking into account the reasons for non-use (e.g. fear of side effects), including development and utilization of contraceptives with fewer side effects.
- Family Planning brings appreciable health benefits to women and their children (32% of maternal and 10% of child deaths could be averted (Cleland, et al. 2006; UNFPA 2009a).
- One reason cited for the gap is that financial and political support for family planning has decreased over the last 15 years, exacerbated by the lack of priority in the MDGs.
- Some interpret conventional wisdom as showing that contraceptive levels will automatically increase if child mortality decreases. This paper argues that high quality family planning programmes, within high quality health services, are also a precondition, and can have results within few years.

Epidemiology: Globally, the *number of abortions* was estimated at approximately 42 million in 2003. The global trend is downward: the global estimate for 1995 was approximately 46 million abortions (Sedgh et al 2007).

Regionally, abortion rates are the lowest in Western Europe (12 per 1000 women aged 15-44). It is 17/1000 for Northern Europe. China and US fall in a middle range (20-30/1000 women). The Philippines, Chile, Vietnam, Eastern Europe as well as many countries in Africa fall in the high range of 30-80/1000 women. Regional trends are that Eastern Europe and China account for the greatest decline in the period 1995-2003. In most L/MICs there is no decline, and in Africa numbers are increasing (Sedgh et al 2007).

The proportion of pregnancies that result in induced abortion is about one in five: out of 210 million pregnancies, one third (about 80 million) are unintended, one fifth (42 million) result in induced abortion, one fifth (33 million) result in miscarriage or stillbirth (Sedgh, et al. 2007; Singh, et al. 2009) and three fifths (135 million) in live births. This means that globally there were 31 abortions for every 100 live births, with the highest ratio being in Eastern Europe (105 for every 100 live births) (Sedgh, et al. 2007; UN 2011c).

As can be seen from the priority area heading above, the focus in international consensus is on eliminating *unsafe abortion*. Unsafe abortion was recognized as an urgent health concern at least as far back as the World Health Assembly in 1967 (WHO 2011d).³⁶ Most ‘unsafe’ abortions take place outside the

national legal system, that is, they are 'illegal'.³⁷ Whereas not all illegal abortions are unsafe, or all legal ones are safe, the overlap is great – an abortion service which is driven underground faces additional quality challenges.

Whereas the total number of abortions is declining, this is due to a decrease in legal/safe abortions.

On the other hand, the number of unsafe abortions has not decreased: in 1995 the number was estimated at 20 million, in 2003 19.7 million, and in 2008 21.6 million. Almost all (97%) of these take place in developing countries, and this number is not decreasing, in fact the total number of abortions in developing countries is not decreasing. That is, the global unsafe abortion rate remains unchanged at about 14 unsafe abortions per 1000 women aged 15–44 years annually (WHO 2011d).

The public health focus on unsafe abortions is because they are closely linked to *maternal deaths* and ill health. Globally, 47 000 maternal deaths occur as a result of unsafe abortion, and the trend is downward at the global level: it was 56 000 in 2003 and 69 000 in 1990. However, the proportion of total maternal deaths is unchanged at 13% of all maternal deaths (Shah and Åhman 2010; WHO 2010c; WHO 2011d).

There are stark geographic differences: only 90 of those 47 000 deaths occurred in developed countries, the rest in developing ones, with sub-Saharan Africa accounting for 28 000 (UN 2011d). The proportion of maternal mortality caused by unsafe abortion in southern Africa is lower than in any other part of that region. South Africa legalized abortion in 1994; as a result of its efforts to make contraception and safe abortion care more widely available, the rate of maternal mortality caused by unsafe abortion has declined by roughly 90 percent. In Tunisia, in North Africa, abortion has long been legal and accessible, and rates of unsafe abortion are also significantly lower (*ibid.*: 30).

Determinants of abortion levels: Two determinants are of particular interest: contraception and legal regulation. Intuitively, one expects *contraceptive prevalence* rates to be inversely related to abortion rates, and experience shows that to be true in the long run. However, in early stages of fertility decline, when women begin to want fewer children, but family planning programmes are still new, women may initially resort to abortion to achieve lower levels of fertility. Later in the transition, once family planning programmes are more established, abortion rates decline. One estimate is that abortion rates start to plateau when contraceptive prevalence reaches 30% (*ibid.*: 30). This has been the case for many regions, with some striking examples including Japan and Tunisia. Eastern Europe is a particularly compelling example: until two decades ago contraception was not widely available, and abortion rates were extremely high. The ICPD singled out the region to strongly advocate that better contraceptive services be introduced in order to reduce abortion rates. In the last two decades contraception has become much more available, and abortion rates have decreased remarkably, even with birth rates stable or declining (Marston and Cleland 2003; Marston and Cleland 2004; Requena 1970; Shah and Åhman 2009; Streatfield 2001).

Countries in middle and East Africa also demonstrate this phenomenon: overall the contraceptive prevalence rates are low (19 and 26 percent, respectively), abortion laws are highly restrictive (usually permitted only to protect a woman's life or health) and the abortion rates, almost all illegal and unsafe, are 36 abortions per 1000 women aged 15–44 – that is, 2–3 times higher than Western Europe. As a result, more than one-third of all deaths from unsafe abortion worldwide take place in these two sub-regions.

Young women are particularly affected by unsafe abortion, especially in Africa where nearly half of all women of reproductive age are between the ages of 15 and 24. Cultural attitudes that disapprove of adolescent sexual activity contribute to a severe lack of access to reproductive health information and services. Young women are therefore less likely to be able to prevent pregnancy, putting them at the greatest risk for unsafe abortion.

Thus, in general there is exceptionally strong evidence that access to quality contraception reduces abortion rates.

Another important issue is *legal regulation*. Overall, there is no indication that rates of abortion are lower where it is illegal. In general, abortion is much more likely to be illegal in L/MICs than in HICs, yet in HICs abortion rates are lower, and have declined much more (Sedgh, et al. 2007). The recent report on unsafe abortion underscore that in countries with liberal abortion laws, and greater access to contraception, unsafe abortion is low to non-existent (WHO 2011d). By contrast, in countries where abortion laws are

most restrictive and women have low rates of contraceptive use, induced abortion rates are higher overall, and unsafe abortion poses a particular health risk for women.

Every method of family planning has some contraceptive failure, but altogether, modern contraception is estimated to avert 112 million abortions in the developing world every year, especially where programmes are well established, high quality and accessible to all parts of the population. Given that in most societies family planning is less available to poorer, less educated and more marginalized groups, they will often have higher abortion rates. For example, studies in Western Europe show immigrants to have abortion rates 2-3 times higher than the native population (Carballo, et al. 2005; Carballo and Mboup 2005).

Consequences of abortion: The main consequences that have been investigated are physical and mental health effects. With respect to physical health, abortions performed under safe (and early) conditions result in minimal adverse effects (Sedgh, et al. 2007; Shah and Åhman 2009). For example, in the US the case fatality rate is 0.6 per 100 000 procedures – about the same as for an injection of penicillin. For sub-Saharan Africa however, where most abortion is unsafe, the rate is 800 times higher. Even in developed countries, the case-fatality rate for unsafe abortion is 40 times higher than for legal induced abortion (WHO 2011d).

There is compelling evidence that making abortion illegal increases health risk. One very well documented case is Romania, where both abortion and access to contraception were severely restricted in 1967, as part of a pro-natalist policy of the Ceausescu regime. As a result, Romania in 1989 had the highest recorded MMR of any country in Europe – 159 deaths/100 000. An estimated 87% of those deaths were due to illegal and unsafe abortion. Romania also had a unique problem of large numbers of abandoned children in orphanages. Immediately after the 1989 revolution, the new government removed restrictions on contraception and legalized abortion, and MMR dropped to 83 in 1990. Several international organizations (e.g. UNFPA, USAID) have worked with the Romanian ministry of health, increasing access to free contraception in low-income communities, and contributing to an increase in contraceptive prevalence (from 29.5%, 1999 to 38.2%, 2004); a decrease in the average number of abortions a woman has in her lifetime from 2.2 in 1999 to 0.84 in 2004; and a 36.8% decline in abortion-related maternal mortality during this period (USAID 2006b).

Another example is South Africa, where the incidence of infection resulting from abortion decreased by 52% after the abortion law was liberalized in 1996 (Jewkes, et al. 2005).

The consequences of unsafe abortion go beyond mortality. Of every 5 women who have an unsafe abortion, at least one suffers an RTI as a result (WHO 2004e: 14). As mentioned above under family planning, (repeat) unsafe abortions also may lead to infertility. For example, in Romania, the upsurge in unsafe abortions after 1967 resulted in a lifetime number of abortions of 5 abortions in 1989, and 20% having acquired infertility (Kirkorian 2004).

With respect to mental health effects, evidence for both safe and unsafe abortions is thus far difficult to find. Studies claiming that women have increased risk of adverse mental health effects are generally not very robust. They should also be placed in the perspective that pregnancy in general is associated with 10-15% risk of maternal depression (see Annex 6). A few authoritative recent studies demonstrate no increased risk for mental health (Cohen 2006; Munk-Olsen, et al. 2011).

Response: There is no question that abortion is a controversial issue. Therefore, it may be helpful to expand on what international agreement does exist.

At the ICPD in 1994, the 179 government delegations in attendance

- recognised unsafe abortion as a major public health concern
- pledged their commitment to reducing the need for abortion through expanded and improved family planning services, with particular reference to areas where abortion rates were high due to poor family planning services (esp. Eastern Europe)
- recognised that, in circumstances where not against the law, abortion should be safe
- noted that women should have access to post abortion counselling and care.³⁸

In 1995, the Beijing Women's Conference reaffirmed these agreements. It also called for Governments to "...consider reviewing laws containing punitive measures against women who have undergone illegal abortions..." (UN 1995a).

The United Nations General Assembly review and appraisal of the implementation of ICPD in 1999 (ICPD + 5) further agreed that

"... in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women's health" (WHO 2003b).

There is no international agreement to consider abortion as human right, and only few national constitutions (US since 1973 and South Africa since 1993) which refer to it as a right (UNFPA 2009a). Several constitutions state that life (personhood) begins at conception. However, as pointed out in a recent decision in Nepal, there is no international agreement on the beginning of human life either, and therefore none to say that abortion is against human rights.³⁹

Regional fora have also addressed the issue. In Africa, health ministers have recently been increasingly outspoken about the public health hazards of unsafe abortion. The Maputo Protocol and Plan of Action, adopted by African Union Ministers of Health and subsequently at the Summit by Heads of State, or the ECOWAS meeting in 2009, are such examples.

Nationally, abortion law varies greatly across the world. In particular, it is worth noting that, in most countries, abortion is restricted under some circumstances and permitted under others. The variation may be either the grounds on which abortion is permitted (on demand, for a wide range of social reasons, for health reasons only, or totally forbidden even to save the life of the mother). The UN lists 6 states where abortion is illegal, even to save the life of the woman: Chile, El Salvador, Dominican Republic, Nicaragua, Malta and the Holy See. 53 allow it only to save the life of a woman, 81 for a variety of other reasons, and 56 on request (at least within a certain period of pregnancy). This represents less than 1%, 17%, 44% and 39% of all women, respectively (UN 2011c; WHO 2011d). However, in addition to legal status, many other factors may intervene, including provider bias, cost, stigma, etc.

Most country laws also graduate restrictions according to the length of the pregnancy (e.g. those countries where it is available on demand, including Denmark, it is usually so only in the first trimester). At times, health ministry staff may not be aware of these nuances, and this may make access more difficult, even where it is legal. In some countries, there seems to be no legal limit, but technical protocols limit the period for which abortion is available on demand (e.g. China).

In many countries abortion was made explicitly illegal in the last 100-200 years, with most countries having again relaxed their laws in the last few decades. However, there is also recent evidence that restrictions are increasingly being introduced, e.g. in the US. Since 1997, the grounds on which abortion may be legally performed were broadened in 17 countries: Benin, Bhutan, Cambodia, Chad, Colombia, Ethiopia, Guinea, Iran, Mali, Nepal, Niger, Portugal, Saint Lucia, Swaziland, Switzerland, Thailand and Togo. One territory and three states in Australia (Capital Territory, Victoria, Tasmania and Western Australia) and one state in Mexico (Mexico Federal District) also liberalized their laws. In contrast, El Salvador and Nicaragua changed their already restrictive laws to prohibit abortion entirely while Poland withdrew socioeconomic reasons as a legal ground (Singh, et al. 2009).

Most legal systems address the issue of the timing of the abortion, and this is at times the topic of discussion and confusion. We have therefore been requested to clarify some basic terminology.⁴⁰

- Fertilization (conception) occurs in the Fallopian tubes, and the fertilized egg is called a zygote.
- After a few hours/days, this zygote reaches the uterus. Only a small proportion of zygotes are implanted in the uterus. WHO defines a pregnancy as beginning at implantation, and abortion as termination of a pregnancy.
- An embryo refers to a pregnancy less than 8 weeks of gestation, and a foetus thereafter.
- 'Viability' refers to the ability of the foetus to survive outside the womb. This used to refer to 28 weeks of gestation. With improved technology, the limit of survival has been pushed back to 22

weeks in many countries (at which time the foetus weighs around 500g). However the health of a newborn born at 22 weeks of gestation may be very poor.

- 'Termination of pregnancy' according to the WHO definition refers to any outcome – live birth, miscarriage, stillbirth or provoked abortion. In popular useage it sometimes is used to refer to provoked abortion only.
- 'Menstrual regulation' is a procedure similar to that for insertion of an IUD – a thin tube is inserted in the uterus through the cervix. Vacuum pressure is applied to remove the lining of the uterus which would normally be expelled through menstruation. It is performed before any pregnancy test can be applied, up to 2 weeks after a delayed menstruation, and is legal in many countries which limit abortion.
- The exact mechanism by which the 'morning after pill' works is not entirely known, but it is thought that it primarily works by preventing implantation, that is, before a pregnancy begins.

Most legal frameworks and religious considerations address the issue of time frame. The Roman Catholic Church considers human life to begin at conception, and therefore that any termination from that point onwards constitutes murder. Islamic scholars give more nuanced interpretations, e.g. some determinations are that life begins at 100 days gestation or 'quickening' of the foetus.

Many national laws present a gradual approach, where the right of the woman are balanced against the right of the foetus. Many set the point of viability as a limit, or the end of the first trimester (12 weeks) (WHO 2007d). Some feminists object to this and feel that abortion is always preferable to bearing an unwanted child (Gita Sen, June 2009, personal communication).

Misoprostol is another issue drawing much attention. Focus has been placed on misoprostol as a means to increase women's access to postabortion care (Blum, et al. 2007). Trials of the technique in Burkina Faso (Dao, et al. 2007), Mozambique (Bique, et al. 2007), Tanzania (Shwekerela, et al. 2007) and Uganda (Weeks, et al. 2005) have shown promising results of misoprostol being a satisfactory substitute for the treatment of incomplete abortion and misoprostol is increasingly being considered a way to address women's poor access to postabortion care. Hence, there is a growing consensus of misoprostol having the potential to achieve good treatment outcomes and save lives if made available for treatment of abortion complication at primary health facilities (ACOG 2009).

In summary:

- *About one in five pregnancies worldwide results in abortion. The numbers have decreased: from 46 million in 1995 to 42 million in 2003. The lowest rates are in Western Europe, and the greatest decrease is in Eastern Europe. Africa has some of the highest rates, and increasing numbers.*
- *Abortion rates decline where high quality family planning is widely available. Making abortion illegal does not decrease abortion, but it does increase unsafe abortion.*
- *Unsafe abortion leads to 47 000 maternal deaths every year, 99% in L/MIC (only 90 in HICs).*
- *Laws regarding abortion vary greatly. Generally, abortion is much less restricted in HICs than in L/MICs. Only 6 countries make it illegal even to save the life of the mother. Especially post abortion care is legal in most countries, and is recommended by the ICPD.*
- *Medical professionals at times have a mistaken impression that it is totally illegal. Thus, even with existing laws, some care may be possible.*
- *Recommended action (in agreement with ICPD) would include*
 - *Clarify the legal situation of the country of concern*
 - *Ensure that permitted reasons for abortion are supported through health systems*
 - *Ensure access to services for management of complications*
 - *Provide post abortion care*
 - *Provide contraceptive services which will also help avoid repeat abortion*
- *Granting access to services for the management of complications arising from unsafe abortion*

Epidemiology: WHO estimates that every year more than 340 million new cases of common and treatable bacterial and protozoal sexually transmitted infections (i.e. syphilis, gonorrhoea, chlamydial genital infections and trichomoniasis) occur throughout the world in men and women aged 15-49 years. In addition there are millions of cases of mostly incurable viral infections (WHO 2004d).

A major problem for many STIs is that many of them are asymptomatic, at least in the early stages, and especially for women. This means that treatment is less likely, and prevention of further spread is made more difficult.

Viral infections of course include HIV. In 2009, 2.6 million new HIV infections were reported worldwide, 370 000 of which were mother-to-child transmissions. 1.8 million AIDS-related deaths were reported in 2009. Whereas this note will not go into great detail of this enormously complex issue, this area has seen remarkable progress. Preventive interventions have shown their effectiveness and antiretroviral treatment (ART) is saving millions of lives: the number of new HIV infections has decreased from a high of 3.1 million in 1999 to 2.6 million in 2009, and the number of deaths from 2.1 million in 2004 to 1.8 million in 2009. The number of women in low and middle-income countries with access to prevention of mother-to-child transmission of HIV is estimated to have grown from 45 to 53% in just one year (2008-9). ART coverage has increased from less than half a million in 2004 to 5.2 million although a total of 15 million in L/MIC need it according to the new treatment protocols from WHO. It is particularly notable that there has been great progress in stabilising or declining HIV epidemics and scaling up access to treatment in sub-Saharan Africa. Eastern Europe and Central Asia on the contrary show signs of further deterioration, with sharply increasing HIV epidemics due to a lack of implementation of evidence-based prevention interventions and a low ART coverage in the region causing AIDS related mortality to increase (UNAIDS 2010). Almost half of all new HIV infections are among young people, and about twice as many young women as men are infected with HIV in sub-Saharan Africa. Despite global success in curbing the HIV epidemic, the mission is still far from being accomplished. HIV transmission continues at alarming rates in many countries of the world, in particular in L/MICs and the number of people living with HIV increases steadily due to improved access to effective life-saving medicine. Millions of HIV infections and millions of deaths due to AIDS could be averted if universal access to HIV prevention, treatment and care is secured (UNAIDS 2010).

As an example of cancers, infection with the sexually transmitted human papilloma virus increases the probability of developing carcinoma of the cervix. The incidence of cervical cancer is about half a million every year, and the number of annual fatalities was estimated at 240 000 women in 2004, constituting the second leading cause of cancer-related mortality in females worldwide (WHO 2004f; WHO 2007a). Newer estimates give the number as 275 000 (Ferlay, et al. 2010). Papilloma virus also increases the risk of anal cancer and is especially prevalent among men who have sex with men (Bean and Chhieng 2010). ICPD, and the WHO STI strategy, do not mention other male cancers, e.g. prostate (testicular) cancer. Although prostate cancer is a disease of the reproductive organs, it is not sexually transmitted, and it is close to absent from international discourse and will not be elaborated here. It is notable that this, and other conditions affecting the reproductive health of men, receives low visibility.

Causes: Predisposing factors are as varied and complex as the diseases involved. Unprotected sex, multiple concurrent sexual relationships, pre-existing infections/conditions, stigma attached to STIs and in particular HIV, political hesitation to implement prevention and treatment programmes, weak health systems, legal barriers, discrimination and other social determinants such as poverty, gender based violence and lack of education are contributing to the continued spread of STIs including HIV and to the development of cancers of reproductive organs (WHO 2007a). Infection with one STI increases the risk of becoming infected with certain other STIs, by a factor of up to ten (WHO 2007c). Extreme cases exist, for example, WHO estimates that genital ulcers or a history of such diseases increase the risk of transmission of HIV 50-300-fold per episode of unprotected sexual intercourse (WHO 2007a).

Consequences: WHO estimates that globally, 60-80 million women suffer infertility and consequent involuntary childlessness as a result of untreated or inadequately treated STIs (ibid.: 15). Such infections may cause tubal blockage, resulting in both adverse outcomes of pregnancy, such as stillbirth and perinatal death due to syphilis, and blindness caused by gonococcal and chlamydial infections. Chlamydial infections, gonorrhoea and syphilis can produce serious and often life-threatening conditions in unborn and newborn children, including congenital disease, pneumonia and low birth weight.

STIs (including HIV), RTIs and cancers of the reproductive organs together account for 8% of the global burden of disease (WHO 2004b) and several STIs may have a deadly outcome for infants as well as adults. HIV infection is of course a special case and represents the main cause of adult mortality in Africa (ibid.: 18). HIV is arguably the only single disease which has caused a long term decline in life expectancy in a whole region (e.g. in a number of countries in Southern Africa, life expectancy declined by up to 20 years 1980-2000) (UN 2008). In addition to the health burden, these diseases place a huge economic burden on individuals as well and societies as a whole. Loss of productivity due to these diseases is severely compromising the development potential of countries. STIs and their complications rank in the top five disease categories for which adults seek health care in developing countries and thus place a huge burden on health systems (ibid.: 5).

Response: With the notable exception of HIV, this is clearly an area that has received very little attention. STIs (excluding HIV), RTIs and cancers are not visible in the MDGs, despite their considerable burden of disease and death. Many reasons are quoted for this: the general population may be unaware of the diseases, the fact that many of the infections are asymptomatic and do not cause death, there may be low interest in funding due to the stigma attached to the diseases, and there may be difficulties in integrating into other health system efforts (ibid: 15).

However, HIV and AIDS is a special case. The high burdens of disease and mortality have contributed to the attention it has been given. It has translated into phenomenal increases in financial support. From the 1990s until 2009, funding for the HIV epidemic increased substantially. In 2008, an estimated \$15.6 billion was spent on HIV and AIDS (UNAIDS and Kaiser Family Foundation 2009) compared to \$300 million in 1996 (UNAIDS 2006). From 2002-2008, in particular, funding increased six-fold. Since 2009, however, total global funding for HIV and AIDS has remained flat. This means that the funding gap (the difference in the amount of money needed and the amount actually allocated) was \$7.7 billion in 2009, compared to \$6.5 billion in 2008 (UNAIDS and Kaiser Family Foundation 2010).

In conclusion, the HIV epidemic has had exceptional impact, political and financial support, and, in the last few years, there has been exceptional success in controlling it. Yet, it is not clear that this momentum will be maintained, if political and financial support wane. On the other hand, conventional wisdom rarely addresses other aspects of STIs, cancers and infertility – they are close to invisible, despite their major contribution to the burden of disease and mortality. Integrating and linking HIV programmes with STI control and sexual and reproductive service programmes is gaining global momentum as a way to strengthen STI control, reproductive health programmes as well as the HIV response.

In summary:

- *There has been unprecedented attention to HIV and AIDS, and in the last decade, also much progress.*
- *For the other STIs and cancers, despite their great burden of disease, there is little attention, and little progress. There is particularly little focus on male morbidity.*
- *The response to STIs, cancers of the reproductive organs and HIV will benefit from an integrated approach to health service delivery including prevention, treatment, care and support.*

Epidemiology: As will be clear from the above discussion, all areas of SRHR have some conceptual, measurement and political challenges, and perhaps this is particularly true for sexual health and rights. Concerns related to sexual functioning are universal, but they have culturally specific forms.

However, there are few data on the global epidemiology. Generally it is estimated that between 8% and 33% of the adult population in developed countries experience some kind of sexual dysfunction in their lifetime, although some studies suggest that the true figure may be higher (Laumann, et al. 1999).

WHO identifies 'unsafe sex' as the second most important risk factor for disability and death in the world's poorest communities and the ninth most important in developed countries. However, presumably promotion of sexual health is more than simply the prevention of disease, it is closely linked to the concept of sexual rights and indeed the ICPD implies as much: '*Reproductive health therefore implies that people are able to have a satisfying and safe sex life...*' (para 7.2).

The WHO notes that 'Sexual health concerns are wide-ranging, encompassing sexual and gender identity, sexual expression, relationships, and pleasure. They also include issues such as:

- Infections with human immunodeficiency virus (HIV), sexually transmitted infections (STIs) and reproductive tract infections (RTIs) and their adverse outcomes (such as cancer and infertility)
- Unintended pregnancy and abortion
- Sexual dysfunction and infertility
- Violence related to gender and sexuality (including FGM)⁴¹
- Young people's sexual health and sexual health education
- Sexual orientation and gender identity
- Mental health issues related to sexual health
- The impact of physical disabilities and chronic illnesses on sexual well-being
- The promotion of safe and satisfying sexual experiences.

One might add:

- Sexual discrimination, both homosexuality but also discrimination, e.g. against older people and people with disabilities.⁴²

Financial necessity is often the cause of some types of high-risk sexual behaviour. Health interventions can only be effective if the relationship between economic need and health outcome is understood. The relationship between individual sexual behaviour, power dynamics and financial dependence is often underestimated (Luke 2003; Luke and Kurz 2002). There is an assumption that, with the necessary information and tools, everyone will make decisions that improve or preserve their health, but this has been shown to be unjustified, for example in relation to the HIV pandemic (Kamali, et al. 2003).

The context in which behaviour change is expected to take place is especially important. A woman or girl who is poor may know about the dangers of HIV and other STIs, but engaging in transactional or commercial sex may be the only way for her to earn money. How can her risk and vulnerability best be reduced? In the short term, strategies that encourage her clients to use condoms may be the best approach. In the longer term, however, her risk and vulnerability will be reduced only when her economic power and position are improved (Weiss and Rao Gupta 1998).

Response: There is nascent discussion of what the programmatic response should be. Most sources agree that these are not only health system issues, but must go beyond:

- Laws, policies and human rights
- Education
- Society and culture
- Economics

Programmes that have improved sexual health outcomes include those of Senegal, Thailand and Uganda (for reducing HIV infection) and Bangladesh, Romania and Vietnam (for reducing unwanted pregnancies). They often owe their success to a variety of actions that were implemented simultaneously (Celentano, et

al. 1998). Early debates focused on whether these “interventions” should be offered in an integrated manner, or whether vertical programmes (implemented alongside one another) can achieve equivalent results. The broad consensus now is that a comprehensive approach is needed (Askew and Berer 2003).

The recommended sexual health services can be provided as part of primary health care, including reproductive health services, or as a stand-alone service, and should address the most significant sexual health problems and concerns. The health system of a country should provide at least the following:

- Sexual health education and prevention information for young people, single adults, and couples, where confidentiality and privacy are assured
- Sexuality counselling for the client’s sexual health concerns or needs, and desired sexuality, reproductive or contraceptive preferences.
 - Identification and referral for victims of sexual and other forms of violence
 - Voluntary counselling, testing, treatment and follow-up for STIs, including HIV
 - Diagnosis, screening, treatment and follow-up for RTIs, reproductive cancers, and associated infertility
 - Diagnosis and referral for sexual dysfunction
 - Safe abortion to the full extent of the law
 - Post-abortion care, including provision of contraceptive information, counselling and methods

Accessible, acceptable, affordable and high-quality sexual health services are fundamental for achieving a sexually healthy society (WHO 2002).⁴³

As mentioned in the introduction, until very recently, the issue was close to invisible in academic literature and technical debates, but in the last few years it has gained some prominence in international policy debates, attempting to arrive at discussion and consensus.

These discussions have focused on the thought that sexual health and sexual rights are closely inter related. Sexual rights have been particularly invisible, and indeed it has not always been clear what they encompass. Issues such as gender based violence have become vastly more visible in the last decade, but child marriage, sexual orientation or other issues are rarely addressed.

A few significant developments in the last decade include:

1. At the initiative of Louise Arbour (then UN High Commissioner for Human Rights) a technical group of human rights lawyers and other technical experts was convened in Yogyakarta in November 2006, and the resulting ‘Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity’ were subsequently presented to the UN Human Rights Council. The principles address documented evidence of abuse of rights of lesbian, gay, bisexual and transgender (LGBT) people, noting grave human rights abuses against persons due to sexual orientation and gender identity. For example, at the time, in 77 countries homosexuality was illegal, and in 7 the death penalty was imposed on homosexuals.
2. In October 2008 IPPF published a declaration which was the result of intense consultation over several years. This declaration closely links sexual rights to sexual health, and to general human rights (IPPF 2008). This approach is increasingly taken by many civil society organizations and activists, as well as academic institutions (Berer 1998). There is a growing and rich literature on the issue (Berer 2011; Dixon-Mueller, et al. 2009; Gruskin 2005; 2006; IPPF 2008; Miller 2001; Miller and Vance 2004; Parker 2007; Petchesky 2000). It is also the approach now taken at the technical level (WHO 2010b).
3. At the level of the General Assembly of the UN, no mention was made until 2008, when France and the Netherlands presented a statement, backed by the European Union. It was originally intended to be adopted as resolution, but prompted an Arab League-backed statement opposing it. Both statements remain open for signature, with neither officially adopted by the United Nations General Assembly, and therefore are not in force.
4. On June 17, 2011, South Africa submitted a request to the United Nations Human Rights Council requesting the United Nations High Commissioner for Human Rights to draft a report detailing the

situation of LGBT citizens worldwide. The resolution passed 23 to 19 with the three abstentions being Burkina Faso, China, and Zambia.

In summary:

- *Further studies are needed to describe the epidemiology and effective programmatic approaches to sexual health and rights.*
- *Until recently, sexual health, and sexual rights, have been close to invisible in international consensus documents. Technical and programmatic discussions have become more frequent in the last decade, both in academic or civil society fora, as well as at technical level of UN organizations.*
- *In the last five years, this is beginning to gain speed, with increasing discussion also at political level. This includes a recently adopted (June 2011) resolution in the UN Human Rights Council.*
- *Clearly, this is not the easiest area for advocacy, however, the fact that there are now several definitions, the beginnings of possible guidelines on what the operative components, as well as the beginnings of discussion at political level, is promising.*

Critical Cross Cutting Issues

As noted by Cook and colleagues, reproductive health is quite different from other areas of health. It is central to 'social and cultural' identity. Therefore, for as long as there have been cultures, their leaders (not only medical practitioners) have instituted strong norms for reproductive behaviour and values; for example, all the major religions attribute fertility and faithfulness as ideal female characteristics (Cook, et al. 2003). The fact that reproductive health is lifelong also makes it unique, extending well beyond the years of reproduction. It is closely related to gender, to personal relations, to human rights, and to the role of those rights in inter-personal relations, among not only two, but potentially three people – mother, father, child (Clévenot, et al. 1987: 569, 571-577; UN 2002; Vallet 1994: 110; WHO 2004d). Therefore, it is perhaps not surprising that politics intrude on the health response to reproductive health (Gruskin 2004).

Political support for reproductive health, especially international assistance, has undergone several shifts in the last few decades. In the 1974 population conference in Bucharest, there was strong support for family planning, and for limiting population growth, by a number of developed countries including the US. Developing countries as a group, including China, were quite sceptical. By the 1984 Population conference in Mexico City, the positions had shifted: China strongly supported family planning for demographic reasons, whereas the US, under the Reagan administration, considered population 'a neutral factor' for development (Singh 2009; US National Academy of Sciences 1986). At the same time, concern was growing about human rights violations in family planning programmes, especially in Asia.

The ICPD conference in 1994 was perhaps a (short-lived) window of opportunity for agreement, where also women's groups had an unprecedented effect on the outcome document, and with all 179 states in attendance associating themselves with the consensus. Developing countries have continued to increasingly embrace the broad concept of reproductive health, and family planning in particular. The number of developing country governments that supported family planning increased from two in 1960 to 115 in 1996 (UN 2004c).

Until very recently however, support for family planning from developed countries has waned – many observers confess they still do not understand entirely why, but some of the reasons could include the failure to establish a clear link between population and economic growth (although there are few other linkages which can be made more clearly either), the fact that birth rates had begun to decline and therefore concerns about population growth abated, increasing concern about violations of human rights in family planning programmes, and, especially until recently, a shift toward more conservative leadership in some countries such as the US. There is also a diffuse notion that the fact that women's issues had been given such prominence was in itself frightening to some (Glasier, et al. 2006). In financial terms, this has resulted in a number of estimates that funding for family planning has declined, with one estimate being a reduction from USD 723 million in 1995 to 338 million USD in 2007 (Obaid 2009).

The US has had an important role, both in support and lack of support. The expectation is that the Obama US administration may be more positive, as every previous change of US administration has occasioned a change in position on this issue, and indeed major changes have already taken place since the change in the US administration in 2009.

Abortion was the most visibly controversial issue in the ICPD conference, and remains so today. This is closely linked to religion. The only religion which has a position consistently stating that all abortion is murder is Catholicism – other religions have more nuanced or varied views. For example, some Islamic leaders determine that abortion is acceptable up to 100, or 120 days, of gestation. Contrary to some popular views, most estimates are that Catholics do not have fewer abortions than others; this is supported by the fact that some Latin American countries have high abortion rates (and very high maternal mortality due to unsafe abortion) (Sedgh, et al. 2007).

Biology may help explain part of the discussion. Conception occurs in the fallopian tubes, and some days pass before the fertilized ovum is implanted in the uterus. There are few recent estimates of the proportion of fertilized ova, which are actually implanted, but most estimates are that a significant proportion are not implanted. The WHO definition of 'abortion' is therefore 'the termination of a pregnancy', with a 'pregnancy' defined as beginning after a fertilized ovum is implanted in the uterus. Catholic teachings are that life begins at conception, and this has been translated into the constitutions of several Catholic countries. All the 6 countries, which outlaw abortion even to save the life of the mother are Catholic. Yet many others also oppose abortion e.g. US evangelicals, and the issue is increasingly part of political campaigns including in Europe.

The other issue resulting in major disagreement at ICPD was that of the 'family'. The position of several delegations was that any sexuality outside marriage between a man and a woman (a family) was unacceptable. Thus, several delegations agreed to the term 'couples and individuals' only on the understanding that 'individuals' meant 'married individuals', and that families meant unions between a man and a woman.⁴⁴

The family issue is linked to approaches to youth and their sexual behaviour, and young people⁴⁵ have particular reproductive and sexual health issues.

Much opposition has centred on provision of sex education to young people. Thus, one reason the US has not ratified the Convention on the Rights of the Child is that it suggest sex education for young people. Yet, evidence indicates that in societies where youth have more education, including sex education, they have later onset of sexual debut, and lower risk taking behaviour (ref).

Youth have lower access to or utilization of all the services mentioned above. About half of abortions are in young people (WHO 2004e), and young women have a higher unmet need for family planning than older women. Out of the approximately 340 million new cases of curable STIs, the highest rate is among 20-24 year olds, followed by 15-19 year olds. One in 20 young people is believed to contract an STI every year, excluding HIV and other viral infections. Yet, a minority of adolescents have access to acceptable and affordable STI services (Dehne and Riedner 2005). About half of all new HIV infections are in young people; most of them girls in sub-Saharan Africa and Asia. Ratios of new female-to-male infections among young people between ages 15-24 run as high as 8:1 in South Africa (UNFPA 2009b; WHO 2004e).

As mentioned above, maternal mortality is often estimated as being 2 times higher for women 15-18 than for older women, and 5 times higher for women under 15 (WHO 2001a). Many factors may contribute to this including physical, social and financial factors (UNFPA 2004b; UNFPA 2005; WHO 2004a; WHO 2006a). Yet, in Asia, 30% and 60% of women are married by the ages 15 and 18, respectively; (Bruce and Clark 2003), e.g. the estimates in India for 2005-6 were that 45% of women were married by age 18, and 300 000 had given birth to at least one child by age 15. The proportion of first births that take place during adolescence is about 2% in China, 18% in Latin America and the Caribbean and more than 50% in sub-Saharan Africa (2006; UN 2008).

The acceptable age of marriage is a rather unclear issue in terms of human rights, with most human rights scholars interpreting it as being 18, based on the Universal Declaration of Human Rights (1948) and the Convention on the Rights of the Child (1989), however, many countries have marriage laws condoning much earlier marriage, and some Muslim scholars interpret early marriage to be acceptable.

Age of mother at time of giving birth is also important for the health of babies, e.g. in Vietnam the infant mortality rate was 27/1000 for mothers aged less than 20, and 15/1000 for mothers aged 20-29,⁴⁶ and globally, among mothers under age 20, infant mortality rates average 100 deaths per 1000 live births; among mothers aged 20-29 and 30-39, the rate is 72-74 deaths per 1000 live births. Stillbirths and death in the first week of life are 50 per cent higher among babies born to mothers under 20 than among babies

born to mothers who are 20-29 years (UNFPA 2007; WHO 2008b). HIV is also a particular risk in early marriage (Clark 2004) (Data compiled by Population Council).

ICPD addressed this issue, calling for reduction of adolescent birth rates, reproductive health education for adolescents, and the full participation by adolescents in the “planning, implementation and evaluation” of reproductive and sexual health information and services. To achieve this “countries should, where appropriate, remove legal, regulatory and social barriers to reproductive health information and care for adolescents.”^{A7}

World population grew from around 1.5 billion in 1900, 2.5 billion in 1950, 7 billion in 2011, and projected to grow to 9.3 in 2050. Like any projection, this one is based on assumptions, the most important one being that global birth rates will decline from 2.5 today to ‘replacement level’ of 2.1 by 2050, as a result of increased levels of contraceptive use. Experience shows that, as a rule of thumb, contraceptive use has to rise 15 percentage points in order to reduce the fertility rate by one birth per woman.

If instead contraceptive prevalence, and fertility, stay at present levels in the individual countries concerned, then the projection is that population will increase to 11.0 billion by 2050 (and 27 billion by 2100) (UN 2008; UN 2011d).

Population growth is much faster in developing countries than it was in the now industrialized countries. The United Kingdom’s population increased about 3.5 times in the century between 1800 and 1900; Uganda’s is likely to increase 18 times in the century between 1950 and 2050 – even with a serious HIV/AIDS epidemic, and even with fertility reductions assumed in the UN’s medium scenario (Turner 2009).

In the 1960s and 1970s, many economists especially in the developed world were of the opinion that family planning, and reduction of birth rates, was a necessary precondition for poverty reduction (Coale and Hoover 1958). Then followed a period of scepticism or neutrality in the 1980s (US National Academy of Sciences 1986). However, since then a growing body of evidence has pointed to the economic benefit of fertility reduction, although it seems as yet to have had little traction (Birdsall, et al. 2003). Thus, the Population and Development Commission that took place 11-15 April 2011 noted that:

“The medium-term effects of fertility reductions on economic growth in both developed and developing countries are estimated to account for about 20 per cent of per capita output growth between 1960 and 1995. Declining fertility has also contributed to poverty reduction. Between 1960 and 2000, demographic change alone accounted for a 14 per cent drop in poverty levels in developing countries and could produce an additional 14 per cent reduction during 2000 to 2015 if fertility decline accelerated in high-fertility countries” (UN 2011a).

At the macro (national) level, one study of 45 countries estimated that the proportion of people living in poverty would have fallen by a third if the crude birth rate had decreased by five per 1000 population in the 1980s, and many others attribute a major part of the economic miracles of Asia to the rapidly declining birth rates of those countries (Bloom, et al. 2000; Bloom and Williamson 1998; Eastwood and Lipton 1999; Eastwood and Lipton 2001).

There is however general agreement on the effect of age structure, which are a direct result of falling birth rates (and to a lesser extent, increasing life expectancy) of the ‘demographic transition’. Populations transit through three stages. In the first phase, high birth rates and death rates result in a high proportion of children. As rates decline, that ‘bulge’ of children ages into a ‘bulge’ of working age. And a few decades later, they result in a bulge of ‘older people’ over 60. The transition can be translated into a demographic window of opportunity, if societies are able to make use of the high proportion of working age population – China being a prime example of such a country (UNDP and Bank 2001).

At the micro (family) level, there is no doubt about the existence of a strong correlation between poverty and fertility. In 56 developing countries, on average, the poorest quintile of women had a fertility rate of six births, compared with 3.2 births in the wealthiest quintile (Gwatkin, et al. 2004). However, interpretations of the direction of the causality have varied. The assumption of many economists is that behaviour is rational, thus fuelling widespread beliefs that poor people need many children, e.g. for help with household production and for security in old age, and that family-planning promotion cannot succeed in very poor countries.

This tends to be unsupported by evidence. Family-planning promotion has succeeded in very poor countries such as Bangladesh. The 'threshold' of income at which fertility starts to decline varies, and it depends on the quality of family planning programmes. This and other examples indicate that much of the fertility difference between rich and poor is due to unmet need for preferred family planning methods and services, not to desired higher fertility (Lipton 1998).

Households with many children are more likely to become poor and less likely to recover from poverty than families with only a few children (Aassve, et al. 2005). Children from large families are usually less well-nourished and less well educated than those from smaller families (Greene and Merrick 2005). In Asia, daughters suffer most of the effects of many siblings in a low-income household (Lloyd 1994; Schultz 1993). In most developing countries, for instance, women's participation in the labour force has increased as fertility has fallen (UN 1995b).

Thus, there is no prospect on immediate agreement on this issue, which seems also to be mired in a political positioning – free market economists tending to deny any connection between fertility levels and poverty, whereas those tending more to the 'liberal' (in the English sense of the term) side arguing that there is such a connection. It should be noted that many relationships are difficult to prove, including what other factors influence economic growth. However, whereas theoretical discussions amongst economists may continue, it is clear that developing country governments are clearer: out of the 50 least developed countries, the percentage which considered population growth in their country to be too high has increased from 26% in 1976 to 76% in 2007 (UN 2010d).

This issue will not be addressed in great detail, as a separate policy briefing note exists (Tellier 2010). In brief, the note highlights that population is indeed one important factor in climate change, and family planning likewise. It also notes that family planning may be an important part of adaptation of families to climate change.

However, it also cautions that seeing family planning as a means to the end of producing less CO₂ is risky. For one thing it may divert focus from the fact that consumption, and carbon emissions, may be hundreds of times higher in rich than in poor countries. Furthermore, experience shows the discourse easily shifts from a focus on meeting unmet need for family planning, to one which tends to accept coercive family planning. This paper takes the position that this is not only against human rights, but also probably both more difficult, expensive as well as being less effective.

As earlier noted, the concept of sexual rights is still contested. They are neither clearly agreed, nor monitored through the MDG framework or any other international consensus document. For example, issues such as sexual orientation (e.g. homosexuality), a satisfying sex life or simply freedom for people – particularly women – to avoid sexual coercion are still contested.

It is also important to note that conferences (Cairo or Beijing) are 'non-binding.' That is, they are not founded in national law, and governments may consider them anything from good aspirations to firm commitments. 'Human rights', on the other hand, are, in principle, binding – that is, they are established in human rights treaties (e.g. CEDAW), which have been ratified in national legislatures. About a third of the world's countries outlaw homosexual acts, and a handful have the death penalty for such acts. Thus,

since the treaties are not explicit, it is difficult to argue that universal human rights treaties accept the right of sexual orientation.

The shortage of human resources for health is a high profile issue, compounded by the issue of brain drain to industrialized countries, in particular so-called 'MOMS' (midwives, or others with midwifery skills). An estimated 700 000 midwives are needed worldwide to ensure universal coverage with maternity care, but there is currently a 50% shortfall. In addition, 47 000 doctors with obstetric skills are required, particularly in rural areas (WHO 2005c). Worldwide, 4.3 million health workers are lacking (UNFPA 2011b; WHO 2006b).

This is an important issue, but is intended to be elaborated in another brief. According to one multi-country survey undertaken by WHO, on average one woman in four suffers violence at the hand of an intimate partner, and 4-20% suffer violence during pregnancy (WHO 2004e; WHO 2005b).

One of the most unfortunate aspects of the political sensitivity surrounding SRHR is the delinking between different components – in particular vertical programmes for HIV/AIDS, other reproductive health including family planning, and other STIs which sometimes get completely lost between the cracks. Such 'verticalization' was also the situation for family planning programmes in the 1970s and 1980s. Part of the cause is the US 'Mexico Conference Gag Rule' which states that no US federal international funding may go to organizations that provide, or inform about, abortion, even if it is with their own funding. Since many family planning programmes do inform about abortion, that has excluded them from funding. To avoid defunding, both national NGOs, but also international organizations have made efforts to delink, e.g. WHO has separated activities dealing with 'safe motherhood' and moved HIV/AIDS to the communicable disease division, from their original place in the division of Reproductive Health and Research. Compartmentalized funding for example in the Global Fund to combat AIDS TB and Malaria has only served to strengthen this, as national government sought to avoid defunding.

Many efforts have been made to 're-link'. For example, UN agencies began a process of consultations to identify linkages in Gion in 2004 (UNFPA 2004a) and consultations have also included NGOs such as the IPPF (WHO 2005a). Recent studies point to cost benefit for both maternal health and HIV programmes to link. Some of the linkages identified are: general management of sexually transmitted infections, screening for HIV status, promoting safer sex including condom use, integrating HIV with Maternal and Infant health care (e.g. for the prevention of mother to child transmission), integrating STI into FP including discussion of counselling regarding sexuality outreach to men, counselling and information regarding sexuality. Organizations such as the Global Fund are now also integrating such ideas into their action plans. The intention is that this would actually imply cost savings or efficiencies, rather than additional costs.

In addition there are many other issues regarding health systems which have been identified as barriers to improving reproductive health, and which should be considered in health system strengthening:

- Mobilizing political will
- Legislative frameworks. For example those influencing access: do unmarried people have access? What is minimum age? Financial barriers for the poor?
- Limitations such as rules which prohibit midwives to remove placenta or administer other basic emergency obstetric care – general task shifting
- Limitations on over the counter commodities such as emergency contraception, or limitations in terms of import of certain drugs
- Lack of access due to distance

- Lack of staff or commodities which limit quality in service provision (especially reproductive health are demanding in terms of permanent flow of commodities, even in times of no emergency)
- Sustainable health financing mechanisms included in plans
- Research community level and general info including strengthen monitoring and e.g. maternal audits (WHO 2004d).
-

Three randomised controlled trials in Kenya (Bailey, et al. 2007), Uganda (Gray, et al. 2007) and South Africa (Auvert, et al. 2005) have shown that adult male circumcision reduces the risk of acquiring HIV infection in female to male transmission of HIV by approximately 60%. Based on these findings, the WHO and UNAIDS in 2007 recommended male circumcision as an additional, important strategy for the prevention of heterosexually acquired HIV infection in men. WHO concluded that the greatest potential public health impact will be in settings where HIV is hyper endemic (HIV prevalence in the general population exceeds 15%), spread predominantly through heterosexual transmission, and where a substantial proportion of men (e.g. greater than 80%) are not circumcised (WHO/UNAIDS 2007).

In addition to preventing transmission of HIV, male circumcision has also been shown to reduce the risk of invasive penile cancer (Larke, et al. 2011) and to reduce the risk of transmitting Human Papillomavirus (HPV) and thereby preventing cervical cancer in women with circumcised partners (Auvert, et al. 2009; Larke 2010; Wawer, et al. 2011). Concerning prevention of other sexually transmitted diseases than HIV and HPV, data from clinical trials indicate that circumcision may be protective against genital ulcer disease, Herpes simplex type 2 and *Trichomonas vaginalis* infection in men. No evidence exists of a protective effect against *Chlamydia trachomatis* or *Neisseria gonorrhoea* (Larke 2010).

A recently published systematic review on the safety and efficacy of non-therapeutic male circumcision showed no reports of mortality due to the procedure itself and the reported adverse effects were infrequent (of three RCT studied, 4,8% adverse events were reported). The included studies differed in the manner in which adverse events were defined, detected, and reported, yet severity of complications were generally reported as mild to moderate, and most resolved within hours or days. Serious, permanent adverse effects, such as erectile dysfunction, occurred rarely (Perera, et al. 2010). Similar findings were observed in a review of the three RCTs. This review found little evidence of serious adverse events from being circumcised (Larke 2010).

A major concern about the increased uptake of male circumcision is that risk compensation will occur among circumcised men (i.e. the men will increase their level of high risk sexual behaviour due to a lowered self-perceived risk of contracting HIV). Data from the three RCTs show little evidence of risk compensation following male circumcision (Auvert, et al. 2005; Bailey, et al. 2007; Gray, et al. 2007; Mattson, et al. 2008). It should though be noted that the RCTs provided the highest standards of preventive care including intensive individual counselling and that participants did not know that circumcision reduced their risk of HIV infection (Krieger 2011). A qualitative study on sexual behaviour change among recently circumcised men found a minority of men reporting increased risk behaviour and a majority of men actually changing to more protective behaviour post circumcision. This change to adopting protective behaviours was associated with the HIV risk reduction counselling and HIV testing that study participants received. Findings from this study show that risk compensation following male circumcision does occur, but also that circumcision can foster protective sexual behaviour change and that this is possibly influenced by the counselling offered (Riess, et al. 2010). Future studies of risk compensation among the thousands of newly circumcised men in sub-Saharan Africa will hopefully provide a clearer picture of the level of risk compensation among men circumcised as part of the HIV prevention strategy.

A recent Danish cross-sectional study on male circumcision and sexual function associated male circumcision with frequent orgasm difficulties and with a range of sexual difficulties in women (Frisch, et al. 2011). This is however in contrast to findings from the RCTs in Kenya and Uganda, which found that male circumcision is unlikely to adversely affect either male or female sexual function or satisfaction (Kigozi, et al. 2009; Kigozi, et al. 2008; Krieger, et al. 2008). As male circumcision is being implemented as a HIV prevention strategy in many sub-Saharan countries it is important to further study the sexual consequences of male circumcision to ensure sexual rights.

Many countries in sub-Saharan Africa are reporting an overwhelming interest in and demand for male circumcision (IRIN News 2008; IRIN News 2010; Lundsby, et al. 2011; Post Zambia 2009). Hence, male circumcision as an HIV prevention strategy can be said to be a successful intervention, at least in terms of number of men demanding and seeking the intervention. Unpublished data (Lundsby, et al. 2011) looking at post circumcision experiences among Zambian men have shown how recently circumcised men ascribe value to and make sense of circumcision through highlighting a variety of values including; enhanced hygiene, perceived lower risk of STIs and cancers, enhanced sexual performance, perceived preference by women and social prestige. These findings are useful in understanding the reasons behind the popularity of this HIV preventive intervention seen in many sub-Saharan countries. It is suggested that the positive take up of this intervention is based on the ability of the target population to give meaning to circumcision as a broader social health matter, which largely transcends the personal HIV risk of the individual.

Interestingly, though less well known, Danish researchers amongst others are addressing the issues of co-morbidities and linkages between SRHR and other health issues, both communicable diseases, non-communicable diseases and nutrition.

For example, pregnancy associated malaria (PAM) affects both maternal and foetal health. Especially in malaria endemic areas in Africa, PAM is associated with low birth weight, due to intrauterine growth retardation (IUGR). The mechanism leading to IUGR is complicated and there is a need for better understanding of this mechanism, as well as at what point in pregnancy malaria has the most detrimental effects on the unborn child's health (Umbers, et al. 2011a). The consequence of malaria on growth may continue after birth with a decreased growth in the first year of life among offspring of mothers who suffered from malaria during pregnancy (Kalanda, et al. 2005; Walther, et al. 2010).

PAM is estimated to result in 75 000-200 000 infant deaths each year (Desai, et al. 2007; Guyatt and Snow 2004). It is also linked to maternal anaemia and possibly hypertensive disorders including pre-eclampsia, leading to an increase in maternal mortality ratio by 9/100 000 (Muehlenbachs, et al. 2006; Ndao, et al. 2009; Umbers, et al. 2011b).

Finally a better understanding of the importance of nutrition in the context of PAM is important, with some studies raising the question whether nutritional status might affect the consequence of PAM on fetal growth (Landis, et al. 2009).

With respect to non-communicable diseases, diabetes is one of several NCDs with a strong negative interrelation with pregnancy. This is a two-way process, and a double danger: on the one hand, obese mothers are at risk of developing gestational diabetes and overweight babies at increased risk for malformations and subsequent diabetes. On the other hand, underweight or anaemia or infection (by parasites e.g. malaria, virus e.g. HIV or bacteria e.g. urinary tract infections) are at risk for LBW and subsequent early development of hypertension cardiovascular disease and type 2 diabetes in particular when changing living conditions and life styles e.g. urbanization. Paradoxically, prevention of NCD in the adult may begin during pregnancy and early childhood amongst others by combating infection as well as under- and over-nutrition. The understanding of 'foetal programming', in particular the relationship between low birth weight and higher rates of non-communicable diseases such as diabetes and cardiovascular disease in later life, has grown rapidly since the 1990s (Barker 1997; Hales and Barker 1992). So has the understanding that breast feeding may help prevent diabetes and heart disease in later life, and the understanding of the importance of controlling gestational diabetes – e.g. one study showing that women with pre gestational diabetes had a lower risk of infant malformations if their condition was under metabolic control (0.9% vs 7.1%).

In summary:

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- The linkages between SRHR, CDs, NCDs and nutrition are rapidly becoming more visible. Recognizing these linkages in health programming holds promise of increasing cost-effectiveness, avoiding building up vertical programmes for each disease.
- There is a great need for further research, feeding also into our understanding of the MDGs.

mHealth

A particular issue which should be addressed in the future is that of mHealth, that is, the utilization of IT in health, in particular mobile phones, either for health information, consultation or financial transactions. In the last few years, mobile phone ownership has increased from a few percent to over 50 percent of the population of L/MICs, much faster than, for example, computer ownership or telephones (UN 2010a). It is as high as it was in a HIC such as Denmark less than a decade ago. Thus, it holds particular promise to dramatically increase access to health information and services. This is particularly true for adherence issues related to SRHR, e.g. the importance of follow-up visits e.g. for STIs/HPV or rapid consultation for complications of pregnancy. There is as yet many declarations of intent to utilize this, and also many studies showing increased utilization of the technology for health, but as yet only one RCT study showing impact in terms of health outcome (Lester, et al. 2010)

The costs of the present situation include what has been mentioned above – overall reproductive ill health accounts for 32% of the global burden of disease for women (WHO 2004b) and complications from pregnancy and childbirth are the leading cause of death among young women in the developing world (UNFPA 2007).

If the gap between demand and supply for family planning was met, the number of women dying in pregnancy or childbirth would be cut by approximately one-third. Fulfilling the unmet need for modern family planning in the developing world would reduce unintended pregnancies from 75 to 22 million, a reduction of over 70 per cent and unplanned births would drop from 30 to 8 million. This would result in 25 million fewer induced abortions ever year. The healthy years of life lost due to disability and premature death of women and their newborns would be reduced by more than 60 per cent if the need for maternal and newborn health services and family planning were met. Depending on what services are offered, each dollar spent of family planning can save governments 4 dollars in spending on health, housing, infrastructure (UNFPA 2009a; USAID 2006a).

A few studies have attempted to quantify the financial cost – e.g. one widely cited study that pregnancy-related death of women and newborns costs the world \$15 billion in lost productivity every year (Gill, et al. 2007; Starrs 2007).

For an overview of one list of the components of a full sexual and reproductive health package, see Annex 6.

The second question is how much it would cost to remedy the situation.

Altogether, ODA for health has increased dramatically over the last decades, from 5.59 billion USD per annum in 1990 to 10.69 in 2000 to 21.79 billion in 2007 (Ravishankar, et al. 2009). However, much of that has gone to HIV/AIDS, and altogether around half is for MDG6 (HIV AIDS, malaria, TB) (Piva and Dodd 2009). Since the mid-1990s, funding for reproductive health services, including family planning, has declined as a percentage of health spending and in many cases in real terms as well.

Government spending for health in developing countries in constant US\$ from domestic sources increased by approximately 100% from 1995 to 2006. Overall, this increase was the product of rising GDP, slight decreases in the share of GDP spent by government, and increases in the share of government spending on health. At the country level, while shares of government expenditures to health increased in many regions, they decreased in many sub-Saharan African countries (Lu, et al. 2010).

ODA funding for family planning rose quickly in early stages of development assistance, from 168 million USD in 1971 to 512 million in 1984 (UNFPA 1988). Estimates vary, but agree that the peak donor support earmarked for family-planning commodities and service delivery was in 1995, with one estimate being 723 million USD committed for that year, while the estimate for 2007 was about 338 million USD (Obaid 2009; UN 2004a; UNFPA 2009a; UNFPA 2009b). The World Bank gave 18% of its health funding to Reproductive health in 1995, by 2007 it was 10% (World Bank 2010). Overall, for reproductive health the ODA investment is 12 billion a year (UNFPA 2009a). Yet, demand for modern contraception will continue to rise during the next decade because of the anti-

pated increase in the number of women of reproductive age and the number of women who wish to have smaller families.

What would be needed? The estimated cost of providing access to both family planning and maternal and newborn care to all women in developing countries who need them is estimated to cost \$24 billion per year by 2015, or double today's investment. Providing each pregnant woman in the developing world with quality care would cost an average of \$123 – \$43 for antenatal care; \$75 for delivery, newborn, and postpartum care; and \$5 for post-abortion care, or 4.50 per capita (ibid.: 28). Fulfilling the unmet need for family planning would cost an additional USD 3.6 billion every year, for a total of 6.7 billion annually (ibid.)

What would be the result of such investment? The estimate is that such additional investment would prevent 70% of the current levels of maternal deaths and 44% of neonatal deaths (ibid.: 28).

As a final comment, it is remarkable how much dynamic change has taken place since 2007. The Women Deliver Conference took place in an environment where there was little to show progress in RH, nor much commitment to tackling the problems. Reproductive health, family planning and maternal mortality were seen as outstanding examples of inadequate policy commitment. However, the last two years have seen many positive developments (Women Deliver 2010).

- The 2009 Consensus for Maternal, Newborn and Child Health and the Women Deliver conference in July 2010 provided a common set of priority actions. One particularly visible new support was by Melinda Gates, who announced a commitment of 1.5 billion USD in grant money for maternal and newborn health.
- New estimates of maternal mortality and AIDS in 2010 demonstrated progress for those issues, although little is apparent for family planning.
- The Maternal mHealth Initiative within the mHealth Alliance, was launched in June, engaging a wide variety of stakeholders, both public and private.
- The Renewal of the Maputo Plan at the 15th African Union Summit, July 2010.
- G8/G20 Commit to Improving Maternal Health, June 2010 (Mushoka/Ontario called for 5 billion USD over the years 2011-15 for a maternal health fund).
- Secretary-General Ban Ki-moon launched the Global Strategy for Women's and Children's Health, and variety of stakeholders (private, government, international, non-profit, research) pledged new over \$40 billion during the global summit on the Millennium Development Goals.
- Establishment of the United Nations Commission on Information and Accountability for Women's and Children's Health.
- Recognition e.g. by the World Bank that it has given insufficient attention to RH in the past, and commitment to do more in the future (World Bank 2010).⁴⁸
- ICDP extended, by UN General Assembly decision, mid December 2010.
- UN Commission on Information and Accountability for Women's and Children's Health.
- Several donors have put family planning high on their agenda again, such as the German government with its new Initiative on Voluntary Family Planning.⁴⁹
- In April 2011 WHO, UNICEF and UNFPA launched a priority list of medicines for women's and children's health.
- There is also increased focus on adolescent health, by the Commission on the Status of Women in 2011, and by the UN organizations UN Women, UNFPA, WHO and UNICEF, as well as by IPPF, e.g. the UN Adolescent Girls Task Force (UNAGTF).

ANNEX 1: RELEVANT QUOTES FROM THE ICPD

“Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases” (Paragraph 7.2).

“Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.

It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents...” (Paragraph 7.3).

“Governmental goals for family planning should be defined in terms of unmet needs for information and services. (...) All countries should, over the next several years, assess the extent of national unmet need for good-quality family-planning services...” (Paragraphs 7.12 and 7.16).

“In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women’s health, to deal with the health impact of unsafe abortion as a major public-health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions” (Paragraph 8.25).

Source: Programme of Action of the 5th International Conference on Population and Development, New York, United Nations, 1994.

ICPD+5 added the following “Key Actions”:

“(ii) Governments should take appropriate steps to help women avoid abortion, which in no case should be promoted as a method of family planning, and in all cases provide for the humane treatment and counselling of women who have had recourse to abortion.

(iii) In recognizing and implementing the above, and in circumstances where abortion is not against the law, health systems should train and equip health- service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women’s health” (Paragraph 63).

Key Actions for the Further Implementation of the ICPD Programme of Action⁵⁰. Special session of the United Nations General Assembly ([ICPD+5](#)), June 1999.

Sources: (UN 1994a; UN 1994b).

ANNEX 2: THE MILLENNIUM DEVELOPMENT GOALS, TARGETS AND INDICATORS

Millennium Development Goals (MDGs)	
Goals and Targets (from the Millennium Declaration)	Indicators for monitoring progress
Goal 1: Eradicate extreme poverty and hunger	
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1.1 Proportion of population below \$1 (PPP) per day ^a 1.2 Poverty gap ratio 1.3 Share of poorest quintile in national consumption
Target 1.B: Achieve full and productive employment and decent work for all, including women and young people	1.4 Growth rate of GDP per person employed 1.5 Employment-to-population ratio 1.6 Proportion of employed people living below \$1 (PPP) per day 1.7 Proportion of own-account and contributing family workers in total employment
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.8 Prevalence of underweight children under-five years of age 1.9 Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education	
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1 Net enrolment ratio in primary education 2.2 Proportion of pupils starting grade 1 who reach last grade of primary 2.3 Literacy rate of 15-24 year-olds, women and men
Goal 3: Promote gender equality and empower women	
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	3.1 Ratios of girls to boys in primary, secondary and tertiary education 3.2 Share of women in wage employment in the non-agricultural sector 3.3 Proportion of seats held by women in national parliament
Goal 4: Reduce child mortality	
Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate 4.2 Infant mortality rate 4.3 Proportion of 1 year-old children immunised against measles
Goal 5: Improve maternal health	
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel
Target 5.B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage (at least one visit and at least four visits) 5.6 Unmet need for family planning
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years 6.2 Condom use at last high-risk sex 6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS 6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6 Incidence and death rates associated with malaria 6.7 Proportion of children under 5 sleeping under insecticide-treated bednets 6.8 Proportion of children under 5 with fever who are treated

Official list of MDG indicators

All indicators should be disaggregated by sex and urban/rural as far as possible.

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unstats Millennium Indicators	4/3/11 8:30 AM
	with appropriate anti-malarial drugs 6.9 Incidence, prevalence and death rates associated with tuberculosis 6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment short course
Goal 7: Ensure environmental sustainability	
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	7.1 Proportion of land area covered by forest 7.2 CO2 emissions, total, per capita and per \$1 GDP (PPP) 7.3 Consumption of ozone-depleting substances 7.4 Proportion of fish stocks within safe biological limits 7.5 Proportion of total water resources used
Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	7.6 Proportion of terrestrial and marine areas protected 7.7 Proportion of species threatened with extinction
Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	7.8 Proportion of population using an improved drinking water source 7.9 Proportion of population using an improved sanitation facility
Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	7.10 Proportion of urban population living in slums ^b
Goal 8: Develop a global partnership for development	
Target 8.A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development and poverty reduction - both nationally and internationally	<i>Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States.</i> <u>Official development assistance (ODA)</u> 8.1 Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income 8.2 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation) 8.3 Proportion of bilateral official development assistance of OECD/DAC donors that is untied 8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes 8.5 ODA received in small island developing States as a proportion of their gross national incomes
Target 8.B: Address the special needs of the least developed countries Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction	<u>Market access</u> 8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty 8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries 8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product 8.9 Proportion of ODA provided to help build trade capacity
Target 8.C: Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)	<u>Debt sustainability</u> 8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) 8.11 Debt relief committed under HIPC and MDRI Initiatives 8.12 Debt service as a percentage of exports of goods and services
Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	
Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	8.13 Proportion of population with access to affordable essential drugs on a sustainable basis
Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	8.14 Telephone lines per 100 population 8.15 Cellular subscribers per 100 population 8.16 Internet users per 100 population
The Millennium Development Goals and targets come from the Millennium Declaration, signed by 189 countries, including 147	
http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm	Page 2 of 3

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heads of State and Government, in September 2000 (<http://www.un.org/millennium/declaration/ares552e.htm>) and from further agreement by member states at the 2005 World Summit (Resolution adopted by the General Assembly - A/RES/60/1, <http://www.un.org/Docs/journal/asp/ws.asp?m=A/RES/60/1>). The goals and targets are interrelated and should be seen as a whole. They represent a partnership between the developed countries and the developing countries "to create an environment - at the national and global levels alike - which is conducive to development and the elimination of poverty".

- ^a For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.
- ^b The actual proportion of people living in slums is measured by a proxy, represented by the urban population living in households with at least one of the four characteristics: (a) lack of access to improved water supply; (b) lack of access to improved sanitation; (c) overcrowding (3 or more persons per room); and (d) dwellings made of non-durable material.

ANNEX 3: PROCESS OF INCLUDING MDG TARGET 5.B ON UNIVERSAL ACCESS TO REPRODUCTIVE HEALTH

Following the 2005 World Summit, four additional MDG targets were identified by the UN Secretariat and recommended by the UN Secretary-General in his report on the “Work of the Organization” which was noted by the 61st General Assembly in October 2006.

The four targets are:

- Achieve full and productive employment and decent work for all
- Achieve, by 2015, universal access to reproductive health
- Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it
- Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss.

The Inter-Agency Expert Group on the MDG Indicators (IEAG), mandated to propose technically sound indicators for the four new targets, reached agreement in November 2006.

The new MDG Framework was adopted by the 62nd General Assembly in October 2007 when delegates took note of the UN Secretary-General’s report, “Work of the Organization,” in which the Framework was proposed.

The new MDG Framework became effective on 15 January 2008 when the UN Deputy Secretary-General sent a written communication to UN agencies instructing them to use it as the basis for all global and national reporting and monitoring.

The official website of the MDG Indicators, managed by the UN Statistics Division, lists the new MDG Framework (UN 2011b).

Indicators

- *Contraceptive prevalence rate*
- Number of women of reproductive age (15-49) married or in union who are using contraception to the total number of women of reproductive age
- *Adolescent birth rate*
- The number of births occurring to all women aged 15-19 per 1000 women in the 15-19 age group
- *Antenatal care coverage*
- Percentage of women who used antenatal care provided by skilled health personnel for reasons related to pregnancy at least once and at least four times during pregnancy, as a percentage of live births in a given time period
- *Unmet need for family planning*
- The proportion of women who are married or in consensual union who are at risk of pregnancy who desire to delay their next birth at least two years or avoid another one who are not using a method of family planning

ANNEX 4: DEFINING SEXUAL HEALTH AND RIGHTS

Panel 3: Definition of sexual issues

Sexual health

Sexual health is a state of physical, emotional, mental, and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health needs a positive and respectful approach to sexuality and sexual relationships, and the possibility of having pleasurable and safe sexual experiences that are free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all individuals must be respected, protected, and satisfied.

Sexuality

Sexuality is a central aspect of humanity and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships. Although sexuality can include all of these dimensions, not all are always experienced or expressed. Sexuality is affected by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious, and spiritual factors.

Sexual rights

Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus statements. They include the right of all individuals, free of coercion, discrimination and violence, to:

- The highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- Seek, receive, and impart information related to sexuality;
- Sexuality education;
- Respect for bodily integrity;
- Choose their partner;
- Decide whether or not to be sexually active;
- Consensual sexual relations;
- Consensual marriage;
- Decide whether or not, and when, to have children;
- Pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all individuals respect the rights of others.

These working definitions were elaborated as a result of a WHO-convened international technical consultation on sexual health in January 2002, and subsequently revised by a group of experts from different parts of the world. These definitions do not represent an official WHO position, and should not be used or quoted as WHO definitions.

Sources: (Glasier, et al. 2006; WHO 2011c).

Attention to sexual health (and sexual rights) includes:

- Prevention, screening and treatment for sexually transmitted infections
- Prevention, treatment, care and support for people with HIV
- Decriminalization of HIV transmission, homosexuality, and some believe also sex work. Each of these is very controversial. Do give DANIDA the RHM journal issue on criminalisation. We can send you more if you want
- Dealing with sexual violence, sexual abuse, sexual harassment, sexual coercion, forced marriage and child marriage
- Comprehensive sexuality education
- Sexual problems in women and men
- Intersection of HIV and sexual and reproductive health

Source: Marge Berer, personal communication to Tine Gammeltoft, 2011.

ANNEX 5: TIP OF THE ICEBERG – MATERNAL MORBIDITY

Obstetric fistula is one of the most devastating complications of childbearing, but there are many others. These may include anaemia, infertility, damaged pelvic structure, chronic infection, depression and impaired productivity. These problems, in turn, may lead to others, including marital problems, household dissolution, social isolation, shortened life spans and suicide. Costs of medical care and lost productivity may drive women and their families into poverty.

Depression is one of the most prevalent complications of pregnancy and childbirth. About 10 to 15 percent of women in developed countries, and an even higher percentage in developing countries, experience serious depression during pregnancy or after childbirth.

Perinatal depression is a severe disorder, which needs appropriate treatment and care. It differs from postpartum blues, which are experienced by nearly half of women following childbirth, but which spontaneously disappear, usually within a few days. Perinatal depression is associated with maternal physical morbidity, substance abuse and suicide. Gender-based violence can be a cause of depression and can also increase a woman's risk of it.

The consequences of maternal depression on the child can be severe as well, including premature delivery, low birth weight, malnutrition, poor growth and stunted emotional, cognitive and behavioural development.

Source: (UNFPA 2011a).

ANNEX 6: UNFPA PRIORITY CONCERNS

UNFPA gives priority to providing basic reproductive health services to young people, pregnant women, and hard-to-reach populations, including those displaced by humanitarian crises. Linking reproductive health services to HIV and AIDS prevention, treatment and care is increasingly being seen as a critical strategy to expanding access to both types of care. In recognition that men are integral to reproductive health, the Fund also is expanding its support to services that can make men healthier and more responsible sexual partners.

Both men and women need access to information and appropriate health services throughout their lives. Such information and services should be gender sensitive and allow:

- All individuals to make informed choices about sexuality and reproduction, and to have a safe and satisfying sexual life, free of violence and coercion
- Women to go safely through pregnancy and childbirth
- Couples to have the best chance of having a healthy infant
- Women to avoid unwanted pregnancy and to address the consequences of unsafe abortion
- Access to prevention, treatment and care for sexually transmitted infections, including HIV.

Almost all programme countries struggle to expand access to services. Because of limited resources, many countries initially offer a core package of basic services, which can be expanded as resources become available. For the convenience of users, and streamlining of management, reproductive and sexual health services should be integrated within a system that offers primary health care and referrals for more specialized needs.

A full sexual and reproductive health package includes:

- Family planning/birth spacing services
- Antenatal care, skilled attendance at delivery, and postnatal care
- Management of obstetric and neonatal complications and emergencies
- Prevention of abortion, management of complications resulting from unsafe abortion
- Prevention and treatment of reproductive tract infections and sexually transmitted infections including HIV/AIDS
- Early diagnosis and treatment for breast and cervical cancer
- Promotion, education and support for exclusive breast feeding
- Prevention and appropriate treatment of sub-fertility and infertility
- Active discouragement of harmful practices such as female genital cutting
- Adolescent sexual and reproductive health
- Prevention and management of gender-based violence

NOTES

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¹ The paper has been drafted by Siri Tellier, with overall comments by the whole ENRECA SRH group, and particular quality check on individual topics as follows: Stine Lund (maternal health), Tania Dethlefsen (family planning), Vibeke Rasch (abortion), Maiken Mansfeld (STI/HIV), Tine Gammeltoft (sexual health), Ib Bygbjerg/Christenze Schmiegelow (NCD linkages) and with subsections input drafted by Vibeke Rasch (misoprostol), Sarah Villadsen (antenatal care) and Kathrine Lundsby (male circumcision).

² *Family planning* is a wider concept than *contraception*. According to WHO family planning 'allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary

infertility'. One might note that this is not a very precise definition – it is important to clarify whether the term 'contraceptive methods' includes total or periodic abstinence, other traditional methods such as coitus interruptus, reducing fertility through breast feeding, as well as abortion, which is not a contraceptive.

³ The ICPD was the 5th International Population Conference, with earlier ones held in New York in 1954, in Belgrade in 1965, in Bucharest in 1974 and in Mexico City in 1984. See Annex 1 for particularly relevant quotes.

⁴ See Annex 3.

⁵ Para 1.12. Other time bound and quantified targets included (a) universal access to primary education by 2015 (b) reducing IMR to <35/1000 and U5M to <45/1000 by 2015 (c) reducing MMR to half the 1990 levels by 2000, and by half again by 2015 (d) increasing life expectancy at birth to 75 yrs or more by 2015 (e) Raise 17 billion US\$ per year for implementation of the ICPD, one third (5.7) from DC, two thirds (11.3) from LDC. There is no quantitative goal on contraceptive prevalence rates, fertility or population growth

⁶ *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), was a United States Supreme Court decision on July 3, 1989 upholding a Missouri law that imposed restrictions on the use of state funds, facilities and employees in performing, assisting with, or counseling on abortions. The Supreme Court in *Webster* allowed for states to legislate in an area that had previously been thought to be forbidden under *Roe*.

⁷ For the European Union, where legislation on abortion is less restrictive than any other region, the Council Presidency has clearly stated that the Council's commitment to promote 'reproductive health' did not include the promotion of abortion: European Parliament, 4 December 2003: Oral Question (H-0794/03) for Question Time at the part-session in December 2003 pursuant to Rule 43 of the Rules of Procedure by Dana Scallon to the Council. In the written record of that session, one reads: Posselt (PPE-DE): "Does the term 'reproductive health' include the promotion of abortion, yes or no?" (European Parliament 2003). Likewise, the European Commission, in response to a question from a Member of the European Parliament, clarified: The term *reproductive health* was defined by the United Nations (UN) in 1994 at the Cairo International Conference on Population and Development. All Member States of the Union endorsed the Programme of Action adopted at Cairo. The Union has never adopted an alternative definition of 'reproductive health' to that given in the Programme of Action, which makes no reference to abortion (European Parliament 2002).

⁸ The Beijing Platform for Action includes the statement: 'The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behavior and its consequences' (Beijing Platform for Action, para. 96).

⁹ Ambassador Ellen Margrethe Løj State Secretary, Ministry of Foreign Affairs, Denmark, Hague Forum, 8-12 February 1999.

¹⁰ A *maternal death* is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. To facilitate the identification of maternal deaths in circumstances in which cause of death attribution is inadequate, a new category has been introduced: *Pregnancy-related death* is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death (WHO 2011b). The word *termination* at times causes confusion, as it is associated with abortion; however that is not the intention in this definition – it refers to live birth, or any other outcome – provoked abortion, spontaneous abortion (Stillbirth or miscarriage).

¹¹ Maternal mortality ratio (MMR): maternal deaths per 100 000 live births.

¹² *Live birth* refers to the complete expulsion or extraction from its mother of a product of conception (an infant), irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life – e.g. beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles – whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered a *live born* infant.

¹³ In addition, for every woman who dies, another 30 women suffer permanent injuries or illnesses that could result in pain throughout their lives, disability, and socioeconomic exclusion (UN 2006; UNFPA nd; WHO 2000).

¹⁴ An opening between the birth canal and the urethra or colon, caused by trauma associated with prolonged and obstructed labour, and resulting in incontinence and other sequelae.

¹⁵ Falling or sliding of the uterus from its normal position in the pelvic cavity into the vaginal canal, sometimes protruding from it. There are various risk factors, one being multiple vaginal deliveries accompanied by hard physical labour (Bodner-Adler, et al. 2007).

¹⁶ In most cases, *miscarriage* refers to spontaneous termination of pregnancy before *viability* of the foetus, and *stillbirth* to spontaneous termination after viability. However, the lower limits of gestational age (20-28 weeks) and birthweight (350-1000 g) that are used to define stillbirth vary across geographical areas. Dying in utero during the last 3 months of pregnancy.

¹⁷ Newborn or Neonatal deaths: number of deaths during the first 28 completed days of life per 1000 live births in a given year or period. May be divided into early neonatal (deaths during first seven completed days of life) or late neonatal (deaths to children after 7 completed days and up to 28 days of life) (WHO 2011a).

¹⁸ The intrapartum period extends from the beginning of contractions that cause cervical dilation to the first 1 to 4 hours after delivery of the newborn and placenta. The first stage of labour refers to the time between serious regular contractions start and until the cervix is fully dilated (10cm). The second stage is the time when the baby is pushed out. The third stage of labor refers to the period following the completed delivery of the newborn until the completed delivery of the placenta (The Free Dictionary 2010).

¹⁹ Cause of death as defined in the International Classification of Disease, ICD10

²⁰ See also under the paragraph on 'co-morbidities'

²¹ The original definition of skilled attendant was developed jointly by WHO/UNFPA/UNICEF/World Bank in 1999 as referring: "*exclusively to people with midwifery skills on management of normal deliveries, recognition on the onset of complications and performance of necessary interventions including management on referral of obstetric complications which are beyond their capacity in a given environment*" (WHO 1999). This definition was revised by WHO, ICM (International Confederation of Midwives) and FIGO (the International Federation of Gynaecology and Obstetrics) as: "*an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal pregnancies, childbirth and the immediate postnatal period, and in the recognition, management and referral of complications in women and newborns*" (WHO 2004c).

²² See Annex 3.

²³ 6 basic signal functions: Administer parenteral antibiotics, Administer parenteral oxytocic drugs, Administer parenteral anticonvulsants for pre-Eclampsia and Eclampsia, Perform removal of placenta, Perform removal of retained products (e.g. manual vacuum aspiration), Perform assisted vaginal delivery, additional 2 comprehensive signal functions: Perform blood transfusion, Perform surgery (Caesarean Section).

²⁴ The WHO definition is: "*The perinatal period commences at 22 completed weeks (154 days) of gestation (the time when birth weight is normally 500 g), and ends seven days after birth*" (WHO 2007b). Some countries have adopted other periods, in recognition of the fact that the limit of 'viability' is gradually being pushed back to earlier periods of gestation (e.g., METeOR 2011). Perinatal mortality is calculated as the number of stillbirths and deaths in the first week of life per 1000 live births.

²⁵ Postpartum hemorrhage is traditionally defined as blood loss greater than 500 mL during a vaginal delivery or greater than 1000 mL with a cesarean delivery. However, significant blood loss can be well tolerated by most young healthy females, and an uncomplicated delivery often results in blood loss of more than 500 mL without any compromise of the mother's condition (Yiadom and Carusi 2010).

²⁶ Total fertility rate (TFR): indicator often used to indicate birth rates. In brief *'the number of children that women have'*, more precisely, the number of children which a woman would have if she were to pass through her reproductive life conforming to the age specific fertility rates prevailing at the time. Infant mortality rate (IMR): the number of deaths to children under 1, per 1000 live births. Under five mortality rate (U5MR): the proportion of children who die before their 5th birthday.

²⁷ A case before the Inter American Committee on Human Rights in the area of maternal health was resolved through a friendly settlement agreement is the case of Paulina Ramirez Jacinto of Mexico. The petitioners alleged that Paulina Ramírez, aged 13, was the victim of sexual violence, was prevented from exercising her right to a legal abortion because she and her mother were the victims of intimidation and delays on the part of agents of the State. In 2007, the parties ratified a friendly settlement agreement that includes public recognition of the responsibility of the Government of Baja California and a series of measures to compensate the victim and her child, including court costs for processing the case, medical expenses arising from the events and health services, financial support for their maintenance, housing, education and professional development, psychological care, and reparation for moral damages (Organization of American States 2010).

²⁸ Contraceptive prevalence rate (CPR): the percentage of women between 15-49 years who are practising, or whose sexual partners are practising, any form of contraception (WHO 2004d).

²⁹ Many of the data for issues related to reproductive health and in particular family planning come from the Demographic and Health Surveys (DHS) which have been undertaken in around 60 developing countries over the last decades. They also form the basis for monitoring progress towards the MDGs.

³⁰ *Traditional* methods are basically those for which you need no pharmacy – including reliance on lactational amenorrhoea (reduced fecundity due to breast feeding), coitus interruptus (withdrawal), various forms of total or temporary abstinence (INFO Project 2003).

³¹ *"215 million women who want to avoid a pregnancy are not using an effective method of contraception... Women with unmet need for modern contraceptives are those who want to avoid a pregnancy but are not using a modern contraceptive method. Other publications may not define women using traditional methods as having unmet need. However, this report focuses on unmet need for modern contraceptives because traditional methods, such as periodic abstinence and withdrawal, are much more likely to fail than are modern methods"* (UNFPA 2009a). This contrasts with the calculations done by the UN Statistical Division for MDG monitoring: *"According to the standard definition, women who are using a traditional method of contraception are not considered as having an unmet need for family planning. As traditional methods can be considerably less effective than modern methods, additional analyses often distinguish between traditional and modern methods and also report on unmet need for effective contraception. The indicator "contraceptive prevalence" provides complementary information to this indicator by focusing on those women that are currently using a contraceptive method"* (UN 2010a).

³² E.g. Professor Hans Rosling from the Karolinska Institute claims in his TED Talk from February 2006 that TFR falls only, and apparently automatically, after U5MR falls below 10%.

³³ WHO defines infertility as inability to conceive after 2 years of trying – others define differently. In demographic literature, the term fecundity is used to denote ability to conceive, whereas the term fertility is used to refer to actual births.

³⁴ According to the IACHR Maria Marmerita Mestanza of Peru experienced forced sterilization resulting in death. Through a friendly settlement agreement between the parties signed in 2003, the State of Peru recognized its responsibility for having violated the victim's right to life, physical and mental integrity, and personal integrity, to equal protection of the law, and to live free of violence. In the Czech Republic, especially Roma women have also sued the state for forced sterilizations

³⁵ Kenya 1967, Zimbabwe 1968, Mauritius 1958 (UNECA 2000).

³⁶ An unsafe abortion is “a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both” (WHO 1992).

³⁷ In international dialogue, some delegations favouring restricting access to abortion will state that abortion can never be ‘legal’ and therefore the wording is frequently ‘against the law’.

³⁸ ICPD Programme of Action, para 8.25; ICPD+5 para 63, see Annex 1.

³⁹ In a 2009 decision in the case of *Lakshmi Dhikta v. Nepal*, the Supreme Court of Nepal ruled that the country’s government must guarantee access to safe and affordable abortion services, noting that there is no international agreement on when a human life begins. Nepal’s 2002 constitution does recognize reproductive health as a right, and the decision notes that this cannot be piecemeal, but must also include abortion. It decides that the government must provide abortion services to women who cannot afford to pay.

⁴⁰ Fetal death: “*Death prior to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles*” (UN 2001). Stillbirth: “*Birth of a baby showing no signs of life (fetal death). For international comparisons of perinatal mortality rates only such stillborn infants with a birth weight of 500g or more are included. If the baby is not weighed, a gestational age of 22 completed weeks can be taken as equivalent*” (WHO 2007b). Spontaneous abortion: “*Termination of pregnancy by expulsion of embryo / fetus before 22 weeks of pregnancy or below 500g or weight*” (WHO 1996).

⁴¹ The Beijing Platform of Action (1995) identifies 12 types of GBV.

⁴² The Convention on the Rights of Persons with Disabilities states that States Parties need to “provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and populationbased public health programmes.” Art 23

⁴³ Richard Horton, editor of the *Lancet*, personal communication

⁴⁴ UN report of the ICPD, Singh *ibid*.

⁴⁵ In international discussions, *young people* often refer to those between 10 and 24, ‘*youth to those between 15 and 24*’, and *adolescents* to those between 10 and 19 (WHO, UNICEF, UNFPA agreement on conventional usage, 1998). **The betrothal and the marriage of a child shall have no legal effect**, and all necessary action, including legislation, shall be taken to specify a **minimum age for marriage** and to make the registration of marriages in an official registry compulsory (UN 1979; Article 16.2). “*A child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier*” (UN 1989; Article 1). However, a majority of national laws do not follow this, e.g. Uzbekistan (14), Nepal (16), Pakistan (18 for males, 16 for females) and with exceptions for married minors and minors in the armed forces. “*States Parties [...] shall ensure that the child has **access to information** and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and **physical and mental health***” (UN 1989; Article 17). See also: CRC Art. 12, 13, 28, 29 B, CEDAW Art. 10, 14, 16, ICERD Art. 5 (e) (v), 7, ICESCR Art. 13,14, CMW Art. 13.

⁴⁶ Population Reference Bureau, based on data from Macro DHS.

⁴⁷ ICPD PoA, Para. 7.45-7.47

⁴⁸ “*A renewed global consensus on the need to make progress on Millennium Development Goal 5, together with greater attention to gender issues within and outside the Bank is refocusing attention on reproductive health and offering an unprecedented opportunity to redress the neglect of the previous decade*” (World Bank 2010).

⁴⁹ BMZ, GIZ, DSW, UNFPA. New York 11 April 2011, side event organized during the 44th session of the UN Commission on Population and Development (CPD). Family Planning: Key to Saving Lives.

