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Monitoring of population programmes, focusing on health, morbidity, mortality and development

Report of the Secretary-General

Summary

The present report on the monitoring of population programmes, focusing on health, morbidity, mortality and development has been prepared in response to the topic-oriented and prioritized multi-year work programme of the Commission on Population and Development, which was endorsed by the Economic and Social Council in its decision 2009/239. In its decision 2008/101, the Commission decided that health, morbidity, mortality and development should be the special theme for the forty-third session of the Commission.

The report provides an overview of the programmatic work of the United Nations Population Fund to improve maternal health and reduce morbidity and mortality. It focuses on activities related to maternal and newborn care, investing in family planning and midwifery, enhancing reproductive health commodity security, preventing and treating obstetric fistula, abandoning the practice of female genital mutilation/cutting, eliminating gender-based violence, addressing adolescent pregnancy and child marriage, preventing mother-to-child transmission of HIV, comprehensive condom programming to prevent unintended pregnancy and HIV infection and providing reproductive health services in emergency situations.

It points out that reproductive ill health impacts mortality and accounts for a large share of the global burden of disease, particularly among women and children. The most cost-effective interventions to reduce maternal mortality are family planning, skilled birth attendants during delivery and emergency obstetric care.

* E/CN.9/2010/1.

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I. Introduction

1. The present report on the monitoring of population programmes, focusing on health, morbidity, mortality and development has been prepared by the United Nations Population Fund (UNFPA) in response to the topic-oriented and prioritized multi-year work programme of the Commission on Population and Development, which was endorsed by the Economic and Social Council in its decision 2009/239. The special theme for the forty-third session of the Commission was adopted by the Commission in its decision 2008/101.

2. Reproductive ill health impacts mortality and accounts for a large share of the global burden of disease, particularly among women and children. Poverty and gender discrimination exacerbate reproductive health problems. Violence against women and girls also negatively affects their sexual and reproductive health and can result in other chronic health and mental health problems.

3. Sexual and reproductive health interventions are a good investment and the benefits of such interventions are far-reaching. Besides the obvious medical benefits, they contribute to achieving broader development objectives, including higher levels of education, social equity, economic growth and productivity. Family planning services allow women to achieve higher education and combine child-rearing with employment. Antenatal, obstetric and neonatal care results in an increase in healthy years of life due to reduction in disability and premature death among women and their newborns. HIV prevention and treatment programmes reduce morbidity and mortality stemming from the AIDS pandemic and other sexually transmitted diseases.[1]

4. In many developing countries, weak health systems fail to address the needs of women and marginalized groups because they do not provide appropriate, accessible and affordable sexual and reproductive health services. Indeed, constraints in health system performance are increasingly recognized as a major contributing factor to the delays in achieving better health outcomes and the health-related Millennium Development Goal targets. Severe underinvestment in national health systems has adversely impacted the capacity of countries to provide quality and accessible health services, particularly for the poor and marginalized. This has been further weakened by the often limited alignment between donor aid and country priorities, unbalanced funding of different services, fragmentation and unpredictability, all of which have weakened national ownership and long-term sustainability.

5. The Fund has adopted national capacity development as an overarching principle of its assistance to country-led processes and policy dialogue as an important approach to integrate the International Conference on Population and Development agenda and related Millennium Development Goals more effectively into national development frameworks (including poverty reduction strategy papers) and relevant sector planning frameworks. Emphasis is placed on the integration of all elements of reproductive health into the national and subnational health planning processes, including the costing of maternal health roadmaps and reproductive health strategies. The Fund seeks to strengthen the capacity of its staff and country counterparts to position sexual and reproductive health/Millennium Development

[1] Guttmacher Institute and United Nations Population Fund (2009). *Adding it Up. The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health.*

Goals 4, 5 and 6 in national policies, plans and budgets to ensure that increasing attention and resources are programmed at all levels of the system. UNFPA is addressing weaknesses in procurement systems, utilizing reproductive health commodities as an entry point to address capacity constraints and weak coordination while addressing broad synergies, particularly in the area of HIV/AIDS.

6. In addition, UNFPA is disseminating best practices to enhance capacity in the area of health system strengthening and innovative financing to increase access to sexual and reproductive health and rights services and reduce out-of-pocket payments. In a number of countries, UNFPA is working on strengthening health information systems, including facility-based data and surveys, to ensure that quality data are available to inform the planning, budgeting and monitoring processes.

7. UNFPA works with many partners, both within and outside the United Nations system, including Governments, non-governmental organizations, civil society, faith-based organizations, religious leaders and others, to achieve its mission. To better respond to local needs, UNFPA increasingly devotes resources to country-led efforts, placing emphasis on country-focused and country-led implementation to achieve improved results, at the same time addressing mutual accountability and strengthening harmonization and alignment.

8. The present report provides an overview of the programmatic work of UNFPA related to maternal and newborn care, investing in family planning and midwifery, enhancing reproductive health commodity security, preventing and treating obstetric fistula, abandoning the practice of female genital mutilation/cutting, eliminating gender-based violence, addressing adolescent pregnancy and child marriage, preventing mother-to-child transmission of HIV, comprehensive condom programming to prevent unintended pregnancy and HIV infection and providing reproductive health services in emergency situations.

II. Maternal health and family planning

9. More than 500,000 women die in childbirth every year, 99 per cent of them in developing countries.[2] Africa suffers from the highest maternal mortality ratio at 820 maternal deaths per 100,000 live births, followed by Asia (320), Oceania (180) and Latin America and the Caribbean (130) as compared to a maternal mortality ratio of 13 in Europe and 10 in North America (see figure 1). In 2005, 14 countries had maternal mortality ratios of at least 1,000, of which 13 (excluding Afghanistan) were in sub-Saharan Africa.[3]

10. Maternal mortality rates reflect the vast disparities between developed and the less and least developed countries. Millennium Development Goal 5 calls for, inter alia, a reduction in the maternal mortality ratio by three quarters between 1990 and 2015. In order to reach this target, the global maternal mortality ratio would have to be reduced by an average of 5.5 per cent a year between 1990 and 2015. However, the reduction between 1990 and 2005 was only 0.4 per cent a year.[4] Given this rate

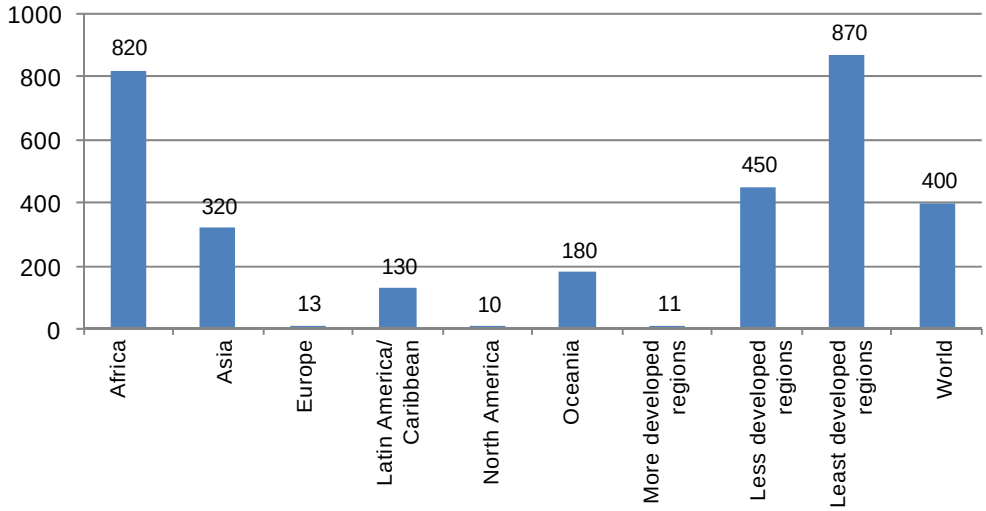
[2] World Health Organization (2009). *Women and Health*.

[3] World Health Organization (2007). *Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA and The World Bank*, annex 3.

[4] Ibid., appendix 14.

of progress, the world will remain far behind the Millennium Development Goal target for maternal mortality ratio reduction in 2015.

Figure 1
Estimates of maternal mortality ratio by United Nations Population Division regions, 2005



Source: World Health Organization (WHO, 2007). *Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA and The World Bank.*

11. Most maternal and newborn deaths can be prevented if women have access to family planning services and receive the appropriate care during pregnancy and childbirth. The most cost-effective interventions to reduce maternal mortality are family planning, skilled birth attendants during delivery and emergency obstetric care and, more generally, the empowerment of women and the elimination of gender inequalities which prevent women from making their own decisions and from having the support of their partners.

12. Providing women with both family planning and maternal and newborn health services would result in a decline in maternal deaths by an estimated 70 per cent compared to a decline of 57 per cent if developing countries invested in maternal and newborn health care alone. If contraceptive needs were adequately addressed, the reduction in unintended pregnancies would result in considerable declines in abortion and related health complications. It is estimated that the number of women requiring medical care for complications from unsafe abortion would decline by 73 per cent. It is also estimated that meeting the need for both family planning and maternal and newborn health services would result in a reduction by more than 60 per cent of healthy years of life lost owing to disability and premature death among women and newborns as measured in disability-adjusted life years (DALYS). More women would survive haemorrhage and infection, fewer would suffer from fistula, infertility and other pregnancy/childbirth-related health problems, and newborns would have a better chance of surviving asphyxia, low birth weight and infection.[1]

13. At the core of the UNFPA mandate is ensuring that every pregnancy is wanted and every birth is safe. UNFPA includes maternal health as part of a package of interventions in the area of sexual and reproductive health and assists countries in the development of needs assessments to ensure that health plans are Millennium Development Goal-driven and performance-based towards universal access to reproductive health. As part of the effort to fulfil its mandate, UNFPA initiated a Maternal Health Thematic Fund, which provides additional support to priority countries to improve the health of women and newborns. For example, with the Maternal Health Thematic Fund seed fund, UNFPA provided support to Malawi and Ethiopia to launch a national Campaign for Accelerated Reduction of Maternal Mortality. In partnership with UNICEF, Columbia University and the Ministries of Health, emergency obstetric and neonatal care needs assessments were carried out in Haiti and Ethiopia and maternity services at the district level are being strengthened. That cooperation seeks to develop a network of regional institutions and a roster of experts to build national and regional capacity in emergency obstetric and newborn care.

14. Ensuring coverage of emergency obstetric care and quality delivery care is critical for saving the lives of mothers and newborns. In Côte d'Ivoire, for example, the Ministry of Health, with assistance from UNFPA, instituted a maternal and perinatal death review system, which allows health facilities to document, analyse, and address causes of maternal death to improve care and reduce future deaths. The next step will be to establish routine maternal audits in comprehensive emergency obstetric care and to record maternal deaths.

15. Removing financial barriers to universal access to reproductive health is essential to ensuring that the poorest, who are the most affected, have increased access to delivery care. Madagascar received technical assistance from UNFPA and additional resources to launch its exemptions fees policy for caesarean sections, and in Ghana, obstetric care is now included in the National Health Insurance Scheme.

16. The lack of a qualified health workforce, especially a strong cadre of midwives, is an impediment to acceleration of progress towards the achievement of Millennium Development Goal 5. To help address this issue, UNFPA launched an Investing in Midwives Programme in 2008 in collaboration with the International Confederation of Midwives. The programme, which is under way in 15 countries, mainly in sub-Saharan Africa, addresses all three pillars of safe motherhood: family planning, skilled attendance at all births and emergency obstetric care. The programme seeks to achieve its goals by building a critical mass of experienced midwifery advisers who work at the national level and collaborate with all national stakeholders in strengthening midwifery.

17. Since the programme's inception, countries have conducted reviews and needs assessments with regard to standards of midwifery training, legislative and regulatory environment to allow midwives to deliver life-saving interventions, and assessment of the status of professional midwifery associations. For example, in Benin, national supervisory guidelines on maternity services at peripheral levels were established. The Ministry of Health in Djibouti adopted a law that equates a midwifery certificate with a first-level university degree. Cambodia has a new Midwifery Council and will be drafting a midwifery education, services and regulations framework. In Côte d'Ivoire, the programme is supporting a project for strengthening obstetric capacities of midwife graduates before deployment. Ethiopia

conducted an assessment of midwifery training institutions and equipped them with training materials and supplies. Ghana also conducted an assessment of all midwifery schools and discussions are under way to develop a code of ethics for midwives. A midwifery census in Guyana will determine the baseline number of midwife graduates; the country is also providing support to the General Nursing Council to improve regulations.

18. Family planning is a key factor in achieving Millennium Development Goal 5. It is one of the most cost-effective strategies to reduce maternal mortality and ensure a continuum of maternal health care as part of reproductive health and the right to health. Despite the critical need for family planning, funding has virtually stagnated since 2001.[5] Family planning is usually omitted in the planning, budgeting and implementing of maternal health programmes.

19. In 2008, UNFPA continued efforts to ensure the right of all people to decide the number and spacing of the birth of their children. UNFPA works with Governments, civil society and United Nations partners to forecast needs, provide and coordinate the distribution of contraceptives and maternal health supplies and build logistical capacities of countries. For example, efforts are under way in Benin to re-position family planning in the health system. Madagascar adopted a policy of long-term methods for family planning free of charge, the provision of free family planning services in all health facilities, an integration of family planning at all HIV voluntary testing and counselling centres, the expansion of contraceptive method choices and an improved monitoring system. In Haiti, family planning protocols are being revised and supply delivery is being scaled up, with a focus on communities where the demand is greatest.

20. Commodities, such as contraceptives and medicines for emergency obstetric care, help improve maternal health by preventing unintended pregnancies, facilitating reproductive health and averting the spread of HIV. UNFPA is the lead United Nations agency working with the private and public sectors to ensure that reproductive health commodities are accessible and affordable. Continued funding from the Global Programme to Enhance Reproductive Health Commodity Security enabled the Fund to expand its support to Governments to mainstream Reproductive Health Commodity Security into national health policies, programmes, budgets and plans. As of 2008, 80 countries had national budget lines for contraceptives and other reproductive health supplies.

21. To meet urgent reproductive health commodity needs and avoid supply “stock outs” in 2008, UNFPA provided technical assistance for logistics and information systems and about $20 million of reproductive health commodities to some 60 countries. These commodities included male and female condoms, other contraceptives and drugs to protect maternal health. UNFPA used its “RHCS Dashboard” tool to monitor global progress towards Reproductive Health Commodity Security, giving countries scores that measure their overall progress in key categories.

22. International coordination to reach Millennium Development Goal 5 gained in strength and momentum. The H4 partnership — WHO, UNFPA, UNICEF and the

[5] United Nations Population Fund (2009). *Financial Resource Flows for Population Activities in 2007*, and United Nations Population Fund (2008). *Donor Support for Contraceptives and Condoms for STI/HIV Prevention 2007*.

World Bank — contributes to a global effort to accelerate progress in maternal and newborn survival, issuing a Joint Statement on Maternal and Newborn Health in 2008, followed by the development of a Joint Country Support Plan for Accelerated Implementation of Maternal and Newborn Continuum of Care. The H4 is intensifying in-country work beginning in 25 priority countries with a view to provide enhanced support over the next five years to all 60 countries with high maternal mortality.

23. In the framework of the Partnership for Maternal, Newborn and Child Health, the International Health Partnership and other related initiatives, UNFPA and its partners promote universal coverage of essential interventions for reproductive health while advocating for harmonized approaches in support of nationally led efforts. UNFPA has been active in the High-Level Task Force on Innovative Financing for Health Systems, which assessed the challenges and financial requirements for scaling up to achieve the health-related Millennium Development Goals, including Millennium Development Goal 5.

III. Obstetric fistula

24. Obstetric fistula is a devastating childbirth injury that leaves women incontinent, ashamed and often isolated from their communities. It is a stark example of unacceptably high levels of maternal death and disability. The condition disproportionately affects impoverished women and girls living in rural communities in the least developed countries. Obstetric fistula is almost entirely preventable through access to quality maternal health care. Bringing an end to obstetric fistula requires addressing underlying social and economic inequities, including gender inequality, that hinder women from fulfilling their reproductive rights.

25. Prolonged, obstructed labour causes the vast majority of obstetric fistulas worldwide. Globally, obstructed labour occurs in nearly 5 per cent of deliveries. While robust population-based measurements are lacking, it is generally accepted that at least 2 million women, and as many as 3.5 million, are suffering from obstetric fistula.[6] WHO estimates that approximately 73,000 new cases occur annually,[7] which may be an underestimate as it is based on facility data and the majority of women likely never reach a hospital.

26. To address the need for data, a number of countries[8] included modules on obstetric fistula in their Demographic and Health Surveys. Modules varied between countries, but contained questions regarding obstetric fistula knowledge and experience of symptoms.[9] Figure 2 below provides estimated lifetime prevalence of

[6] L. L. Wall, “Obstetric vesicovaginal fistula as an international public-health problem”, *The Lancet*, vol. 368, Issue 9542 (30 September 2006), pp. 1201-1209.

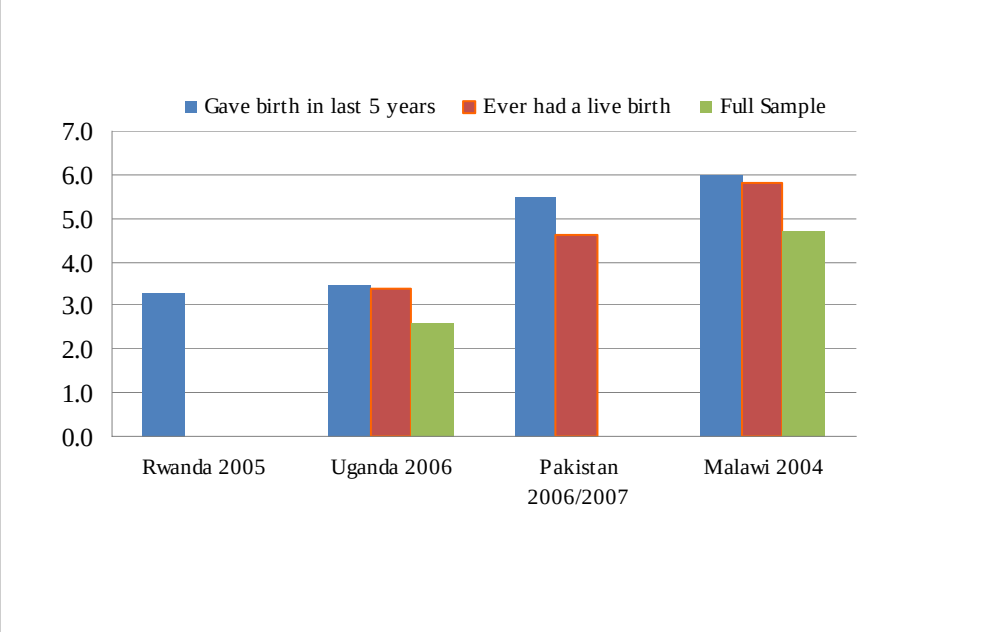
[7] C. AbouZahr, “Global burden of maternal death and disability”, *British Medical Bulletin*, vol. 67, No. 1 (December 2003).

[8] The Democratic Republic of the Congo, Ethiopia, Malawi, Mali, the Niger, Nigeria, Pakistan, Rwanda and Uganda.

[9] Central Statistical Agency, Addis Ababa and ORC Macro, Maryland, United States of America, *Ethiopia Demographic and Health Survey 2005*; Salif Samaké et al., *Mali: Enquête Démographique et de Santé (EDSM-IV) 2006*.

fistula symptoms for all women who reported ever having experienced symptoms described by the Demographic and Health Surveys question.

Figure 2
Estimated lifetime prevalence of fistula symptoms among selected samples of women in countries with latest available Demographic and Health Surveys data



Source: Compiled by Population and Development Branch, UNFPA. National Demographic and Health Surveys 2005/2006. USAID (2008) DHS Analytical Studies. Incontinence data from Demographic and Health Surveys: Comparative analysis of a proxy measurement of vaginal fistula and recommendations for future population-based data collection.

27. Among the countries for which data are available, Pakistan and Malawi have a fistula prevalence among women who had a live birth in the past five years between 5 and 6 per cent. The rates for Rwanda and Uganda are between 3 and 4 per cent. Ethiopia has a prevalence rate of 1.0 per cent among women who have ever had a live birth. Lifetime prevalence in Mali, the Niger, the Democratic Republic of the Congo, and Nigeria would be significantly lower, under 1 per cent. Owing to the sensitive nature of the subject and problems with recalling events that may have happened in the distant past, it is likely that these figures underestimate the real extent of fistula prevalence.

28. In 2003, UNFPA and partners launched the global Campaign to End Fistula, which includes interventions to prevent fistula, treat affected women and help women who have undergone treatment return to full and productive lives. The ultimate goal of the Campaign is to make fistula as rare in developing countries as it is in the industrialized world by 2015. The Campaign is currently active in more than 45 countries in the Africa, Asia and the Arab States regions. An international partnership, the Obstetric Fistula Working Group, was created to ensure global coordination of efforts to eliminate obstetric fistula. The Campaign strives to build political commitment and broad support for achieving the international goals related

to maternal and newborn health by highlighting the human consequences of failure to act.

29. The results to date are encouraging: at least 38 countries have completed a situation analysis of fistula prevention and treatment; more than 25 countries have integrated the issue of fistula into relevant national policies and plans; at least eight countries have developed national fistula-elimination policies; more than 12,000 women have received fistula treatment and care with support from UNFPA; thousands of health personnel have received training in fistula management and care and, at the close of 2008, 31 countries included the issue of fistula in their country programmes.

30. As part of national efforts to increase access to fistula care, many countries are working to reduce the cost of prevention and treatment services. In Ghana, fistula treatment will now be free as part of the National Health Insurance Scheme. In Guinea-Bissau, support was provided to community-based health insurance programmes. In Mauritania, UNFPA supported special emergency obstetric funds in districts with high rates of maternal mortality and morbidity. In Pakistan, a number of regional centres now provide free fistula treatment, and outreach campaigns were conducted throughout the country to make treatment services more accessible for women living in remote areas.

31. In 2008, the United Nations Development Programme granted an award of excellence to the Campaign to End Fistula for championing South-South cooperation. As an example of efforts in this area, in Bangladesh, a 2008 regional fistula capacity-building workshop brought together teams of surgeons, anaesthesiologists and nurses from Timor-Leste, Nepal and Pakistan. Complex fistula surgeries were performed allowing for technical exchange. The Campaign will continue to build upon these experiences and work to facilitate South-South opportunities.

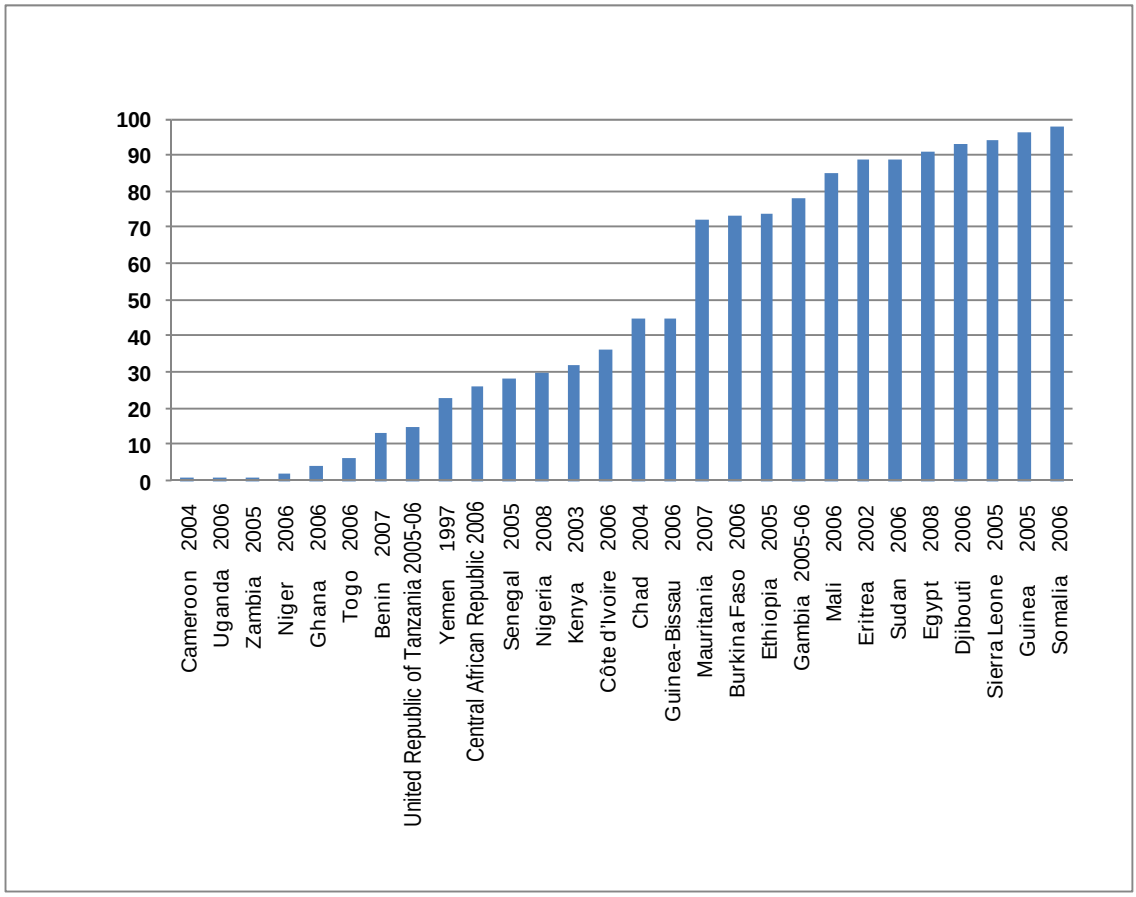
IV. Female genital mutilation/cutting

32. According to estimates by WHO, between 100 and 140 million women and girls in the world have experienced some form of female genital mutilation/cutting. It is estimated that approximately 3 million girls and women in Africa are subject to it each year.[10]

33. Demographic and Health Survey and Multiple Indicator Cluster Survey data on female genital mutilation/cutting are available for 26 countries. The rates vary significantly from country to country, from as low as 1 per cent in Cameroon to as high as 98 per cent in Somalia. Geographic patterns vary: north-eastern African countries (Djibouti, Egypt, Eritrea, Ethiopia, Somalia and the Sudan) have rates ranging from 74 to 98 per cent, while rates in East Africa (Kenya and the United Republic of Tanzania) are significantly lower, ranging from 15 to 32 per cent. Most countries for which data are available show a decrease in the prevalence of female genital mutilation/cutting over time. However, the incidence continues to remain high (see figure 3).

[10] World Health Organization. http://www.who.int/reproductivehealth/topics.

Figure 3
Female genital mutilation/cutting prevalence among women aged 15-49 years, 2000-2008



Source: Compiled by Population and Development Branch, UNFPA. Data for Eritrea 1995, Kenya 1998 and Nigeria 2008 from Demographic and Health Surveys 2008 and UNICEF. ChildInfo (2009).

34. The UNFPA-UNICEF Joint Programme and Trust Fund on Female Genital Mutilation and Cutting was established to support the development and implementation of policies and programmes and to reinforce the efforts of national partners, development partners and civil society organizations to accelerate the abandonment of female genital mutilation/cutting. The programme aims to contribute to a 40 per cent reduction of the practice among girls aged 0-15 years in 17 countries in Africa, with at least one country declared free of female genital mutilation/cutting within a period of five years (2008-2012). Currently, 17 countries in Africa[11] are implementing the programme, which also provides technical support to other countries, including Colombia and Indonesia.

[11] Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, the Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Mali, Mauritania, Senegal, Somalia, the Sudan, the United Republic of Tanzania and Uganda.

35. Data are available for some countries where the programme is implemented. Burkina Faso, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Mali and the United Republic of Tanzania all show a decrease in their national prevalence of female genital mutilation/cutting among girls and women.

36. In 2009, following the launch of the Inter-agency Statement on Eliminating Female Genital Mutilation, signed by 10 United Nations agencies, a Platform for Action of the Donors Working Group on Female Genital Mutilation/Cutting was published in English, French, Arabic and Portuguese and served to widen the endorsement of the common programmatic approach championed by the UNFPA-UNICEF Joint Programme to include Governments, intergovernmental institutions and foundations.

37. The Joint Programme works closely with other United Nations agencies when gaps are identified. The new trend of medicalization of female genital mutilation/cutting by doctors and other trained health-care providers in clinical settings who are performing the procedure is also being addressed. An interregional initiative in sub-Saharan African and Arab countries in collaboration with WHO was put in place to ensure the support of the medical professions in the public abandonment of female genital mutilation/cutting.

38. The Joint Programme has built the capacity of over 34,929 community members in 190 communities, including 1,125 youths in Egypt and 2,400 community members and youth leaders in Kenya to support the abandonment of female genital mutilation/cutting. In 2009, over 500 villages in Senegal publicly declared female genital mutilation/cutting abandonment. This takes the movement of abandonment to over 4,000 communities out of the 5,000 practising female genital mutilation/cutting in Senegal. The programme supported the training of religious leaders concerning female genital mutilation/cutting and religion, and successfully recruited high-level leaders in Djibouti and the Sudan. In several countries, the programme facilitated community dialogue sessions. A lobby group of Muslim scholars was established in Kenya from among communities that do not practise female genital mutilation/cutting to hold dialogue forums with other Muslim scholars in communities that practise female genital mutilation/cutting, using religious arguments to separate female genital mutilation/cutting from Islam to create a national position of Muslim scholars against the practice.

39. In Ethiopia, more than 2,000 uncircumcised girls have been registered in the Afar region, an unprecedented success in the history of that region of the country. In the Gambia, 24 communities from two districts involved in the community empowerment programmes for approximately two years publicly declared the abandonment of female genital mutilation/cutting and child/forced marriage, the first inter-community public declaration in the Gambia. In the Sudan, over 200 women known as “The Saleema Mothers”, who vowed publicly not to excise their daughters, were conferred awards by the First Lady. In fostering partnerships at all levels, the programme supported the creation and enhancement of networks of parliamentarians, the media, traditional communicators, animators, women lawyers, medical associations, the network of public transportation drivers, and grandmothers and midwives.

40. At the policy level, through the support of the Joint Programme, the Egyptian Parliament included female genital mutilation/cutting as a punishable offence in the penal code and amended the child law to require the creation of decentralized child

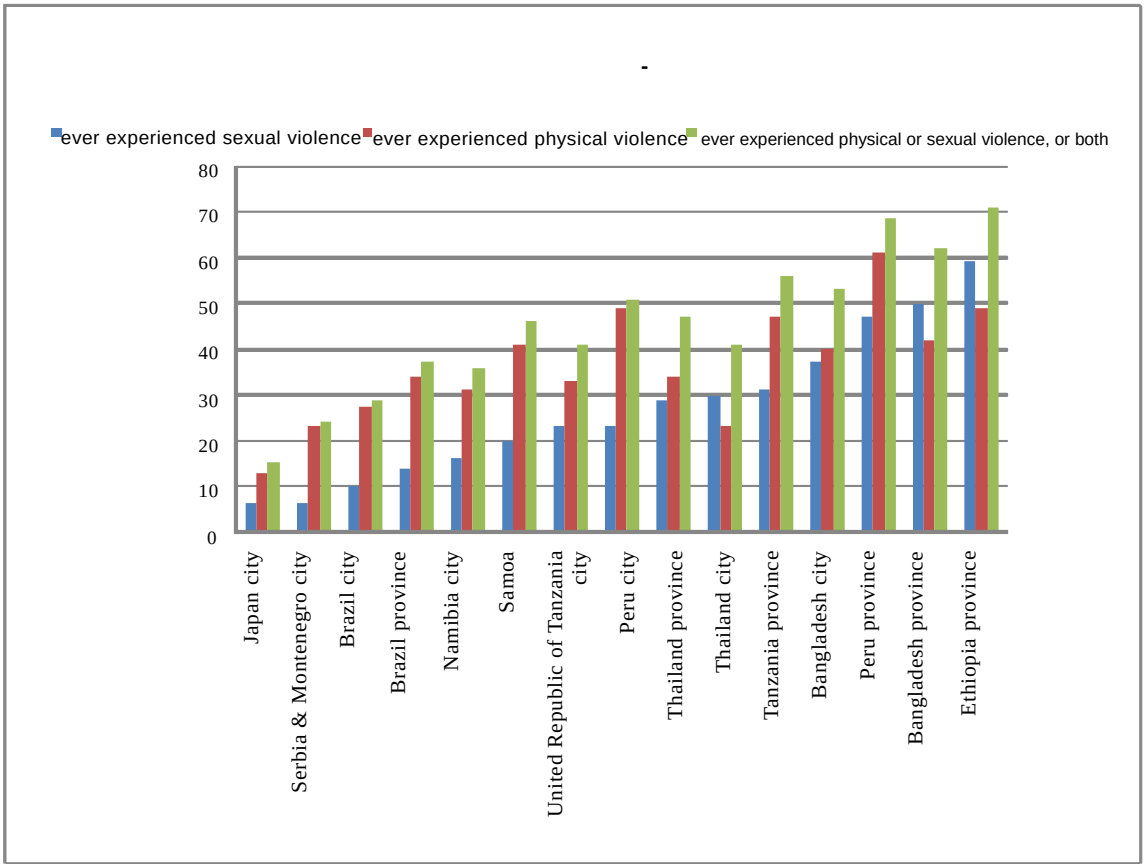
protection committees at the governorate and district levels. Nationwide, 28 Child Protection Committees have been formed, tasked with designing child protection policies and monitoring policy implementation in Egypt. In Kenya and the Sudan, the National Child's Act was revised to include female genital mutilation/cutting as a criminal offence.

V. Gender-based violence

41. Given the right opportunities, women can greatly improve their health and well-being and that of their families and communities. However, discrimination and violence against women and girls and poor reproductive health in many countries serve to minimize women's potential contributions.

42. Gender-based violence is a widespread phenomenon that knows no boundaries and has serious public health implications. It can take many forms, from physical abuse, to sexual harassment and abuse, abuse by persons in authority such as teachers, employers or police officers, trafficking and exploitation for forced labour or sex, traditional practices such as forced or child marriages and dowry-related violence. Abused women have higher rates of unintended pregnancies, abortions, adverse pregnancy outcomes, sexually transmitted diseases, including HIV, and mental disorders, including depression, anxiety, and sleep and eating disorders. Gender-based violence can lead to serious injury, disability and even death.[2] Since most violence against women is committed by intimate male partners, gender-based violence is extremely difficult to measure because many women are afraid to come forward as victims. Figure 4 shows a wide variation in prevalence of lifetime physical violence and sexual abuse perpetrated by an intimate partner across different settings.

Figure 4
Prevalence of lifetime physical violence and sexual violence by an intimate partner, among ever-partnered women, 2005



Source: Compiled by Population and Development Branch, UNFPA. WHO (2005) Multi-country Study on Women's Health and Domestic Violence Against Women, Summary report.
Note: City refers to the capital or a large city and province refers to a region, usually containing both urban and rural populations. A single rural setting was used in Japan, Namibia, and Serbia and Montenegro. In Samoa, the entire country was sampled.

43. As the lead United Nations agency on sexual and reproductive health, UNFPA has a strategic entry point to address gender-based violence, given the intrinsic linkages between sexual and reproductive health and gender-based violence. Addressing gender-based violence through sexual and reproductive health services, including HIV/AIDS programmes, that UNFPA supports is at the centre of the Fund's strategy on gender-based violence. The multi-pronged and multisectoral approach includes support for strengthening the role of the health sector in addressing gender-based violence, focusing on both supply- and demand-side interventions, addressing violence in the home and sexual abuse in childhood and adolescence, addressing gender-based violence in conflict and post-conflict situations, and focusing on the most vulnerable and marginalized. In Haiti, for example, UNFPA pursued an extended partnership with the Ministry of Women's Affairs and key civil society actors to consider inclusion of the reproductive rights

agenda, particularly those of marginalized women and adolescent girls, sex workers, women living with HIV and women living with disabilities. In Liberia, UNFPA worked with the criminal justice system to improve its response to gender-based violence by establishing a special court for the prosecution of rape cases and by increasing the capacity of legal professionals. UNFPA Burundi supported awareness-raising on the links between sexual violence and HIV, with a focus on youth, faith-based groups and demobilized military personnel.

44. One of the key starting points to strengthen country-level processes and accountability mechanisms on gender-based violence as it relates to macro-level sexual and reproductive health issues is at the policy and legal levels. UNFPA has been a key partner in many countries in supporting the drafting of national laws, implementation and public awareness-raising efforts in this regard. The Fund is engaged at the national level in advocacy and technical assistance for the development and monitoring of leading policy and funding frameworks, including poverty reduction strategies, other Millennium Development Goal follow-up plans, sector-wide approaches, and national HIV/AIDS plans. In 2006, for example, the Venezuelan National Assembly passed a new law on violence against women that recognizes "obstetric violence" and "gynaecological violence" as forms of violence against women, a process supported by UNFPA. The Fund has helped to spearhead national campaigns on violence against women including, in recent years, in Latvia, Morocco, Timor-Leste and Turkey. In Burundi, a campaign on sexual violence was initiated. In Belarus, a United Nations campaign with the motto "Domestic violence should not be a part of your life" was begun. In Zimbabwe, a multimedia campaign was launched to garner support for the Domestic Violence Bill.

45. UNFPA is an active member of the Secretary-General's campaign to end violence against women, UNiTE. The Fund is currently Co-Chair of the United Nations Inter-Agency Task Force on follow-up to the 2006 Secretary-General's In-Depth Study on All Forms of Violence against Women. The agency supports the Coordinator of the Task Force and devotes resources to joint programming efforts in 10 pilot countries.[12] It also has an ongoing partnership with UNIFEM, the lead global "champion" on the issue. UNFPA is a lead member of the United Nations Trust Fund on Violence against Women managed by UNIFEM. At the country level, UNFPA serves as Chair of the United Nations Gender Theme Groups, and acts as lead or co-lead on gender-based violence coordination bodies, especially in humanitarian contexts. In the context of delivering as one, UNFPA and its sister agencies address gender-based violence in Viet Nam, including assisting in the implementation, monitoring and evaluation of the Law on Gender Equality and the Law on Domestic Violence Prevention and Control.

46. To ensure reliable and comparable data on violence against women and girls, UNFPA supports a number of key interventions, including developing quantitative and qualitative indicators on gender-based violence and supporting countries in data collection and analysis; Demographic and Health Survey modules on domestic violence; evidence-based sociocultural research; collection of service-based data gathered from public and private agencies that come into contact with victims of

[12] For more information on the work of the United Nations Task Force on Violence against Women, which was established by the Inter-Agency Network on Women and Gender Equality, see www.un.org/womenwatch/ianwge/taskforces.htm.

violence; developing models and projections for decision makers on the costs of inaction; and filling key research gaps, such as abuse during pregnancy.

47. To strengthen demand-side interventions and ensure that services are used by those most in need, UNFPA supports national campaigns on violence against women, training journalists and integrating gender issues and human rights education into curricula of police academies. UNFPA works to strengthen the health sector's role in addressing gender-based violence, raising awareness of reproductive rights violations in the health sector as a form of gender-based violence, instituting health sector policies and human rights mechanisms for redress, developing capacities and supporting the institutionalization of reporting systems with the health and other social service sectors, and institutionalization of training curricula on gender-based violence for health professionals. In Honduras, for example, UNFPA supported the institutionalization of police training on violence against women, claimed as the second greatest achievement of the President's Administration in 2004.

48. UNFPA works to mobilize communities to foster a culture of zero tolerance on violence against women and girls, including working with elders and opinion leaders, and to institutionalize norms and training programmes for strengthened women's human rights protections and legal enforcement, with emphasis on the judiciary and the police, while seeking to draw linkages between legal and security services and the health sector. The Fund supports the establishment of partnerships and programme linkages to promote women's economic opportunities and autonomy, including supporting women escaping abusive situations, such as through microfinance and skills training. In Mauritania, midwives alarmed about sexual violence in their communities began mobilizing against rape. They were later joined by imams. Such mobilization was undertaken with UNFPA support and led to the first national statistics on the issue and the establishment of the first centre for survivors.

49. Promoting gender equality and eliminating violence against women and girls require a concerted effort to actively engage men and boys as partners and agents for change. UNFPA incorporates tailored interventions and messages for men and boys on gender equality and zero tolerance for violence against women in its sexual and reproductive health programmes, including those related to HIV prevention.

50. UNFPA continues to build and strengthen partnerships with faith-based networks and works with religious leaders and inter-faith networks to help eliminate violence against women. It offers capacity development opportunities to religious leaders and inter-faith networks on gender-based violence concepts and strategies to assist them to effectively reach their constituencies and to strengthen their advocacy against violence against women and their participation in service delivery programmes.

VI. Adolescent pregnancy and child marriage

51. An estimated 14 million adolescents aged 15-19 in developing countries gave birth in 2008. Pregnancy rates among adolescents are high in many countries, particularly among the poor. High fertility rates among this age group are associated with higher maternal mortality due to complications from pregnancy and delivery, as well as from unsafe abortions. In the developing world, females aged 15-19

account for 14 per cent of all unsafe abortions.[3] Millennium Development Goal 5 includes an indicator measuring the annual number of births to women aged 15-19 years. Girls under the age of 17, particularly those aged 15 years and under, are more at risk of maternal mortality.

52. High rates of early childbearing in many developing countries result primarily from the practice of child marriage.[13] Worldwide, more than 51 million adolescent girls are married, and in the next decade, 100 million more will be married by their eighteenth birthday should present trends continue.[14] This is despite the fact that child marriage is a violation of the Convention on the Rights of the Child, and that child marriage is against the law in many countries.

53. In addition to being a rights violation, child marriage places adolescent girls at major health risks. Child brides typically have higher levels of unprotected sexual relations (often forced or coerced) and intense pressure to become pregnant. They are typically married to older, more sexually experienced spouses, making them at risk of HIV infection as well. They become the youngest first-time mothers, with little knowledge, health care, and support, often giving birth without a skilled attendant.

54. UNFPA work on adolescent pregnancy and child marriage is multifaceted and includes programmes for reaching marginalized girls, increasing the age at marriage, keeping girls in school, building their life skills, and providing access to contraceptives and other sexual and reproductive health services, including HIV prevention.

55. As a major component of the UNFPA work to uphold the rights of young people, especially marginalized adolescent girls, UNFPA is actively working to counteract child marriage. UNFPA advocacy efforts include raising awareness about child marriage and working with Governments to enact laws against the practice. UNFPA also works closely with communities and religious leaders to find ways to discourage and eventually eliminate child marriage, such as promoting schooling and building leadership skills for young women. In 2009, the General Assembly adopted resolution 64/145 on the girl child, focusing on child marriage and calling on States to take measures to address the root causes of child and forced marriages, to raise awareness of the negative aspects of such practices and to strengthen legislation and policies to protect the rights of the child, especially the girl child.

56. UNFPA country offices support innovative programmes that address adolescent pregnancy and child marriage. In Ethiopia's Amhara region, where rates of child marriage are among the highest in the world, the UNFPA-supported Berhane Hewan programme follows a conditional cash transfer model by encouraging families to allow their girls to participate in the programme rather than marrying them off. Both married and unmarried girls in the programme develop functional literacy and life skills, and receive reproductive health education.

57. In Guatemala, the UNFPA-supported Opening Opportunities programme works with marginalized girls at risk of pregnancy and child marriage to provide them with leadership, entrepreneurial and life skills, as well as information about gender

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[13] United Nations Population Fund (2007). *Giving Girls Today and Tomorrow: Breaking the Cycle of Adolescent Pregnancy.*

[14] United Nations Population Fund (2005). *State of World Population: The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals*.

equality and reproductive health. These models have shown that preventing child marriage (and the associated risks of maternal death and disabilities) requires providing girls with the opportunities, information and skills to imagine an alternative to early pregnancy, childbearing and maternal deaths and disabilities.

58. At the global level, UNFPA has forged a unique partnership with UNICEF, ILO, UNESCO, UNIFEM and WHO to address the multifaceted issues facing adolescent girls, including their education, health, livelihoods and other development concerns. In 2007, the agencies established the United Nations Inter-agency Task Force on Adolescent Girls, co-chaired by UNFPA and UNICEF. The Task Force supports collaboration at the country level — with government ministries, non-governmental organizations, and women's and girls' networks — to identify marginalized adolescent girls at risk of multiple rights violations and to implement programmes aimed at ending their marginalization and enabling adolescent girls to claim their full rights and access to social services, particularly education, health care, employment and human development.

VII. HIV/AIDS prevention

59. HIV is currently the leading cause of mortality in women of reproductive age, with HIV-related maternal mortality rates in sub-Saharan Africa, increasing and surpassing other causes.[3] The high prevalence of HIV in childbearing women is the main cause of child infections, as more than 90 per cent of infant and young child infections occur through mother-to-child transmission, either during pregnancy, around the time of birth, or through breastfeeding. With 370,000 new child infections every year[15] (17 per cent of all new infections[16]), there are 2 million children under the age of 15 living with HIV (an increase from 1.6 million in 2001[16]), resulting in 31 child deaths every hour.[15] Children born to mothers living with advanced stages of HIV are more likely to die irrespective of their own HIV infection status.

Preventing mother-to-child transmission

60. As co-sponsor of UNAIDS, UNFPA leads various initiatives to reduce the spread of HIV and works with partners to support the scaling up of HIV prevention programmes. Among the activities is a comprehensive approach to the prevention of mother-to-child transmission (PMTCT), which includes HIV prevention measures and a continuum of appropriate care for mothers and their children. The approach has four programme components: (a) primary prevention of HIV among women of childbearing age; (b) prevention of unintended pregnancies among women living with HIV; (c) prevention of HIV transmission from a woman living with HIV to her infant (perinatal transmission); and (d) providing appropriate treatment, care and support to women living with HIV and their children and families.

61. The Inter-agency Task Team on Prevention of HIV Infection in Pregnant Women, Mothers and their Children, of which UNFPA is a main partner, is providing support to countries for comprehensive PMTCT, most recently articulating joint strategies through the 2007 Guidance on Global Scale-up of the

[15] UNAIDS, *2008 Report on the global AIDS epidemic* (data from 2007).

[16] *2008 UNAIDS Annual Report: Towards Universal Access* (data from 2007).

Prevention of Mother-to-Child Transmission of HIV, and operationalizing the 2009 UNAIDS Outcome Framework in the priority area of PMTCT.

62. A number of UNFPA country offices carried out activities to support the scaling up of comprehensive PMTCT, although it is still under-programmed in the majority of regions. For example, in Burundi, UNFPA provided support to the Government and civil society in order to promote advocacy and support integration of HIV activities and other reproductive health services, including antenatal care, skilled birth attendance and family planning services for couples and HIV-positive women who do not wish to become pregnant. In Tajikistan, UNFPA supported training of trainers at regional reproductive health centres on integration of PMTCT into effective perinatal care. In Thailand, UNFPA introduced a development model to strengthen PMTCT by encouraging male participation to help prevent HIV infection among pregnant women.

63. In Colombia, UNFPA is supporting a strategy that seeks to increase the voluntary testing of and attention to HIV in the package of reproductive health services having a comprehensive approach to reproductive health. In Kenya, UNFPA, in collaboration with WHO and UNICEF, continues to support the Ministry of Health to strengthen the PMTCT programme in the country. UNFPA has trained a number of counselling staff in family planning as a way of strengthening the provision of these services. In Nepal, UNFPA supported the Government in the development of a national package for linking PMTCT of HIV and sexual and reproductive health services. In Turkmenistan, UNFPA conducted training of trainers on HIV/AIDS counselling of pregnant women for obstetrics/gynaecology and staff of HIV/AIDS centres.

Comprehensive condom programming

64. As part of its strategic response to HIV, UNFPA continues to lead the Global Condom Initiative, which includes comprehensive male and female condom programming for the prevention of STIs, including HIV, and unintended pregnancy. The Initiative is ongoing in 55 countries. For the third consecutive year, overall access to female condoms has dramatically increased and reached a record number of 33 million in 2008. For example, in 2008, despite the difficult economic and political situation in Zimbabwe, the country managed to have the largest female condom distribution per capita, increasing distribution from 2.2 million (2006) to 5.2 million (2008). Other countries have also doubled or tripled access to female condoms for women and girls. Partnership with several agencies helped maximize access to male and female condoms through public, civil society, social marketing and private sectors. Efforts were made to reach populations in remote and rural areas with targeted distribution programmes for vulnerable and marginalized populations including groups most at risk.

65. UNFPA works to strengthen human and institutional capacity of users, service providers and institutions in the area of behaviour change, condom awareness, condom destigmatization, and creative promotion and communication strategies on condoms. In about 50 per cent of the Global Condom Initiative countries, trainers have been equipped with skills to educate populations and users about correct use of male and female condoms. For example, in the Central African Republic, health workers were trained in family planning, including female condom use. Kenya supported the establishment of a condom quality assurance National Quality Control

Laboratory of the Ministry of Health, including the training of staff on the use of condom-testing equipment. Malawi supported the training of hair salon owners in female condom use and disposal. Swaziland supported a national multimedia campaign on condom promotion targeting 15-24 year olds. In Zimbabwe, HIV focal persons from tertiary educational institutions were trained in female condom promotion and safer sex negotiation.

66. Twenty countries drafted national condom strategies and are working to develop a five-year costed operational plan, including a division of labour among implementing partners. In West Africa, UNFPA signed a memorandum of understanding with the Population Council working with and using the expertise of the Council to support reproductive health programmes.

VIII. Reproductive health in emergencies

67. Complex conflicts and acute or chronic natural disasters exacerbate poverty, diminish the access of affected populations to basic information and social services, undermine human rights and security, and increase vulnerability to gender violence and exploitation. Severe economic dislocation and extended political crises also have implications for meeting basic human needs, of which reproductive health needs are notable examples.

68. A decade of UNFPA work in crisis and recovery has followed a set of guiding principles: (a) the right to reproductive health is universal and applies to women, men and adolescents everywhere, including during humanitarian crises and recovery; (b) accurate demographic and health data are the cornerstone of effective humanitarian response, national reconstruction, emergency preparedness and conflict prevention; and (c) attention to gender aspects is critical for effective humanitarian response and reconstruction.

69. UNFPA focuses on supporting capacity development and on building commitment for integrating the International Conference on Population and Development Programme of Action into emergency preparedness, humanitarian crisis response and transition and recovery processes at the national level. The strategy takes into account the ongoing United Nations humanitarian reform and its implications for UNFPA operations and acknowledges the Fund’s central role in promoting reproductive health and rights and gender equality in humanitarian situations. The institutional strategy reflects the UNFPA niche in reproductive health and in the area of data in emergency and humanitarian situations.

70. UNFPA also carried out intensive and effective advocacy on International Conference on Population and Development issues within the Inter-Agency Standing Committee, Inter-agency Working Group on Reproductive Health in Crisis Situations, United Nations Development Group/Executive Committee on Humanitarian Assistance and other bodies, leading to an increased awareness and acceptance of the need to address reproductive health and the differing needs and vulnerabilities of women and girls in emergencies, refugee situations and post-crisis transition. An example of the success of advocacy efforts is the fact that the Conference Programme of Action is now integrated into humanitarian assistance funding frameworks such as the Central Emergency Response Fund, the Consolidated Appeals Process (CAP), Flash and the Humanitarian Emergency Response Fund.

71. UNFPA also works with partners leading the revision of the Inter-agency Field Manual in Reproductive Health in Crisis Settings, targeting reproductive health coordinators, clinicians and care providers in the field, providing them with the latest information available to design, implement and coordinate reproductive health programme components in the field. An Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings has been produced by Save the Children and UNFPA as a companion to the field manual.

72. UNFPA contributed significantly to promoting health and reducing morbidity and mortality before, during and after crises, notably promoting reproductive health and reducing reproductive health-related morbidity and mortality among women, men, girls and boys. Through implementation of the Minimum Initial Service Package in the onset of an emergency situation, UNFPA seeks to: (a) prevent excess maternal and neonatal mortality and morbidity; (b) prevent and manage the consequences of sexual violence; (c) reduce HIV transmission; (d) plan for comprehensive reproductive health services in the early days and weeks of an emergency; and (e) ensure coordination of implementation and among various actors. To effectively implement the Service Package, UNFPA provides reproductive health kits containing medical supplies, drugs and equipment that can be shipped within 72 hours anywhere in the world to respond to the needs of populations caught in emergencies.

73. In 2008, UNFPA provided direct and intensive field support to about 60 country offices requiring assistance in the face of disasters to integrate sexual and reproductive health, HIV and gender-based violence-related services in emergency response and recovery. Training and capacity-building were provided to UNFPA staff and counterparts in more than 100 countries. Among activities in 2009, UNFPA shipped emergency reproductive health supplies to respond to the needs of populations affected by conflict in Yemen and by floods in Burkina Faso, the Gambia, Mauritania and Senegal. In Haiti, which is prone to cyclical natural disasters, reproductive health coordinators were trained and an action plan was developed to integrate sexual and reproductive health in national emergency preparedness plans just in time before the hurricane season.

IX. Conclusion

74. The International Conference on Population and Development Programme of Action recognized that access to information and services for sexual and reproductive health, including family planning, is essential for sustainable development. The international community embraced the concept of reproductive health as an essential component of poverty reduction, which is critical to reducing high fertility and mortality and the spread of HIV/AIDS. Sexual and reproductive health information and services are especially critical to the reduction of maternal and newborn morbidity and mortality. This includes family planning, antenatal and postnatal care, childbirth services, and the prevention of STIs and HIV.

75. Strengthening of health systems is essential to ensure that appropriate, acceptable and affordable services are available to address the needs of women, men and adolescents. Policies and programmes must ensure that gender and socio-economic inequalities do not limit access to information and services. A human rights-based approach to ensure the enjoyment of the highest attainable

standard of health should inform policies and programmes.[17] Scaling up access to an essential package of sexual and reproductive health services delivered through a strengthened health system and targeting the poorest and the most at-risk population is essential to achieve health Millennium Development Goals 4, 5 and 6.

76. UNFPA undertakes a number of programmatic activities at the global, regional and country levels to reduce morbidity and mortality. The Fund promotes maternal health as part of a package of interventions in the area of sexual and reproductive health, together with family planning and STI/HIV prevention. Its Investing in Midwives programme seeks to ensure safe motherhood by providing midwives with the basic emergency life-saving skills to prevent maternal and neonatal deaths and morbidities. The Fund's Reproductive Health Commodity Security programme works with the public and private sectors to ensure access to affordable commodities for those most in need and to avoid stock outs of commodities and essential medicines. The UNFPA Campaign to End Fistula includes interventions to prevent fistula from occurring and to treat women who are affected. The UNFPA-UNICEF Joint Programme and Trust Fund on Female Genital Mutilation and Cutting seeks to increase abandonment of this harmful practice. The Fund addresses gender-based violence through sexual and reproductive health, including HIV/AIDS, programmes, and seeks to strengthen the health sector's role in addressing gender-based violence.

77. UNFPA works to reduce adolescent pregnancy and child marriage by promoting programmes that keep girls in school and build their life skills, and by providing access to sexual and reproductive health services. Through its prevention of mother-to-child transmission and comprehensive condom programming, UNFPA seeks to ensure services to prevent HIV and unintended pregnancies. The Fund provides assistance in conflict areas by supplying, inter alia, reproductive health kits to respond to emergency situations.

78. UNFPA also supports the collection, dissemination and analysis of reliable and timely health and population data that are essential to provide the evidence base for policy formulation, programme planning, and financing, especially given the current global financial and economic crisis.

79. By investing in these activities, UNFPA contributes to the reduction of morbidity and mortality, especially that caused by maternal, neonatal and reproductive causes. UNFPA maternal, neonatal and reproductive health interventions help reduce the loss of healthy years of life because of disability and premature death and contribute to the achievement of broader development objectives, including higher levels of education, economic productivity, and social equity, and help lift families out of poverty.

80. The changing aid environment calls for increased collaboration and partnerships between donors and developing countries and mutual accountability to ensure that scarce resources are used as efficiently and effectively as possible. The UNFPA strategic plan and programmes apply the principles that drive United Nations reform, including the recommendations of the 2007 triennial comprehensive policy review as well as the new aid environment envisioned in the 2005 Paris

[17] See UNFPA report submitted to the Office of the High Commissioner for Human Rights on the topic of preventable maternal morbidity and mortality and human rights for inclusion in the thematic study on the subject requested by the Human Rights Council in its resolution 11/8.

Declaration. By shifting its role from provision of project-related technical assistance to policy support, institution-building and brokering of expertise, UNFPA recognizes the growing importance of capacity development and sustainability that characterizes the new aid environment and contributes more effectively to scaling up successful country-led initiatives to meet the International Conference on Population and Development and Millennium Development Goal targets.