MAKING REPRODUCTIVE RIGHTS AND SEXUAL AND REPRODUCTIVE HEALTH

A REALITY FOR ALL

UNFPA

MAKING REPRODUCTIVE RIGHTS AND SEXUAL AND REPRODUCTIVE HEALTH

A REALITY FOR ALL

REPRODUCTIVE RIGHTS AND SEXUAL AND REPRODUCTIVE HEALTH FRAMEWORK

United Nations Population Fund

(May 2008)

CONTENTS

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS   Acquired immunodeficiency syndrome
ASRH   Adolescent sexual and reproductive health
BSCC   Behavior and Social Change Communication
CEDAW   Convention on the Elimination of All Forms of Discrimination against Women
HIV   Human immunodeficiency virus
HPV   Human papilloma virus
ICPD   International Conference on Population and Development
MDG   Millennium Development Goal
NGO   Non-governmental organization
PHC   Primary health care
PLWHA   People living with HIV/AIDS
PRS   Poverty-reduction strategy
RDTs   Regional Director Teams
RHCS   Reproductive health commodity security
SDP   Service delivery point
STI   Sexually transmitted infection
SWAp   Sector-wide approach
UNAIDS   Joint United Nations Programme on HIV/AIDS
UNCT   United Nations country team
UNDAF   United Nations development assistance framework
UNDG   United Nations Development Group
UNFPA   United Nations Population Fund
UNGASS   United Nations General Assembly Special Session
UNICEF   United Nations Children's Fund
VCCT   Voluntary and confidential counselling and testing (for HIV)
WHO   World Health Organization

Executive summary

1. The Reproductive rights and sexual and reproductive health (SRH) framework has been developed to provide overall guidance and a cohesive- Fund-wide response for implementing the Reproductive Health and Rights elements of the UNFPA Strategic plan 2008-2011. The framework builds on the goals of the International Conference on Population and Development (ICPD), 1994; the Millennium Summit, 2000, with its adoption of the Millennium Development Goals (MDGs); the 2005 World Summit; and the addition, in 2007, of the goal of universal access to reproductive health to MDG 5, for improving maternal health. This includes two parts: the first provides a snapshot of the progress achieved since ICPD, identifies major remaining gaps and priorities and outlines principles and approaches for programme planning and implementation. The second part identifies key priorities and specific strategies for each of the SRH-related strategic plan outcomes.

2. Despite considerable progress since the ICPD, millions of people -- mostly disadvantaged women and adolescents -- still lack access to SRH information and services. In developing countries, about 201 million married women lack access to modern contraceptives. There are about 340 million new cases of sexually transmitted infections (STIs) each year, and 6,000 young people are infected with HIV every day. Millions of women and adolescent girls continue to suffer from death and disabilities during pregnancy and childbirth.

3. UNFPA will invest in four priority areas: (a) support for the provision of a basic package of SRH services including family planning; pregnancy-related services, including skilled attendance at delivery and emergency obstetric care; HIV prevention and diagnosis and treatment of STIs; prevention and early diagnosis of breast and cervical cancers; adolescent sexual and reproductive health (ASRH); and care for survivors of gender-based violence, with reproductive health commodity security (RHCS) for each component of the package – emphasizing the key outcomes under the Reproductive Health and Rights Goal in the Strategic Plan 2008-2011; (b) the integration of HIV prevention, management and care in SRH services; (c) gender sensitive life-skills based SRH education for adolescents and youth; and (d) SRH services in emergencies and humanitarian crises.

4. The first task of UNFPA and its partners will be to ensure that reproductive rights and SRH are given increased priority in policies, planning and budget allocations in the health and other relevant sectors. UNFPA will strengthen its participation in programme-based approaches and sector-wide approaches (SWAps). The placement of SRH at the centre of policies must be reflected in budgets. This requires new technical skills to strengthen the capacity of UNFPA staff.

5. A key lesson learned from the Multi-Year Funding Framework (MYFF) (2004-2007) is the need to sharpen goals and define the Fund's unique niche, especially in the context of strengthened partnerships with other United Nations organizations. As a result, the strategic plan contains specific outcomes for UNFPA support. The plan reflects the principles of national ownership and leadership of programming, strengthened policymaking, capacity development, continued advocacy, knowledge-sharing and South-South cooperation – all of which are essential if the ICPD goals and the MDGs are to be met. UNFPA is best positioned to rally partners to support governments to take leadership on the promise of improved reproductive health as stated in MDG 4, 5 and 6 particularly with the addition of the new target on universal access to reproductive health.

Introduction

6. The reproductive rights and sexual and reproductive health framework has been developed to provide overall guidance for implementing the UNFPA strategic plan 2008-2011. The framework presents the conceptual and operational basis for UNFPA to contribute to achieving the goals of the Programme of Action of the ICPD and the MDGs over a four year period. UNFPA is committed to accelerating action to achieve universal access to reproductive health within a rights-based, comprehensive and multisectoral approach.

7. The framework was developed to provide a cohesive Fund-wide response to address reproductive rights and SRH by promoting, inter alia, synergies between the Fund's thematic areas and linking reproductive rights and SRH relating to both physical and mental health, with population and development, gender, and adolescents and youth. Given the new aid

environment and lessons from the previous MYFF, it offers a rationale for the approach in the Strategic Plan 2008-2011 to engage in policy dialogue, policy analysis and advocacy for the inclusion of SRH issues in national development strategies, plans, budgets and government-driven processes. Examples of this are Sector Wide Approaches, health-sector reform, poverty-reduction strategies (PRSs) and the MDGs, with a stronger emphasis on implementation of these plans. It explains the Strategic Plan's focus on the socially excluded and marginalized in relation to equity aspects of SRH within the health system and gender-equality concerns. It also covers the rationale behind strengthening collaboration among United Nations organizations, especially with the World Health Organization (WHO), United Nations Children's Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS), and other institutions such as the World Bank, fostering partnerships with civil society, women, youth and faith-based organizations. UNFPA's three-year (2007-2009) strategy for integrating ICPD into humanitarian response also is considered within the framework, including close partnerships with

WHO and UNHCR within the Inter-Agency Standing Committee on Humanitarian Affairs.

8. This document is divided into two parts: the first provides a snapshot of the progress achieved in SRH during more than a decade of implementing the ICPD Programme of Action, identifies major remaining gaps, notes the four thematic priorities to implement within the reproductive health and rights area of the strategic plan and identifies principles and approaches for programme planning and implementation. The second part identifies key priorities and specific strategies for each of the SRH-related strategic plan outcomes. It also provides guidance to develop context-specific outputs at all levels. At the country level, the country's needs and priorities will determine the emphasis accorded to each of the outcomes. At the regional level, results will reflect support required by countries at regional and global levels. At the global level, results will reflect common needs and priorities across all regions and support the achievement of both regional and, ultimately, country-level results.

Carina Wint/UNFPA

PART 1

A RATIONALE FOR IMPLEMENTING THE STRATEGIC PLAN IN REPRODUCTIVE RIGHTS AND SEXUAL AND REPRODUCTIVE HEALTH

A. DEFINITION OF REPRODUCTIVE RIGHTS AND SEXUAL AND REPRODUCTIVE HEALTH

9. More than a decade ago, at the ICPD, held in Cairo, 179 countries agreed that:

    (a) All couples and individuals have the right to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so;

    (b) Decisions concerning reproduction should be made free from discrimination, coercion and violence.[1]

10. A major breakthrough at the ICPD, reaffirmed repeatedly since, is that these services are essential for all people, married and unmarried, including adolescents and youth. For people to realize their reproductive rights, the ICPD Programme of Action calls for and defines reproductive and sexual health care in the context of primary health care to include (Para 7.6):

    (a) Family planning;

    (b) Antenatal, safe delivery and post-natal care;

    (c) Prevention and appropriate treatment of infertility;

    (d) Prevention of abortion and management of the consequences of abortion;

    (e) Treatment of reproductive tract infections;

    (f) Prevention, care and treatment of STIs and HIV/AIDS;

    (g) Information, education and counselling, as appropriate, on human sexuality and reproductive health;

    (h) Prevention and surveillance of violence against women, care for survivors of violence and other actions to eliminate traditional harmful practices, such as FGM/C;

    (i) Appropriate referrals for further diagnosis and management of the above.

11. At the Fourth World Conference on Women, held in Beijing (1995), governments recognized that entrenched patterns of social and cultural discrimination are major contributors to sexual and reproductive ill health, along with the lack of information and services. SRH efforts are to be coordinated with interventions that address the patterns of social discrimination, gender inequalities and exclusion that hinder women, men and adolescents from exercising their reproductive rights.

B. PROGRESS SINCE THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT IN 1994

12. In the years since the ICPD, at the global level, various meetings and pronouncements have reaffirmed the central role of reproductive rights and reproductive health in achieving human rights, reducing poverty, attaining gender equality, building a world free of violence against women and girls, preventing HIV/AIDS and attaining the MDGs. Such events included ICPD+5, ICPD+10 and the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS and the political Declaration in 2006.

13. In 2000, world leaders met at the United Nations in New York to commit their countries to achieving the MDGs. In 2005, the World Summit reaffirmed that universal access to reproductive health is critical to achieving the MDGs. In October 2007, of the target of universal access to reproductive health was added to MDG 5, for improving maternal health. By this action, countries validated once more the critical importance of SRH programmes to meeting the MDGs. The inclusion of the target on universal access to reproductive health is an opportunity for a renewed commitment to further advance the SRH agenda.

14. Based on this global political reaffirmation of the ICPD agenda, reproductive rights are now considered a human right for all people, including universal access to reproductive health throughout their life cycle. In addition, family planning is now understood within the broader framework of reproductive health and rights and not as a population control instrument.

15. After the ICPD, many countries passed laws and enacted policies on SRH and began to implement SRH programmes within the health-care system. According to a 2004 UNFPA survey on progress since Cairo, about 86 per cent of countries had adopted policy measures, laws or institutional changes at national levels to promote or enforce reproductive rights, and 54 per cent had formulated new policies.[2]

16. Where country policies, budgets and programmes have reflected the ICPD goals, there has been progress. More girls are now in school, and about two thirds of countries that had data for 2004 had achieved gender parity in primary education.[3] More

women now have access to contraceptives.[4] At least a dozen middle-income countries and even a few low-income countries have reduced maternal mortality.[5] In Eastern Europe, there has been a decline by half in abortion rates due to increased contraceptive use.[6] In 2006, HIV prevalence decreased for the first time in some countries of sub-Saharan Africa.

17. Nevertheless, assessing progress is not simply a matter of identifying statistical indicators or supportive international statements or even public policies. SRH programmes have generally developed slowly. They seldom have sustainable institutionalization and adequate outreach. As a result, SRH programmes have often failed to help disadvantaged women and adolescents, who are less able than others to exercise their rights and more vulnerable to poor health outcomes.[7] As the following section indicates, there is a strong case for increased investments in SRH information and services.

C. SEXUAL AND REPRODUCTIVE HEALTH IN THE NEW MILLENNIUM: CHALLENGES AND TRENDS

18. There is an urgent need for dramatically increased investments in SRH information and services to address the global SRH challenges and the reproductive rights of populations and, particularly, the most vulnerable:

(a) Poor SRH accounts for an estimated one third of the global burden of illness and early death among women of reproductive age.[8]

(b) About 201 million married women in developing countries still have an unmet need for modern contraceptives. Data from 94 national surveys indicate that the unmet contraceptive need among sexually active adolescents is more than two times higher than that among married women. In sub-Saharan Africa, for example, as many as 46 per cent of women face this problem.[9] Globally, 37 countries have an unmet need for family planning that is greater than 20 per cent and 24 countries have a contraceptive prevalence rate for modern methods that is less than 10 per cent.[10]

(c) Every day over 6,000 people are infected with HIV, of which over two-thirds occur in sub-Saharan Africa.[11] In Swaziland, an estimated one in three adults now lives with HIV. Globally, there are about 340 million new cases of STIs

each year. If other STIs are included, the estimates for new infections rise to more than one billion – meaning slightly more than one infection among seven adults of reproductive age.[12]

(d) In developing countries, high fertility rates, early age at birth of first child and high birth rates among adolescents are closely associated with the risk of HIV infection and cervical cancer;[13]

(e) Women and adolescent girls continue to die and suffer from disabilities during pregnancy and childbirth. The latest estimates of maternal mortality worldwide indicate that there were about 535,900 deaths in 2005. Most deaths occurred in sub-Saharan Africa (270,500, 50 per cent) and Asia (240,600, 45 per cent).[14] For every maternal death it is estimated that approximately 30 women suffer a long or short-term morbidity; in some cases like obstetric fistula with debilitating consequences.

(f) It is estimated that close to 70,000 maternal deaths annually (13 per cent) are due to unsafe abortions.[15] About 97 per cent of the unsafe abortions occurred in developing countries;

(g) Adolescent girls are at greater risk of reproductive ill health. Almost 15 million adolescent girls become mothers every year. Among women who become mothers under age 20, infant mortality rates are almost double the ratio among older women. Young women are infected with HIV at a ratio of 8 to 1 when compared with young men of the same age;[16]

(h) Around the world, as many as one in every three women has been beaten, coerced into sex, or abused in some other way – most often by someone she knows, including by her husband or another male family member. One woman in four has been abused during pregnancy;

(i) Women and children account for more than 75 per cent of the refugees and displaced persons at risk from war, famine, persecution and natural disaster. In emergencies and humanitarian crises, women, and especially young people, are especially vulnerable to sexual violence and coercion, unintended pregnancy, pregnancy-related deaths and HIV infection and they typically lack access to essential SRH services;

(j) Poor women are disproportionately affected by reproductive illness and have the least access to services.[17] In sub-Saharan Africa, women in the highest socio-economic quintile use family planning five times more often than the poorest.

In South-East Asian countries, the difference reaches 20 times. The lower a woman's socio-economic status, the less likely she is to have skilled assistance at delivery or lifesaving emergency obstetric care.

19. Poor reproductive health outcomes are not limited to health concerns. The above data, approached from the perspective of human rights, reveals the larger picture of reproductive rights globally. To accelerate progress towards achieving the ICPD goals and the MDGs, UNFPA efforts to address reproductive rights and SRH are guided by the principles of universal human rights, gender equity and social equality.

D. THE UNFPA PROGRAMME

1. THE NEW ENVIRONMENT

20. The environment in which UNFPA will operate during 2008-2011 has changed in many ways. The inclusion of the maternal health goal in the MDGs and the new target of universal access to reproductive health constitute a clear recognition of the central role that SRH plays in development. Therefore, UNFPA will contribute to SRH in a wider development context, one in which the empowerment of women and young people so that they can exercise their reproductive rights is of critical importance. Couples and individuals need access to improved SRH information and services to be able to participate in the social development and economic life of their countries, as well as for improved quality of life. Therefore, UNFPA will increase its efforts to demonstrate how the realization of reproductive rights through improvements in SRH is a necessary condition to achieve poverty reduction at both household and macro-economic levels. This will require coordination of the Fund's main thematic areas and the identification of synergies with its work on population and development, on gender equality and the empowerment of women, and on adolescents and youth. The influence of reproductive rights on population dynamics such as fertility, mortality and age structure and their influence on social and economic development support a strong argument for policymaking on poverty reduction to increase interest in reproductive health investments.

21. There is also increasing awareness and acceptance of the necessity of SRH and specific approaches

Diego Goldberg/Pixel Press/UNFPA

addressing the differing needs and vulnerabilities of women and girls in emergencies, refugee situations, and post-crisis transition, including the importance of HIV as a humanitarian and security issue, the lack of access to essential reproductive health services and the prevalence of sexual violence in these situations. Nevertheless, UNFPA will need to continue its advocacy to communicate the urgency of inclusion of ICPD issues in overall humanitarian response, including SRH services as part of the basic health package and implementation of Security Council Resolution 1325 on Women, Peace and Security. Considering the increasing number and intensity of natural disasters (now referred to by OCHA as "climate-related disasters"), there is greater urgency for UNFPA to promote emergency preparedness planning and capacity development that incorporates issues of SRH.

22. SRH services should also benefit from a multisectoral approach. For example, efforts to decrease gender disparities in education and support for economic opportunities and decision-making in households are essential to empower women to exercise their reproductive rights, to access SRH services and, as a result, to improve health outcomes. Linkages with income-generating activities for women and adolescents, community economic development projects and work-based social insurance schemes can serve as the first, and sometimes the only, opportunity to reach women and adolescents with SRH programmes.

23. The 2005 Paris declaration on aid effectiveness and the recently launched Global Campaign for the Health Millennium Development Goals endorsed the principles of national ownership, aid coordination and results-based financing. These principles underpin the adjusted approaches to SRH programming. UNFPA will move away from fragmented, donor-driven projects towards more systemic approaches such as SWAps, health-system development and general budget support. Therefore,

UNFPA will play a proactive role to creatively and effectively place SRH in policy and financing spheres. It is no longer enough that national policy initiatives mention reproductive health – the agreements to place SRH at the centre of policies must be reflected in budgets and in the level of resources assigned to the implementation of such policies, as well as plans to ensure implementation at all levels of the system. This requires new technical skills to strengthen the capacity of UNFPA staff and that of its partners to integrate SRH fully into national development plans, overall health and non-health reforms, policies, budgets and relevant programmes.

24. UNFPA must also contribute to and align with global and national efforts to harmonize support for health and health systems. The leaders of eight international agencies active in health (WHO, UNICEF, UNFPA, UNAIDS, World Bank, Bill and Melinda Gates Foundation, The Global Fund to fight AIDS, Tuberculosis and Malaria and GAVI Alliance Health System Strengthening) or the H8 have formed a informal group aimed at better coordinating respective agencies' work, particularly at the country level. The group recognizes the need to strengthen health systems and improve service delivery for better outcomes; to move away from vertical to more horizontal approaches in support of national processes; and to work towards supporting One National Strategy, One National Plan, One Monitoring and Evaluation System and One Overall Coordination Structure under the leadership of the country and one Validation system. This approach acknowledges that to strengthen health systems and improve service delivery at the national level, including human resources for health, there is a need for predictable financing, infrastructure strengthening, and harmonization of support to logistics management and monitoring.

UNFPA is also an active player in the International Health Partnership Plus (IHP+), an initiative composed of UN, private foundations and donors that was established in September 2007. Its main objective is to support national efforts in scaling up coverage towards achieving global health outcomes, with special focus on the Health MDGs. A compact is established between the IHP+ partners and the government of recipient country with defined lines of accountability from both parts. The IHP + work plan sets steps to: enable countries to identify, plan and address health systems constraints to improve

health; generate and disseminate knowledge, provide guidance and tools in specific technical areas; enhance coordination and efficiency in aid delivery and strengthening health systems; and ensure accountability and monitoring performance. Within these partnerships and in line with strengthened support to one national health plan and health systems, UNFPA will plan how as part of the new strategic plan, it will influence these efforts and place SRH at their centre, particularly in relation to promoting universal access to RH, maternal health and adolescent health and establishing linkages in the delivery of reproductive health and HIV-prevention services.

25. UNFPA will continue to operate in the context of United Nations reform, which strengthens collective responsibilities for the achievement of MDGs at global, regional and national levels. Participating in joint programming exercises, UNFPA is better positioned to place the ICPD goals under United Nations development assistance frameworks (UNDAFs); expanding and strengthening its partnerships with technical agencies and United Nations partners, in particular, WHO, UNAIDS, UNICEF and the World Bank. For example, WHO and UNFPA have a joint collaborative action plan for furthering evidence-based advocacy in SRH through research and development, technical knowledge, and programme performance improvement, including the placement of the essential drug list in national streams. The ongoing humanitarian reform and its three pillars (the cluster approach, strengthening of the humanitarian coordinators system, and humanitarian financing) presents UNFPA with significant opportunities to integrate the ICPD agenda into international humanitarian work. UNFPA will also continue inter-agency collaboration with its role as focal point for gender, reproductive health and sexual and gender-based violence in the Inter-Agency Standing Committee on Humanitarian Affairs and country-level participation in UN Country Teams in crisis-affected countries.

26. UNFPA is now implementing a reorganization plan, which includes regionalization and will bring its technical and programme capacity together and move them closer to country programmes. The regionalization plan has been developed to respond to the new environment in which UNFPA will operate. Its main goal is to accelerate the achievement of national development goals through

coordination, harmonization, country ownership and national capacity. This has clear implications for the manner in which UNFPA will contribute to SRH programmes. Crafted to increase UNFPA effectiveness at the country level, the plan requires specialized and high-quality technical skills to succeed at including SRH in public policies and at developing the sustainable capacity of democratic institutions in countries. Moreover, at regional levels, technical expertise in SRH and specialists in results-based management and evaluation will be needed to support programme specialists who, in the past, were involved in overseeing the daily tasks of monitoring programme expenditures.

27.   The perception that SRH and family planning programmes have lost ground to other priority areas presents serious challenges but also immense opportunities to innovate and to use the power of partnerships to move SRH outside the confines of vertical programmes.

2. PRIORITY THEMATIC AREAS

28.   To implement the strategic plan's goals in reproductive rights and SRH and to contribute to achievement of the related outcomes, UNFPA will invest in four priority areas:

(a)   SRH services in the basic health-care services delivered at district and local levels, particularly primary health care, through functioning health systems that prioritize quality, equity and integration and are equipped with accountability mechanisms for users and providers. The SRH package should universally include: family planning services; pregnancy-related services, including skilled attendance at delivery, emergency obstetric care and post-abortion care; STI and HIV prevention and diagnosis and treatment of STIs; prevention and early diagnosis of breast and cervical cancers; prevention of gender-based violence and care of survivors; ASRH; and RHCS for each component of the package. UNFPA will emphasize the key components of the package as relates to the outcomes of the Strategic Plan while at the same time promoting progressive realization of comprehensive SRH care;

(b)   The integration of HIV prevention, management and care in SRH services. The integration of HIV and SRH services matters enormously from a user's perspective, providing users in dealing

Diego Goldberg/Pixel Press/UNFPA

with the health-care system as one, in testing its quality and in feeling supported. This will determine the extent to which users trust the system and its value in resolving their problems, which, in turn, will determine continuity of use;

(c)   Gender sensitive life-skills based SRH education and a package of social protection services for adolescents and youth, including SRH. At a minimum, these will include life-skills education, psychosocial counselling, contraception, HIV-prevention, STI- prevention/treatment and maternal health services; [13]

(d)   SRH in emergencies and humanitarian crises, which will include the same services defined above in the SRH package to safeguard the SRH and reproductive rights of women and adolescents affected by conflict and disasters.[18]

29. Achieving progress towards reproductive rights and SRH, including HIV prevention, treatment and care, depends upon a strong and functional health system in every country, especially at the primary and first referral levels. Therefore, UNFPA must address three policy challenges: health-sector financing and SWAps, decentralized health systems and vertical disease-centred programmes and systems.

30. The first task of UNFPA and its partners will be to ensure that reproductive rights and SRH are given increased priority in policies, planning and budget allocations in the health sector, with linkages established between SRH policy and other relevant sectors, including education, agriculture, youth, women's affairs, environment and finance. In the health sector, plans at national, sub-national and district levels should reflect SRH services, in particular, pregnancy-related services; contraception; HIV and STI prevention and diagnosis and treatment of STIs; and reproductive health commodities; and integrate services for gender-based violence.

31. A means to ensure the inclusion of SRH in health-sector planning and make functioning health systems work for SRH is to strengthen UNFPA participation in programme-based approaches and SWAps and promote attention to SRH within national health-sector strategic planning and budgeting. In addition, the most effective and cost efficient way to ensure that SRH issues are part of humanitarian response is to incorporate them into emergency preparedness plans and to develop national capacities for preparedness. These efforts are not yet common practice in all countries where UNFPA has a presence.

32. Special attention is to be given to financing SRH, based on evidence of highest cost benefit. For example, it is estimated that the global economic impact of maternal and newborn deaths amounts to US$15 billion a year in lost productivity.[22] The estimated spending in 2004 for maternal and newborn health totaled $US 530 million, and according to the most recent UNFPA cost estimates, it should be 30 times as much, about $13.3 billion in 2005 rising to $24 billion to achieve MDG 5 by 2015.[23] Projections show that these funding requirements could be met if countries invested 15 per cent of their national budgets in health and if official development assistance climbed further towards 0.7 per cent of gross national income in the OECD countries.

33. Although SWAps are being encouraged, vertical programmes for malaria, tuberculosis and HIV exist and involve enormous amounts of funding. Consequently, some essential components of SRH have received insufficient attention, due, in part, to global pressures to give priority to diseases addressed through vertical programmes. UNFPA should advocate for these verticalized funds to be increasingly directed to strengthening health-systems. For example, such funds could be invested in national plans for adequate skilled and motivated human resources able to provide, for example, integrated services at the primary health-care level, such as in the area of SRH, HIV, malaria and tuberculosis; or to integrate emergency care skills for health providers at the first referral level.

34. Another task for UNFPA is to focus on ensuring that health systems integrate SRH into basic health services, particularly at the primary health-care level. To do so, UNFPA staff would have to acquire the necessary skills to address a variety of issues. The issues range from health-care financing and costs to understanding how entire health systems are managed, how procurement and logistics structures function, what elements are needed in human resources plans, how overall quality could be improved and what is needed to enhance data quality and availability. In the case of health-care financing, it is not only about advocating for additional resources but also ensuring that all resources, irrespective of the source, are utilized in an efficient, effective and equitable way to deliver results. Therefore, UNFPA should support countries to strengthen their planning and budgetary processes at all levels, including financial accountability, managing for results and evidence-informed decision-making, and promote universal access to healthcare in a sustainable and effective way.

35. Some countries have come up with creative ways to ensure that resources are allocated in a more transparent and equitable way, for example, budget assignments based on the percentage of populations living in poverty, the median distance of the population to health centers and age distribution. This is another area in which UNFPA could have

a comparative advantage by supporting capacity in poverty diagnostics through its population and development programme. Some countries have also been championing results-based financing in the health sector, on both the demand and the supply side. On the demand side, examples include conditional cash transfers, whereby individuals/households are provided cash for a specific health visit. On the supply side, examples include contracting out services to the private sector linked to performance-related incentives. Therefore, it is critical that UNFPA absorb and draw upon lessons learned and experiences gained at the country level.

36. To address the brain drain of the work force, human resource plans should include human resource planning, retention and reward strategies. UNFPA-supported programmes emphasize capacity development of human resources, with particular emphasis on midwives. Historical evidence illustrates the fundamental role of professional midwives in decreasing maternal morbidity and mortality.[19] When trained to competence, midwives also have the ability to deliver the full package of SRH services at the primary health care level. Therefore, support for midwives will contribute to achievement of MDG5. Additionally, working at the level of community and the primary health-care system, midwives are the point of entry into the health-care system for many women. Midwifery competencies include cultural sensitivity, to the end that, in many countries, midwives serve as a liaison between the community and the formal health sector.[20] A number of countries have undertaken specific measures including policy development, advocacy and the revision of regulatory systems to scale up and professionalize midwifery which can provide lessons for other contexts.[21]

37. Strengthened data collection through health information systems and routine population based and facility based surveys to inform health sector planning is another key area where UNFPA can contribute. With new information technologies developing rapidly and greater access to mobile telephone service expanding, new techniques of collecting and analyzing data should also become a priority for the evaluation and improvement of performance.

38. Increasing decentralization of health systems to bring services closer to the people in need may result in a risk to the priority given to reproductive

Safebagar/UNFPA

rights and SRH if these concerns are not part of local authorities' main concerns. UNFPA will support national-level planning that includes direct investments in programmes for good governance and the participation of civil society in setting national health priorities. UNFPA has a strong role to play in this area for supporting training, outreach and advocacy among local non governmental organizations (NGOs). In addition, UNFPA should work with the government and partners to ensure capacity development at sub-national, district and municipal levels for translation of national plans into decentralized planning and budgeting.

39. The role of the private sector in the provision of SRH services is increasingly growing and recognized by UNFPA. In Sub-Saharan Africa, the private sector delivers 50 per cent of health-care goods and services. The private sector is therefore a critical partner in the goal of universal access to SRH. Partnerships with the private sector have proved to be crucial for improving both the supply of and the demand for SRH services. In many countries, the private sector has proved a reliable partner in developing insurance coverage,

social marketing and social franchising initiatives. The private sector has developed new strategies to make quality SRH services and commodities affordable at private clinics, pharmacies and insurance companies. However, as increased emphasis is placed on cost recovery, including user fees, and on privatization, care must be taken to ensure that these mechanisms do not pose barriers to women's and young people's access to SRH care.

40. Finally, health systems should be transformed into responsive social institutions that reach out to the marginalized and do not discriminate because of sex, marital status, age, economic background, geographic location, disability, ethnicity or caste. A well-managed and functioning health system contributes to poverty reduction, citizenship and democracy if accountability mechanisms are developed so that citizens, in particular, women and young people, are able to use these mechanisms to uphold their entitlement to exercise their reproductive rights in a transparent manner. The experience of social participation should be seen as

Diego Goldberg/Pixel Press/UNFPA

part of building democratic, gender-equal societies that respect the human rights of their citizens.

41. As part of efforts to ensure that young people's concerns are incorporated in health sector policies and plans, UNFPA will engage in policy dialogue and policy analysis by including young people's issues in national development strategies, plans and other national processes such as SWAps and PRS. UNFPA will leverage its broad base of partnerships and alliances to drive increased investments aimed at young people, and particularly at excluded and vulnerable groups. UNFPA will also take advantage of the global focus on HIV and AIDS, and the growing recognition that the epidemic is increasingly affecting young women, to draw attention to adolescent sexual and reproductive health (ASRH) in policy arenas. In terms of programme opportunities, UNFPA will advocate and support an essential package of social protection interventions for adolescents and youth, comprising education, health and livelihood components.

4. PRINCIPLES

42. The SRH framework will be implemented within a set of three principles and approaches: a human rights-based approach, gender equality and cultural sensitivity; equity; and social participation.

a. Human rights-based approach, gender equality and cultural sensitivity

43. UNFPA will implement the SRH framework in the context of applying the principles of human rights, gender equality and cultural sensitivity. It understands the human rights-based approach as a set of obligations (entitlements for citizens) of States to their citizens to allow them to exercise their reproductive rights through access to affordable, quality SRH services. To fulfill this right, UNFPA supports the development of accountability mechanisms within health-care institutions so that diverse social actors can participate and exercise control over the way health systems deliver services. At the same time, UNFPA emphasizes the need to build cultural legitimacy for human rights principles so that communities can make them their own.

44. With special attention to understanding how values, practices and beliefs affect individuals in their communities, UNFPA works closely with communities to understand and adapt to cultural diversity of perceptions, language and norms. In the same way, UNFPA promotes gender equality through ensuring access to SRH services as a way of empowering women and adolescent girls to control their sexual and reproductive lives. This SRH framework and the strategic plan underscore this principle and have created synergies with the gender-mainstreaming framework approved in 2007 to enhance the empowerment of women in addressing entrenched patterns of social and cultural discrimination with complementary initiatives.

b. Equity

45. The framework will be applied with an equity perspective, requiring that increased attention be given to several dimensions of social disadvantage, including wealth, locality, gender, age, religion, disability and ethnic/indigenous origin. UNFPA will promote equitable access to SRH services. To do so, UNFPA and its partners should develop skills to include this dimension as a focal aspect of policies and programmes, even in decentralized health systems. These skills entail the ability to identify exclusion due to age, exposure to risk and geographic and cultural diversity. They will also require advocacy for regulations that bring about the distribution of health-care resources on a fair-share basis, regulating costs in favour of those who are impoverished and holding the system accountable to serve them.

c. Social participation

46. The engagement of civil society at local and national levels is fundamental to setting health-sector priorities. It is also vital to holding governments accountable for their commitments. Thus, UNFPA will advocate with governments to include stakeholders in planning at all levels and to invest in their capacity to do so, an effort that has become especially important at local levels in countries with decentralized health systems. This also includes support to social actors (women, youth and faith-based organizations, organizations working to engage men and boys) that could lead to popular mobilization and will encourage governments to allow access to decision-making documents and processes, programme implementation, monitoring and evaluation.

PART 2

REPRODUCTIVE RIGHTS AND SEXUAL AND REPRODUCTIVE HEALTH IN THE UNFPA STRATEGIC PLAN 2008-2011

47. The following section describes the SRH outcomes and outputs in the context of the SRH framework, highlighting priorities, strategies and key possible activities, and identifying indicators for measuring progress.

48. The framework outlines the distinctive role and contribution of UNFPA vis-à-vis other United Nations organizations, in line with the concept of "Delivering as One" – the need for cooperation and collaboration within the United Nations in responding to national and regional needs and with special emphasis on a field focus.

A. OVERALL GOAL

49. The overall strategic plan goal for SRH and HIV prevention is to contribute to the achievement of MDGs 5 and 6 and the ICPD Programme of Action goals. The identified goal is:

Quality of life improved through universal access to reproductive health by 2015 and universal access to comprehensive HIV prevention by 2010

50. In pursuing this goal, UNFPA will build upon the progress already made under the Multi-Year Funding Framework 2004-2007. The overarching strategy will be national capacity development, particularly in: designing national planning frameworks, including emergency preparedness and recovery processes, that reflect ICPD goals and the MDGs; strengthening national institutions, systems, human resources and civil society; ensuring that United Nations reform efforts support capacity development, especially through South-to-South cooperation; and, lastly, ensuring that global, regional and national technical support is focused on strengthening national capacity.

51. National capacity development will be advanced through: building and using a knowledge base, undertaking advocacy and policy dialogue, promoting and strengthening partnerships, developing systems for improved performance and adopting human rights and culture- and gender-sensitive approaches as outlined in the Strategic Plan 2008-2011.

52. The indicators selected in the strategic plan to monitor progress on the goal include: the adolescent fertility rate, unmet need for family planning, maternal mortality ratio, and HIV prevalence among adults and sex differentials.

B. OUTCOMES

53. The strategic plan's five SRH outcomes, outlined below, are all elements of an integrated package of SRH information and services, including commodities, in the context of strengthening basic health services within national development frameworks.

54. Of the five SRH and HIV-prevention outcomes, the first deals largely with the promotion of reproductive rights and the delivery of a comprehensive and integrated package of SRH services within basic health services and empowering couples and individuals to exercise their reproductive rights. Outcomes 2, 3 and 4 cover three core aspects of the SRH package: improving maternal health, reducing maternal mortality and morbidity and preventing and managing the complications of unsafe abortion (outcome 2); providing high-quality services for family planning (outcome 3); and combating STIs, including HIV and reproductive tract infections (outcome 4). Outcome 5 covers the important target group of adolescents and young people.

1. OBJECTIVE OF OUTCOME 1

55. Interventions in each of the above-mentioned areas are mutually supportive. The long-term objective, identified in outcome 1, is the eventual integration and linkage of all aspects of SRH, including HIV prevention, care and treatment as well as services for survivors of gender-based violence.

Outcome 1: Reproductive rights and SRH demand promoted and the essential SRH package, including reproductive health commodities and human resources for health, integrated in public policies of development and humanitarian frameworks with strengthened implementation monitoring
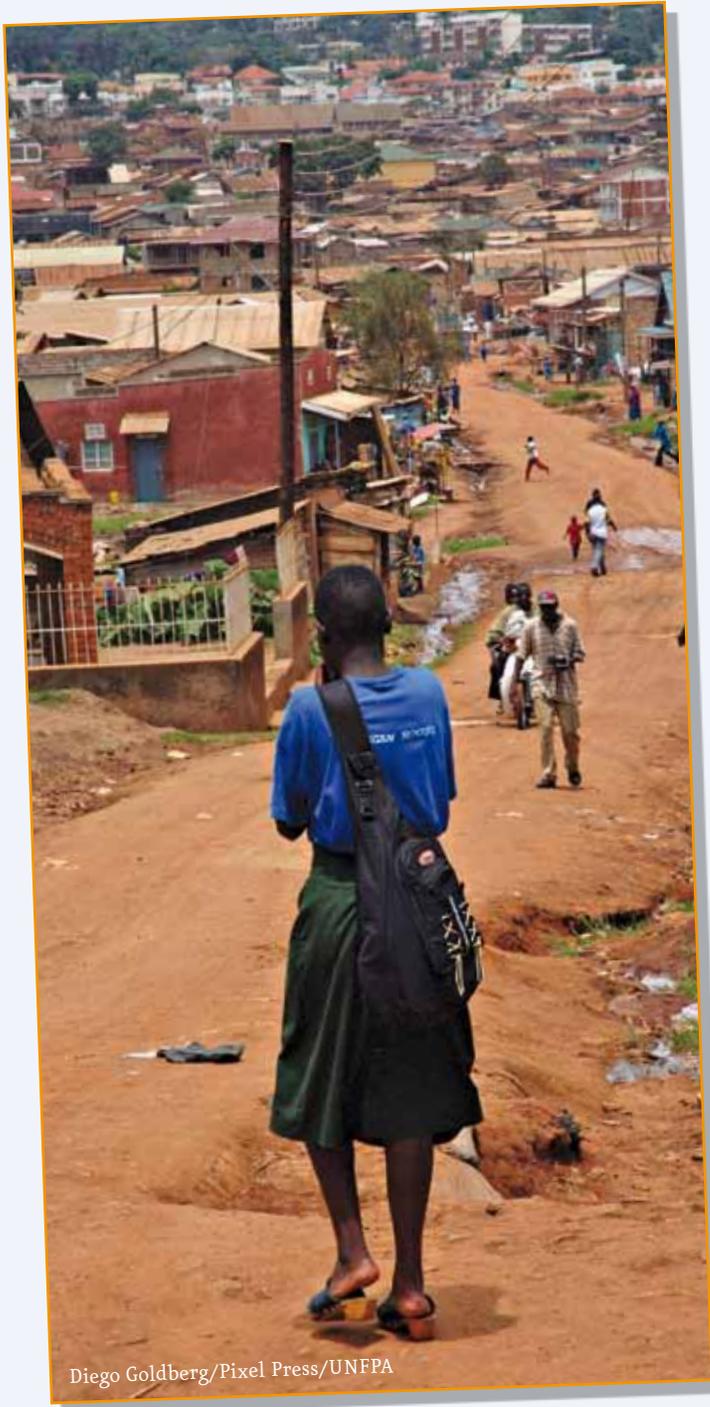
---

a. Priorities

56. To achieve outcome 1, the priority given to SRH in policies and budget allocations for health systems and in development frameworks needs to be significantly increased. Policies should be accompanied by the appropriate allocation of resources for implementation and be given prominence in PRSs and negotiations on SWAps. Within health-sector planning, advocacy is necessary for the delivery of an essential SRH package as part of basic health services, particularly at the primary health care level. Varying models based on experience over the last decade need to be documented, compared and evaluated to demonstrate to governments the possibilities for operationalizing the package. Elements related to health systems to take into account include the necessary human resources and competencies (with possibility for task shifting), application of standards and protocols, logistics systems, health information systems, costing, budgeting and financing, and the infrastructure and referral systems between levels. Continuous monitoring should also take place to ensure that policies are actually being translated into action.

57. Access to essential medicines is recognized as part of the right to the highest attainable standard of physical and mental health. Hence, policies that support and ensure adequate supplies and the provision of such drugs need to be put in place for the achievement of optimal SRH. International standards for the provision of medical services, including pharmaceutical and other health-related regulations and quality-control mechanisms, need to be incorporated into countries' policies and regulations.

58. The availability of services should be complemented by comprehensive information and counselling to empower couples and individuals to exercise an informed choice in matters of SRH. These efforts will lead to social and behavior changes, increased utilization of services and ultimately to improved health outcomes. Therefore, efforts will be directed at determining the key communication and social mobilization approaches to ensure that couples and individuals have the information and the social support they need. Civil society will be a vital partner in developing and implementing these approaches. It is also essential to continue building on and expanding approaches that involve men and boys to enlist their support to their partner's choices and needs and as direct recipients of services for their own health and well-being.

Diego Goldberg/Pixel Press/UNFPA

Building partnerships with humanitarian relief agencies to integrate SRH services within their programmes to respond to the needs of populations in crises is a key element.

b. Strategies and key activities

60. Four main strategies will be undertaken to ensure the operationalization of reproductive rights, with prominence given to the SRH package in resource allocation, review of regulations and demand creation for services.

61. Strategy: Undertaking advocacy and policy support for the integration of SRH in development policies and humanitarian frameworks.

62. Key activities:

   (a) Advocating for the inclusion of SRH in poverty-eradication, MDG and other development and humanitarian policies, frameworks and strategies, using evidence-based arguments and emphasizing reproductive rights;
   (b) Ensuring involvement in health- and education-sector reforms and SWAps and health-sector planning for the incorporation of SRH services into health and education plans and budgets;
   (c) Advocating for the accessibility of SRH information and services for marginalized and vulnerable populations such as adolescents, young people, the poor, marginalized groups, people living with HIV and AIDS, persons with disabilities, refugees and internally displaced persons, and ageing men and women;
   (d) Mobilizing civil society organizations to undertake evidence-based advocacy and participate in policy dialogues;
   (e) Supporting the inclusion of RHCS as an essential component of SRH.

63. Strategy: Supporting technical assistance for policy and regulation analysis and development.

64. Key activities:

   (a) Reviewing and advocating for modification of laws and policies or the development of new laws and policies to ensure the facilitation of universal and equitable access to SRH education, information and services, including commodities and human resources for health and emergency preparedness planning and response;

59. SRH should also be included in the plans and funding frameworks for emergency preparedness and humanitarian response and during transitions and recovery. As the lead agency for reproductive rights and SRH information and services in emergency situations, UNFPA bases its work on human rights and targets universal access to reproductive health to women, men and adolescents in all circumstances, including crises.

(b) Providing guidance for the development of an effective regulatory environment to ensure public- and private-sector accountability for providing high-quality SRH care, including mechanisms for civil society participation;

(c) Providing technical assistance for development of norms and good practices for SRH components within health planning and reforms, including standards and protocols, competency definition and certification, human resources development and planning, costing, budgeting and financing, logistics and infrastructure and health information systems.

(d) Supporting and providing technical assistance for the adoption of regulations and mechanisms and tools to ensure that commodities -- medicines, equipment and supplies -- are made available on a sustainable and equitable basis and that they meet international quality standards;

(e) With partners, providing technical assistance for the development of norms and standards that recognize and protect young people's rights to SRH information and services.

65. Strategy: Developing an objective evidence base for decision-making.

66. Key activities in partnership with research institutions:

(a) Supporting policy analysis and research on SRH as part of poverty-eradication, gender-equality and public health issues, including in humanitarian crises setting;

(b) Supporting policy studies on the extent to which current SRH information and services meet the needs of the poor;

(c) Generating the evidence base to influence policy debates on SRH, including such aspects as public expenditure tracking studies, benefit incidence analysis and cost-benefit analyses of SRH interventions and programmes;

(d) Supporting policy studies and research on gender-based violence and its links to SRH, including HIV transmission;

(e) Reviewing local practices and supporting the adaptation of international evidence-based standards of care, in collaboration with universities, research centres and professional associations;

67. Strategy: Strengthening capacity among a variety of civil society actors to increase demand for SRH.

68. Key activities:

(a) Strengthening the ability of community-based organizations and leaders to raise awareness of reproductive rights, leverage resources and community support and enhance their role in monitoring the quality of the service delivery, including in humanitarian crises setting;

(b) Enhancing the capacity of service providers, teachers, peer educators and counsellors in interpersonal communication skills to increase access of couples and individuals to information and to avail of existing services;

(c) Strengthening the knowledge and ability of the media to accurately report on SRH issues;

(d) Providing support for innovative communication programmes that increase access to information and services, especially for adolescents, including social marketing and mass media;

(e) Partnering with schools and other programmes for youth (e.g., peer education) for the provision of SRH information and education both in and out of school, including the institutionalization of gender-sensitive life-skills SRH education in schools.

c. Indicators proposed for outcome 1

69. The following are the indicators in the Strategic Plan for assessing outcome 1:

• Proportion of countries with national development plans that allocate resources for an essential sexual and reproductive health package.
• Proportion of humanitarian crisis and post-crisis situations where the Minimum Initial Service Package was provided and utilized.
• Proportion of SRH/RR assistance in the overall ODA and humanitarian assistance.
• Demand for family planning.

Additional indicators to consider are as follows:

(a) SRH incorporated in national development budget;

(b) A costed HIV plan;

(c) Implementation of Minimum Initial Service Package for humanitarian crisis and post-crisis situations situation;

(d) Unmet need for family planning.

Outcome 2: Access to and utilization of quality maternal health services increased in order to reduce maternal mortality and morbidity, including prevention of unsafe abortion and management of its complications

a. Priorities

70. One of the central roles of UNFPA is to support the achievement of MDG 5. Among the MDGs, MDG 5 is a goal with the least progress, requiring substantial political will to be achieved. Yet, the interventions needed to achieve it are simple and relatively inexpensive. An increased focus on maternal mortality and morbidity reduction within the basic SRH package is essential. Tackling the challenges will require that UNFPA work on strengthening the health-care system, in close coordination with partners, especially United Nations organizations such as UNICEF, WHO and the World Bank, for agreement on a clear division of effort. UNFPA is well-positioned to lead the call to inspire action and urge governments and other partners to deliver on the promise of improved maternal health. With additional institutional capacity at regional and country levels, UNFPA would also be in a position to lead supporting countries to scale up maternal health programmes. UNFPA has already taken a leadership role in ensuring that maternal health is integrated in humanitarian response and recovery within the Inter-Agency Standing Committee on Humanitarian Affairs.

Carina Wint/UNFPA

71. Targeted interventions of UNFPA to support countries in reducing maternal mortality and morbidity are centred on three main pillars – family planning to ensure wanted pregnancies, skilled attendance at all births and access to emergency obstetric care for all women in need – in all settings, including humanitarian crises. A review of evidence from a number of countries shows that ensuring skilled attendance at all births at the primary health-care level, combined with effective referral to facilities in case of complications, has been fundamental to reducing maternal mortality and morbidity. Access to comprehensive modern contraception, emergency obstetrical care and skilled birth attendance can prevent abortion, and complications of unsafe abortion, including mortality and morbidity, such as severe post-partum disabilities, including obstetric fistula.

72. Among the health worker cadres classified as skilled birth attendants, midwives are unique in that their competencies encompass delivery of SRH services at the primary health-care level. Therefore, they provide pregnancy and delivery care, including basic emergency obstetric care, as well as the full package of SRH services, including family planning to prevent unwanted pregnancies. The essential midwifery competencies also recognize the provision of culturally appropriate services as a key competency. Midwives traditionally work in close proximity to women and their communities and have a greater leverage to communicate family planning and safe delivery information and care.

73. Improvements in maternal health require interventions before and during pregnancy and after childbirth. Family planning services are essential to enable women to delay, space and limit pregnancies, potentially reducing maternal deaths by 20 to 35 per cent. Through antenatal care, women can plan and prepare for the coming birth and for post-partum contraception. Post-partum care is important as well to identify and manage complications that can lead to death or chronic morbidity. For example, cases of obstetric fistula can be identified and referred for treatment early, before the social consequences of stigma and abandonment emerge. Specific efforts to ensure management of severe chronic morbidity, such as uterine prolapse and obstetric fistula, may be necessary where prevalence is high and access to treatment care is low. Mental health and psychosocial support must be integrated as part of

existing SRH services so that perinatal depression and other mental health problems can be prevented and treated.

74. Women in low-income countries typically experience barriers in reaching maternal health care, particularly at the time of delivery. Three main delays have been documented: delay in the decision to seek care, delay in reaching emergency care and delay in receiving appropriate care at the facility. The first two delays relate directly to factors in the family and the community and require increases in demand for maternal health care, particularly for skilled care at delivery and preparation for obstetric complications. Communities need to be empowered to take action and to advocate for their rights to quality reproductive health care and, in particular, obstetric care. Mobilized communities have developed innovative solutions to the three delays, including community emergency funds, emergency transportation and referral mechanisms, and increasing interaction with the health system. Traditionally, many of these approaches have centred on women, but men are critical to improving maternal health. Data shows an association between increased understanding and support of men to women's reproductive life stages and improvement of women and new-born children health.

75. In many countries, the major entry point for SRH is antenatal, childbirth and post-partum services, which often form the backbone of primary health care. Consequently, maternal health care offers key opportunities to reach women with family planning and to offer women prevention, counselling, testing and treatment for STIs and HIV and for preventing HIV transmission during pregnancy and birth and through breastfeeding. The integration of other SRH and HIV services with maternal health care is, therefore, an important strategy for attaining universal access to reproductive health.

b. Strategies and key activities

76. The fundamental approach under this outcome will be to assist countries in their efforts to develop, cost, fund and implement national initiatives for reducing maternal mortality and morbidity, within SRH in the basic health package, including for emergency preparedness and response, through the following strategies and activities.

77. Strategy: Undertaking advocacy and policy dialogue for improving maternal health.

78. Key activities:

(a) Promoting dialogues among government, civil society and development partners to adopt the three principles of a national initiative -- one framework, one coordination mechanism and one monitoring and evaluation system;
(b) Promoting the reduction of maternal mortality and morbidity through the availability of family planning, skilled attendance at birth and emergency obstetric care;
(c) Mobilizing resources from both national sources and donors to support the achievement of MDG 5.

79. Strategy: Building strategic and multisectoral partnerships.

80. Key activities:

(a) Assisting in the functioning of the national multisectoral committee or other coordination mechanism and in the development of its terms of reference and biannual work plan, in which the respective roles and contributions of all partners are clearly delineated;
(b) Reinforcing partnerships to ensure the required technical and financial support to the national initiative, including joint programmes, in particular, with UNICEF, WHO and the World Bank at national and district levels, with a clear delineation of the roles and responsibilities of each partner.

81. Strategy: Strengthening the capacity of countries to develop and implement national plans to ensure quality maternal health care.

82. Key activities:

(a) Supporting countries in carrying out policy analyses and strengthening policy dialogue for developing national strategies for the integration of maternal health issues, as part of the basic essential SRH package, in national development instruments and sectoral frameworks, such as PRSs, UNDAFs and SWAps, and humanitarian response and recovery processes;
(b) Promoting decentralized approaches and the development of decentralized SRH plans adapted
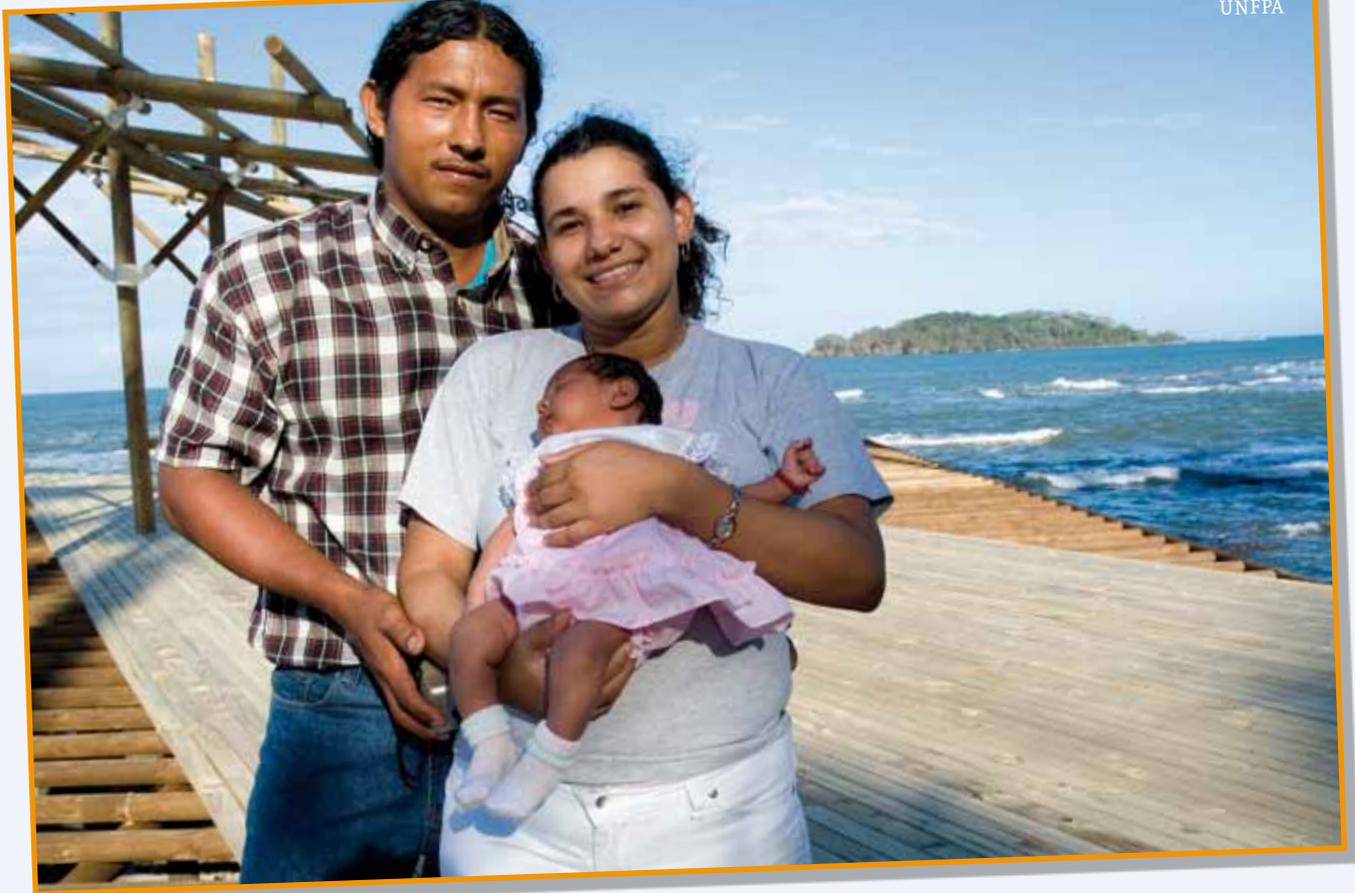
to local contexts; decentralized accountability; and ownership in planning, managing and monitoring maternal health care;

(c) Contributing to health-system strengthening and reform processes to enhance capacity to deliver maternal health care, including situation analyses; political mapping; national and sub-national planning; budgetary processes; implementation and management; costing; national and international resource mobilization; complementary financing (e.g., resource-pooling); human resource development and supervision; scaling up of universal coverage; and monitoring and evaluation;

(d) Strengthening the capacity for government and civil society to incorporate maternal health care in national emergency preparedness, response and recovery planning and implementation. This includes meeting needs in emergency, humanitarian and displacement situations through rapid assessments, and the distribution of emergency supplies and equipment, and the implementation of the Minimum Initial Service Package;

(e) Contributing to the dissemination and use of technical tools and guidelines for improving the availability, use and quality of maternal health services. This would include clinical standards and protocols for care during pregnancy, childbirth and the post-partum period, including the provision of family planning and integration with other SRH and HIV/STI-prevention services. As relevant, this will also include management of maternal morbidity such as obstetric fistula and perinatal depression;

(f) Enhancing capacity to support the provision of quality midwifery care within a supportive environment, linked to national human resources for health policies, including areas of recruitment, deployment and retention, regulatory and legislative protections, and training and supervision, among others. Effort is required to promote the involvement of national and regional health professional organizations;

(g) Supporting the strengthening of safety nets, including resource-pooling, to protect households from the financial consequences of accessing services;

(h) Supporting the strengthening of emergency referral systems including elements of transport and communication;

(i) Promoting greater participation of the private sector (private for profit and non-profit) in the provision of maternal health services.

83. Strategy: Empowering communities to demand and support access to quality maternal care.

84. Key activities:

(a) Within health-sector planning, collaborating with other health areas to develop mechanisms of health-sector accountability and strengthen the capacity of NGOs to participate in such processes;

(b) Enhancing the capacity of NGOs to improve the demand for maternal health care and mobilizing communities to support women in accessing essential and emergency obstetric care, including emergency funding and transport schemes;

(c) Developing and implementing strategic and innovative communications plans with partners to increase awareness of and demand for quality maternal health care.

c. Indicators proposed for outcome 2

85. The following are the indicators in the Strategic Plan for assessing outcome 2:

• Proportion of births attended by skilled health personnel.
• Caesarean sections as a proportion of all births.

Additional indicators to consider are as follows:

(a) To the extent possible, the proportion of births in health facilities and the proportion of births by Caesarean section among rural women, based on the best and most available data;

(b) Family planning included in protocols for provision of post-partum and post-abortion care.

3. OBJECTIVE OF OUTCOME 3

Outcome 3: Access to and utilization of quality voluntary family planning services by individuals and couples increased according to their reproductive intentions

a. Priorities

86. Unmet need will be addressed and complemented by demand creation with behaviour and social change communication (BSCC) and community mobilization. Emphasis will be placed on disadvantaged groups, such as poor people, youth (married and unmarried), refugees and internally displaced persons, and persons with disabilities and ethnic minorities, with consideration given to their special circumstances to improve access. Service provision for family planning must ensure availability of a broad range of methods that meet reproductive health needs and intentions. Family planning services also need to be integrated as part of relevant SRH services, including dual protection for STI and HIV prevention, post-partum care, post-abortion care, prevention of mother-to-child-transmission, services for women living with HIV, services for survivors of gender-based violence, services for women treated for maternal morbidity and services for adolescents and youth, and in humanitarian crisis settings.

87. Capacity development will focus on those cadres of service providers who deliver outreach services. Quality of care, including counselling for method selection and switching, is an important component of capacity development. Care will be taken to offer a wide range of safe and effective modern methods of contraception to enable individuals and couples to choose the method that best suits their perceived needs. There is a need to ensure a sufficient supply of commodities, currently a significant challenge. Commodity security needs to be ensured through a reliable logistics system within the health system as described previously. The existence of effective modern methods of contraception implies research and development, a long-term venture that needs investment to produce both male- and female-controlled new methods.

b. Strategies and key activities

88. UNFPA will focus on the urgent need to reposition family planning programmes as part of an array of comprehensive SRH services, including the reliable and consistent supply of reproductive health commodities. UNFPA will approach the challenges by examining barriers to the use of modern contraceptives, including emergency contraception, and by developing strategies contributing to greater access to a range of family planning commodities, as well as to the quality of services to facilitate informed choice for choosing a method and for continuing or switching the method. In addition, particular focus will be placed on settings of

humanitarian crisis, transition and recovery, which often have the least access to quality family planning services.

89. Strategy: Undertaking advocacy and policy support for quality family planning as part of SRH services.

90. Key activities:

(a) Promoting the development, strengthening and sustainability of family planning information and services, including commodities, with an emphasis on their preventive nature, including emergency contraceptives;

(b) Developing and supporting strategies (e.g. social marketing, community mobilization) to address the population access barriers by reducing out-of-pocket payments and by focusing on target groups;

(c) Promoting consistent and sustainable access to, and correct use of, male and female condoms;

(d) Building partnerships and advocating for research on new methods of contraception;

(e) Undertaking advocacy and partnerships with faith-based organizations, religious leaders and parliamentarians.

91. Strategy: Developing capacity within health systems, particularly among providers, for the provision of quality family planning services.

92. Key activities:

(a) Supporting technical assistance for including or updating family planning modules as part of the basic professional training of nurses, midwives and medical practitioners;

Don Hinrichsen/UNFPA
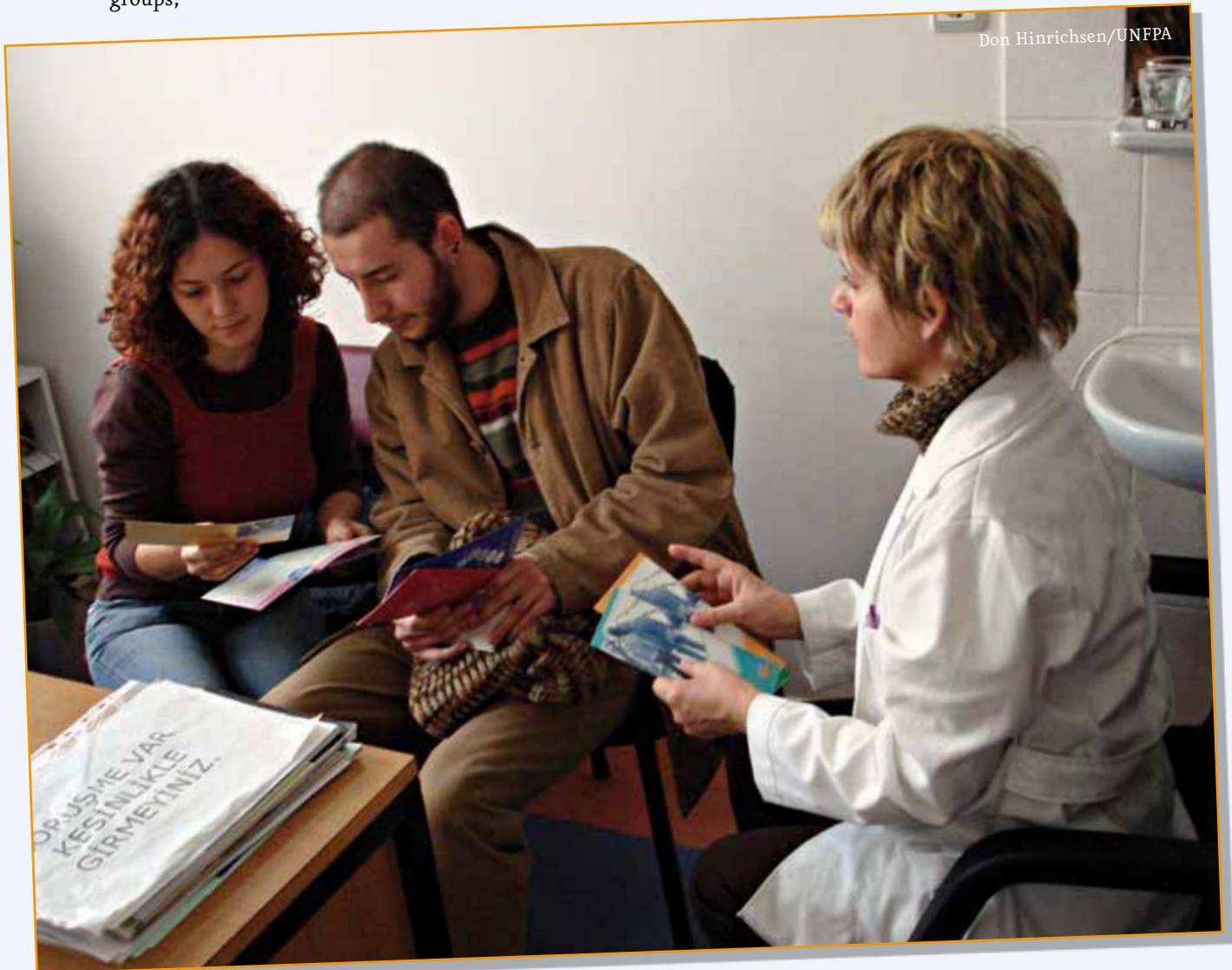
(b) Supporting capacity development for improved management of family planning information and services;

(c) Strengthening national systems for RHCS to ensure the availability of a comprehensive range of contraceptive methods, especially underutilized methods such as emergency contraception;

(d) Developing strategies for improved access for disadvantaged groups such as poor people, youth, single women and refugees and internally displaced persons through multiple settings such as clinics, health posts, workplaces, schools and colleges, camps, community outreach programmes and other community spaces, private-sector providers, pharmacists and other retail outlets;

(e) Supporting demand creation using strategic communications through the application of innovative communication strategies and audiovisual technology that is easily adaptable at the field level;

(f) Meeting needs in emergency, humanitarian and displacement situations through rapid assessments, the distribution of emergency supplies and equipment, training and capacity development, including the Minimum Initial Service Package.

93. Strategy: Integrating family planning within SRH services

94. Key activities:

(a) Establishing coordination mechanisms among SRH programme components, especially service provision for HIV-positive women, prevention and management of gender-based violence, and youth-friendly services;

(b) Applying the results of operations research for innovative approaches to service delivery.

c. Indicators proposed for outcome 3

95. The following are the indicators in the Strategic Plan for assessing outcome 3:

• Contraceptive prevalence rate-modern methods.
• Proportion of service delivery points (SDPs) offering at least 3 modern methods of contraception.
• Percentage of service delivery points (SDPs) offering at least 3 reproductive health services.

• Proportion of countries with family planning included in protocols for provision of post-partum and post-abortion care.

Additional indicators to consider are as follows:

(a) Disaggregate Contraceptive prevalence rate for modern methods by method, geographic location, age and socio-economic status);

(b) Post-partum family planning incorporated in national health policies;

(c) Post-abortion family planning incorporated in national health policies;

(d) RH commodities budgeted in national budget.

4. OBJECTIVE OF OUTCOME 4

Outcome 4: Demand, access to and utilization of quality HIV- and STI-prevention services, especially for women, young people and other vulnerable groups, including populations of humanitarian concern, increased

a. Priorities

96. The integration of SRH and HIV matters from the users' perspective because it provides a way for users to interact with the health system as a whole. In addition, the integration of SRH and HIV has the potential to reduce costs, increase effectiveness and better ensure sustainability.

97. UNAIDS has established four priority domains for the integration of SRH and HIV: learn HIV status and access services, promote safer and healthier sexual behaviour, optimize the connection between HIV and STI services and integrate HIV/AIDS with maternal and infant health services.

98. Programmatic linkages within SRH services include family planning, STI management and maternal care. These are effective entry points for addressing HIV/AIDS prevention, treatment and care. Potential areas for such integration include: information on HIV prevention; counselling on safer sexual behaviour and the provision of condoms to prevent HIV transmission before, during and after pregnancy; HIV voluntary and confidential counselling and testing (VCCT); prevention of
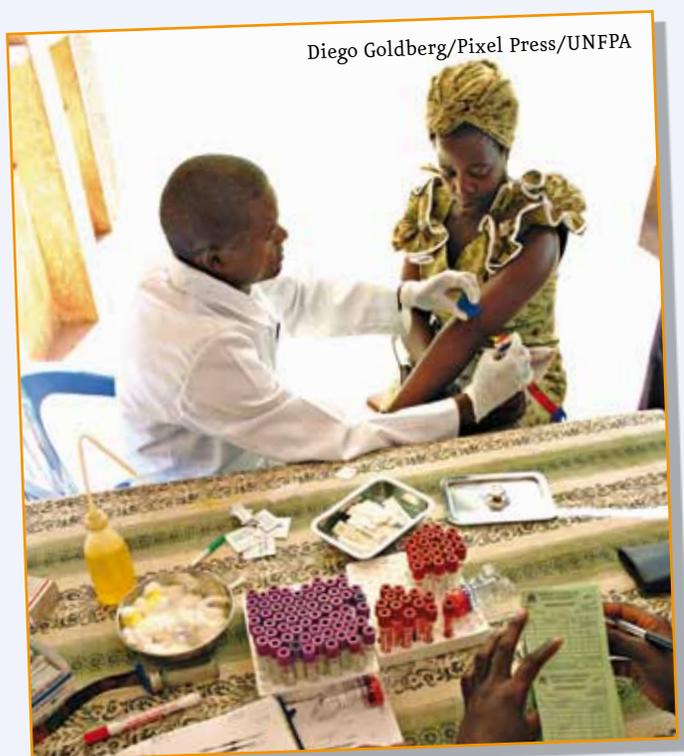
Diego Goldberg/Pixel Press/UNFPA

mother-to-child transmission of HIV; and safer delivery practices, including safe blood transfusion and antiretroviral provision. Antiretroviral treatment services and SRH services should also make cross-referrals, when needed, to ensure access to SRH services for people living with HIV/AIDS (PLWHA).

99. Integrating STI prevention, diagnosis and treatment is essential to the SRH package. STIs are often ineffectively diagnosed and treated by health practitioners, pharmacists, informal drug sellers and traditional healers. Various attempts have been made to reach women by integrating the management of STIs into existing maternal and child health and/or family planning services, with limited success. Nonetheless, experience shows that the integration of STI prevention into family planning services, especially through counselling on sexual health and partner relationships, has increased service utilization and improved the quality of care. These approaches can be improved to expand coverage and outreach to sex workers, men, youth and other groups not previously targeted through family planning. In addition, presumptive treatment in high-risk groups and comprehensive, community-based programmes to control STIs could greatly contribute to the reduction of HIV transmission rates.

100. STI-prevention strategies range from promoting condom usage to delaying the age at first sexual encounter and reducing the number of sexual contacts. Other strategies include periodic presumptive treatment (targeting at-risk populations); social marketing of condoms; user-friendly services for adolescents; and male involvement, male motivation and services for men. These strategies need to involve the private sector and NGOs and to include strong educational and information components. Barrier methods (male and female condoms) continue to be the best options to prevent STI transmission for those at risk. Ongoing research may identify effective microbicides to be used either on their own or in addition to condoms and diaphragms.

101. Behavior change continues to be a complex issue; given the social-economic and cultural context in which this behavior takes place. It is at the very heart of preventing STIs, including HIV. Despite cultural, social, political and religious barriers to comprehensive social behaviour change programmes, multisectoral approaches in various countries have met with success. Field research demonstrates the need to focus on specific populations, consult with them extensively and involve them in the design, implementation and evaluation of programme interventions.

102. Evidence collected worldwide confirms that quality education, including relevant content and life skills related to SRH, and better understanding of the socio-cultural determinants that oppose or facilitate SRH, is strongly predictive of better knowledge and awareness, safer behaviour and reduced risk and vulnerability to STIs and the HIV/AIDS epidemic, especially among girls and women. UNFPA will build on past experiences and comparative advantages in order to strengthen harmonized programming and implementation mechanisms, linking SRH and HIV/AIDS/STI issues. UNFPA will advance coordinated HIV/AIDS responses in both formal and non-formal education at the country level through the partnership strategies and mechanisms in the context of United Nations reform and the UNFPA strategic pan 2008-2011.

103. In addition, there is a need to constantly raise awareness and adapt and adjust national policies according to recent research findings in SRH, e.g., human papilloma virus (HPV) vaccines and internationally agreed strategies.

104. Mass displacements can result in the movement of people between high and low HIV prevalence areas and the breakdown of social networks and support mechanisms and hence increase risk of transmission. This is further exacerbated when rape and sexual abuse are used as weapons of war. Sexually transmitted infections are consequently among the most common illnesses in conflict and displacement settings, with armed forces engaging in the riskiest behaviours. All services indicated above must be made available in the context of emergency and/or humanitarian settings. UNFPA will expand its collaboration with the UN Department of Peace Keeping Operations, on comprehensive HIV prevention efforts among the armed forces.

b. Strategies and key activities

105. Strategy: Undertaking advocacy and policy dialogue for STI and HIV prevention and diagnosis and management of STIs.

106. Key activities:

   (a) Advocating for policy and programmatic linkages between SRH and HIV/AIDS;
   (b) Effectively leveraging available HIV/AIDS resources for SRH interventions that contribute to the prevention of HIV and the promotion of SRH;
   (c) Advocating for resource mobilization and the allocation of resources to address STIs and reproductive tract infections;
   (d) Promoting policies, laws and initiatives on STI management and prevention that support non-stigmatizing, culture- and gender-sensitive programmes and services;
   (e) Advocating for the full inclusion of population affected by emergencies or humanitarian crises, in national policies related to STIs and HIV/AIDS.

107. Strategy: Developing capacity within health systems, particularly among providers, for the provision of integrated SRH and HIV services, including quality STI prevention and treatment.

108. Key activities:

   (a) Providing technical assistance and support for scaling up integrated HIV-prevention programmes as part of the basic SRH package, including in humanitarian settings;

   (b) Supporting capacity development for providers in the prevention, screening and treatment of reproductive tract infections and STIs as part of SRH services, such as antenatal care and family planning;
   (c) Assessing and strengthening the availability of necessary drugs and supplies such as condoms, antibiotics and diagnostic tests for STI and HIV prevention and RTI and STI management, including MISP in humanitarian settings;
   (d) Participating in national efforts to enhance condom programming, including support for condoms as a dual method for family planning and STI/HIV prevention;
   (e) Strengthening the capacity of providers in the prevention, screening and early management of cervical cancer, including immunization and detection for HPV;
   (f) Developing approaches to ensure that priority target populations, such as adolescents, sex workers, refugees and PLWHA, have access to SRH and HIV-prevention information, counselling and services.

109. Strategy: Building the evidence base for HIV and STI prevention and treatment.

110. Key activities:

   (a) Supporting operations research on implementing programmatic linkages between SRH and HIV;
   (b) Building partnerships to advance research on simple STI diagnostics.

c. Indicators proposed for outcome 4

111. The following are the indicators in the Strategic Plan for assessing outcome 4:

   • Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.
   • Condom use at last high risk sex.
   • Percentage of most-at-risk populations reached with HIV prevention programmes.

Additional indicators to consider are as follows:

   (a) Disaggregate proportion of 15-24-year-old population with knowledge of HIV by age and sex)

(b) Percentage of HIV positive pregnant women who received anti retrovirals to reduce the risk of mother-to-child transmission.

Outcome 5: Access of young people to SRH, HIV- and gender-based violence prevention services, and gender-sensitive life skills-based sexual and reproductive health education improved as part of a holistic multisectoral approach to young people's development.

a. Priorities

112. As per the Framework for Action on Adolescents and Youth, support is needed for the development and costing of an essential package of health/reproductive health and other social services, including the prevention of HIV/STIs and gender-based violence, on a fair-share basis so that the poor and the vulnerable are covered. Because several agencies and organizations are supporting components of the package of services, coordination on young people's issues is of utmost importance. Partners should advocate for the package of social and health services for young people to be included in PRSs, SWAps and other national and sub-national development and humanitarian frameworks.

113. In addition, UNFPA will support gender-sensitive life skills-based SRH education for those in and out of schools. The education programme will enable adolescents to develop their identities, values and critical thinking skills and to exercise their rights, including reproductive rights. It will also include ways to ensure equal treatment of girls and boys in school, providing conflict resolution and negotiation skills as well as assertiveness skills. Promotion of strategic communication activities on the role of boys and young men with regard to girls' vulnerability, gender-based violence and HIV prevention will receive special attention. Specific interventions aimed at young men in the army and other defined structures have shown high impact in improving safe sex behaviour among these men and potential increased understanding and respect

of women and girls choices. UNFPA will continue to contribute to enhancing the quality of education through advocacy and policy dialogue, curricular development and teacher training, with a focus on reproductive rights and sexual and reproductive health.

114. For out-of-school young people, UNFPA will take a leadership role in programming for adolescents, with priority for young girls, and, in particular, adolescents at risk of early marriage and pregnancy, working adolescents, young couples and very young adolescents. Youth participation and support for youth leadership, youth-adult partnerships and intergenerational dialogue will receive special attention. Humanitarian, conflicts and natural disasters exacerbate the risk for vulnerability and violence and require special attention.

b. Strategies and key activities

115. Emphasis will be placed on the greater availability of youth-friendly SRH information and services, through schools, pharmacies and outreach activities in the health sector as well as through NGOs and community-based organizations for social services. Youth advisory committees and other youth-to-adult mechanisms should be established for advocacy, policy dialogue and programme development and management. Advocacy will include continued education, vocational and economic opportunities, and empowerment programmes, especially for girls.

116. Special attention will be paid to the needs of adolescents who are either living in poverty, are married or are disadvantaged or marginalized. Girls who are marginalized (e.g., by exclusion from schools, residence in poor or indigenous communities, subject to child labour, child marriage and other harmful traditional practices) are vulnerable in many ways. For example, they are more likely to marry at an early age; and, as first-time mothers, they also bear the highest risks of maternal mortality and morbidity. Marginalized girls are not being reached by conventionally defined services, benefits and entitlements, so are adolescents in humanitarian settings.

117. UNFPA will focus on four key areas: supportive policy environment; life skills-based education, including sexual health and relationships; health service provision; and finally, leadership and participation.

118. Strategy: Undertaking advocacy for a supportive policy environment.

119. Key activities:

(a) Promoting the integration of issues affecting young people in public policies, including the incorporation of such issues in MDG-based national development strategies and emergency preparedness, response and recovery;

(b) Promoting youth-adult partnerships, intergenerational dialogue and youth participation in the programming, monitoring and evaluation of SRH programmes;

(c) Building the evidence for investing in young people by examining population structure and poverty dynamics;

(d) Continuing to provide evidence for the need to ensure quality, equity in access and gender equality in education in the context of PRSs, SWAps, education reforms and youth policies;

(e) Using policy discussions to: encourage research on reproductive health issues of youth for social development and humanitarian response policies and poverty-reduction plans; analyse population structures and advocate for making social investments in young people utilizing the "demographic bonus" argument; and undertake poverty diagnostics to map vulnerabilities of young people based on the understanding that young people are not a homogeneous group.

120. Strategy: Strengthening education and health sectors to provide life skills-based education, including sexual health and relationships.

121. Key activities:

(a) Providing technical assistance for the incorporation of comprehensive gender sensitive life-skills based SRH education in schools and out-of-school education programmes;

(b) Pursuing proactively policy discussions, dialogue and advocacy on quality improvement in the education system and retention of girls in schools;

(c) In translating SRH messages, using gender-sensitive approaches, with a focus on the equal treatment of girls, and skills-oriented approaches, with a focus on critical thinking and negotiation skills, including conflict resolution;

(d) Taking a leadership role in out-of-school education programmes through innovative

approaches, including multipurpose segmented peer education and social change communication strategies, through linkages with other sectors and partners;

(e) Linking gender sensitive life-skills based SRH education programmes in schools and communities with other supportive programmes, such as mass media; social marketing; information, communication, technology (ICT)-based programmes; youth-friendly services; and legal and social support services.

122. Strategy: Strengthening the capacity of health systems, particularly providers, to offer appropriate SRH services for young people.

123. Key activities:

(a) Defining an essential package of services for young people within the basic SRH package, rather than within isolated projects;

(b) Developing strategies to enable access of young people who are out of reach of existing programmes, in particular young girls, both married and unmarried, and marginalized girls;

(c) For SRH services, providing technical assistance to implement a core essential package of contraception, STI prevention and treatment, prevention of HIV and gender-based violence, and maternal health services, when appropriate, including humanitarian settings;

(d) Assisting in establishing mechanisms to combine service delivery through health facilities with multiple channels, such as schools, pharmacies, social marketing, community outreach, and strong referrals, and ensuring that health-care providers are non-judgemental and empathic;

(e) Facilitating the development of plans for linking health facilities with schools and outreach activities in communities.

124. Strategy: Enabling young people's leadership and participation.

125. Key activities:

(a) Identifying institutional mechanisms for incorporating young people's input into policy and programming processes, including planning, implementation, monitoring and evaluation, and ensuring the rights of young people to participate in partnerships with adults;

(b) Investing in capacity development and leadership skills of young people for making them advocates of their own rights and development issues;

(c) Promoting peer educators as multifaceted agents, segmented by age and sex, for communicating gender sensitive life-skills based SRH education, linking peers with services and allying with young people's networks and coalitions;

(d) Tapping into the dynamism of youth movements and their communication networks for advocacy and action on issues of concern, such as HIV/AIDS/STIs, sexual and gender-based violence and age at marriage.

c. Indicators proposed for outcome 5

126.   The following are among the indicators in the Strategic Plan for assessing outcome 5:

• Proportion of countries that offer an essential service package for young people including marginalized and excluded groups
• Proportion of countries with secondary school curricula including gender sensitive, life skills based SRH/HIV prevention

Additional indicators to consider are as follows:

(a) Adolescent fertility rate.

C. COORDINATION WITH POPULATION AND DEVELOPMENT AND GENDER, HUMAN RIGHTS AND CULTURE FRAMEWORKS

127.   There are many synergies among UNFPA efforts on SRH and its other two main fields – population and development and gender. Programme work should be multisectoral and multidisciplinary, with results in one programme area influencing or contributing to the achievement of results in the others. For example, promoting gender equality enables women to have more decision-making power and, thus, better access to SRH information and services and better protection from reproductive ill health. Understanding the socio-cultural factors will better facilitate services that allow women and girls to exercise their right to reproductive health. The availability of data on migration patterns allows for better planning to meet SRH needs. Preventing unwanted pregnancy, STIs and HIV in young girls increases their educational opportunities, their subsequent participation in development

and, ultimately, gender equity and equality. The availability of reproductive health commodities empowers women to protect themselves against, for example, HIV infection.

1. POPULATION AND DEVELOPMENT

128.   Population and development provides the fundamental rationale for the Fund's work in the field of SRH, population and gender. It demonstrates the mutually reinforcing links between these three areas, and provides the evidence for why investing in meeting the ICPD goals is a prerequisite for the achievement of the MDGs and the ultimate goal of poverty eradication. Areas in which SRH and population and development intersect include the following:

(a) Support for the collection of data, especially according to poverty levels, to enable countries to monitor and report on their progress towards the achievement of national development plans, the ICPD goals, the MDGs and other indicators of SRH;

(b) Partnerships for the development of population, health and gender databases and integrated management information systems to inform the development, implementation, monitoring and evaluation of national policies and programmes in these areas;

(c) Rapid assessments in humanitarian crises to provide the necessary data to meet the SRH needs of refugees and internally displaced persons;

(d) In post-conflict countries and those in transition, where the capacity for demographic surveys and analysis is seriously and structurally disrupted, individual and institutional capacity development in population studies and demographic surveys to inform short- to medium-term plans;

(e) Demographic and sociocultural research and analysis, particularly studies demonstrating the impact or informing the design of SRH policies, strategies or programmes;

(f) Research and analysis to provide evidence linking the achievement of the ICPD goals to the achievement of the MDGs and linking the contribution of the Fund's work in SRH to the eradication of poverty.

Diego Goldberg/
Pixel Press/UNFPA

2. GENDER

129. Gender inequality and discrimination are at the root of why so many women and adolescent girls are still unable to exercise one of the most crucial human rights for their empowerment and quality of life: their reproductive rights. Gender stereotypes and roles are also why so many adolescent boys and men remain on the fringes of SRH policies and programmes, despite their key role in this realm.

130. Gender-related barriers to reproductive health and rights operate at various levels. These factors range from lower literacy rates and educational levels of women; limited access to information about prevention or about legal entitlements to services; limited power and resources to negotiate family planning and condom use or use of services; mistrust of health-care providers and delays in seeking help because of disrespectful or judgemental treatment; the low value placed on a woman's life, from the highest levels of policymaking to the community and household levels. Addressing these issues through the gender framework will increase the ability of women to access and use SRH information and services.

131. Other barriers, including gender-based violence and the inability of women to negotiate condom use or other contraceptives in abusive relations, in or outside marriage; the links between sexual violence and HIV, especially among young women in high prevalence countries; and violence during pregnancy – all have repercussions for the health of women. These are all addressed in terms of policy and advocacy in the gender framework. At the same time, the SRH framework provides the opportunity for integrating screening and referrals for women who have been subjected to gender-based violence. Areas where SRH and gender intersect include the following:

(a) Capacity development, including building a knowledge base, for gender mainstreaming into population, development and SRH policies and programmes, PRSs and MDGs, and for gender auditing and budgeting;

(b) Establishment of and/or support for multisectoral mechanisms at the community level to prevent and manage gender-based violence, and linkage of these to the provision of SRH information and services including focusing on mental health as an integral aspect of SRH;

(c) Advocacy to strengthen public awareness of the importance of reproductive rights within a broad-based rights approach to human development;

(d) Advocacy to enrol and maintain girls in school and to access non-discriminatory schooling to ensure long-term success in improving SRH;

(e) Advocacy, mobilization and constructive engagement of men and boys on their critical role as allies in advancing women's rights and gender equality;

(f) Implementation of Resolution 1325 on Women, Peace and Security.

D. MONITORING, EVALUATION AND REPORTING

132. Monitoring, evaluation and reporting are the foundation of the Fund's accountability. It is crucial to ensure with measurable indicators that interventions have the desired effects on process, outputs and outcomes. For the many of the outcome indicators in the Strategic Plan, baselines will need to be established as well as clear plans for continued monitoring of these indicators. In addition, UNFPA and WHO have collaborated to develop a succinct list of indicators that can be utilized to monitor national SRH programmes which may provide additional support to enhance monitoring of output level indicators. Sufficient resources should be allocated for these activities that are often neglected. At the same time, data collection and reporting should not become a burden for service providers. Insofar as possible, data should be obtained from routine sources, provided they are reviewed for optimal performance. Simplification, relevance and reliability are the key words for data collection, with a constant view towards the utilization of these data for identifying gaps and changing procedures or approaches to service delivery.

133. UNFPA is a strong supporter of population-based surveys, allowing a comprehensive analysis of coverage as well as impact. Population-based surveys should always be organized in a way that allows a wide range of distribution variables, such as age, sex, geographic location, and socio-economic status (wealth quintiles). Whenever possible, disaggregated data should be collected based on these distribution variables. Population-based surveys should be performed at regular intervals and with consistent methodologies, so that trends can be identified and analysed. Finally, despite inherent difficulties, the use of new methods of measurement of maternal mortality developed by demographers is now recommended, either by refining the sampling during surveys or by taking advantage of population censuses.

134. The adoption of an additional MDG 5 target on universal access to reproductive health means that more efforts will need to be directed towards obtaining data on reproductive health. The close relationship between different targets of the health MDGs imply that reproductive health indicators can apply to multiple targets and reinforces the universal relevance of SRH programmes. The new guidance on indicators from UNFPA and WHO mentioned above should provide an important additional resource for monitoring progress towards SRH outcomes.

135. The key monitoring tools are those of the strategic plan, including the annual reports of all organizational units and the balanced scorecard, which will track progress in achieving management results initially, with possible expansion to the programme results at all levels at more advanced stages of its implementation. The collected information will be analysed annually, shared with all UNFPA staff and reviewed by the Executive Committee and regional offices. A baseline will be established on the results of the 2007 annual reports and scorecard results. The end-line will be tracked in the 2011 annual reports and the scorecard results, which will be available in the first quarter of 2012.

E. ORGANIZATIONAL ARRANGEMENTS TO IMPLEMENT THE FRAMEWORK

1. RESULTS-BASED MANAGEMENT

136. At regional and country levels, UNFPA will focus on improving the quality and effectiveness of programming towards the national development priorities within the programme's core areas and in the country contexts emerging under the new development aid architecture. It will manage for these priorities through country programmes, which will define its contribution to UNDAFs. Regional programmes will support and complement country programmes by mobilizing the potential of United Nations reform, including resources available through Regional director teams (RDTs) and United Nations country teams (UNCTs). UNFPA will provide technical support to national capacity development, build partnerships with regional institutions and policymakers, utilize regional centres of excellence for technical assistance on programme content and promote South-South cooperation. It will continue actively to engage in joint programmes with other United Nations organizations and agencies present in the field to address issues best approached by concerted United Nations action.

137. Since the foundation of UNFPA work accountability is at all levels of the management structure, the strategic plan defines clear and measurable results-based indicators with baselines and annual targets. It will track and measure progress through a rigorous monitoring and evaluation system, including regular monitoring, reviews, outcome and thematic evaluations, research and assessments, where feasible.

2. DEVEOPMENT OF STAFF CAPACITY

138. The Fund's ability to be effective and efficient in achieving results and implementing its mandate depends heavily on the dedication and professionalism of its staff. At global and regional levels, UNFPA efforts will concentrate on the full implementation of its human resource development strategy. At the country level, along with the progressive introduction of joint offices and common country programming, UNFPA will promote active involvement of national professional staff in UNCTs activities and will seek UNDG support in this effort. Attention will be paid to attracting and retaining the best available professionals and technical support personnel who meet staff competency requirements and to providing learning, career and professional growth opportunities. Such opportunities would include attachments, detail assignments to other country offices and headquarters, and involvement in joint technical missions, along with increasing access to international career opportunities within UNFPA and the wider United Nations system.

3. PARTNERSHIPS AND UNITED NATIONS COORDINATION

139. For UNFPA, being a strategic partner means working together towards common national results, based on the unique abilities, comparative advantages and clear division of responsibilities among the partners. UNFPA will continue to diversify its partnerships and will engage, facilitate and broker bilateral and multilateral partnerships with governments, parliamentarians, civil society organizations, religious and faith-based groups, intergovernmental organizations, United Nations system partners, academia and research partners, and the media, as well as non-traditional partners such as the private sector. Strategic partnerships for UNFPA are critical for coordinating and leveraging the necessary support to advance the

Diego Goldberg/Pixel Press/UNFPA

implementation of national, regional and global priorities in line with the ICPD agenda.

140. At the global level, UNFPA will maintain and expand its partnerships with governments, pertinent global centres of excellence, United Nations system initiatives, intergovernmental and global organizations, including civil society. Through stronger advocacy and more effective external and internal communication, UNFPA will make concerted efforts to improve its image as a reliable and trusted partner in the development field.

141. UNFPA is actively engaged in initiatives, as indicated earlier, that aim to accelerate and support action towards the attainment of the health MDGs, including initiatives around health systems strengthening. This includes the Global Campaign for the Health MDGs, the H8 group of the global health agencies, and initiatives such as the International Health Partnership Plus (IHP+). It also includes partnerships focused on MDGs 4 and 5, such as the H4, and the Partnership for Maternal, Newborn and Child Health and associated Deliver Now Campaign as well as increased coordination within the UN on maternal and newborn health. Other essential partnerships include the RH Supplies Coalition, the Global Health Workforce Alliance and the Inter-Agency Standing Committee on Humanitarian Affairs.

142. In terms of United Nations partnerships, UNFPA will intensify its work towards implementing the agreed principles of One Leader – the United Nations Resident Coordinator, who is accountable to participating United Nations agencies; One Team, with operational capacity and technical expertise to deliver effective and efficient support; One Programme, to serve as a framework for common

United Nations assistance to implementing the national development agenda; and one budgetary framework for all programme resources available through United Nations organizations.

143. UNFPA will continue its participation in and contributions to global mechanisms created for scaling up the joint response of United Nations organizations and other partners to the HIV/AIDS epidemic, through EDUCAIDS, the UNAIDS Inter-Agency Task Team on Education, the Inter-Agency Task Team on Young People, the Global Coalition on Women and AIDS, the Global Youth Coalition on HIV/AIDS and the Youth Initiative on HIV & AIDS. To advance the integration of reproductive rights issues, UNFPA will strengthen its participation in human rights education initiatives jointly with the United Nations Office of the High Commissioner for Human Rights, the United Nations Educational, Scientific and Cultural Organization (UNESCO), UNAIDS, UNICEF and the International Labour Organization (for vocational education) and other partners.

4. ORGANIZATIONAL STRUCTURE

144. To make UNFPA more effective within the context of United Nations reform and the new aid environment, UNFPA, over the past five years, has focused on strengthening country offices. The process began with the field needs assessments, which formed the basis for strategic directions. Subsequent steps have included providing learning and training opportunities, arranging redeployments, relaxing overly bureaucratic procedures, increasing the number of posts at the country level, upgrading posts and raising spending ceilings in order to encourage innovation and the Fund's ability to take advantage of opportunities as they arise, while at the same time ensuring accountability.

145. UNFPA has embarked on restructuring to provide country offices with timely and quality assistance. The restructuring entails integrating the programmatic and technical functions in the geographic divisions, increasing the capacities of these divisions and bringing them closer to country offices. This will strengthen the capacity of country offices and the ability of countries to achieve their development goals.

END NOTES

1   United Nations. Programme of Action. Adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994. New York, 1994, paragraph 7.12.

2   UNFPA. Investing in People. *National Progress in Implementing the ICPD Programme of Action 1994-2004.* New York,UNFPA, 2004.

3   UNESCO. *Education for All Monitoring Report 2007, Strong Foundations.* Paris, 2007. http://www.ungei.org/infobycountry/files/unesco_gmr07_full_report.pdf?bcsi_scan_A8AA4F79F19141A2=0&bcsi_scan_filename=unesco_gmr07_full_report.pdf

4   http://www.un.org/esa/population/publications/worldfertility/Executive_Summary.pdf. Accessed Nov 2, 2007.

5   UNFPA. *State of World Population 2005. The Promise of Equality, Gender Equity, Reproductive Health and the Millennium Development Goals.* New York, UNFPA, 2005.

6   Sedgh, G., Henshaw, S., Singh, S., Ahman, E., Shah, I. "Induced Abortion: estimated trends rates and trends worldwide". In The Lancet, Vol. 370, No 9595 (2007), pp 1338-1345.

7   UNFPA, *State of World Population 2005.*

8   UNDP. *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals.* Bernstein, Millennium Project, 2006.

9   UNFPA, 2005. *State of World Population 2005.*

10   UNFPA and the UN Population Division. 2008.

11   UNAIDS and WHO. AIDS epidemic update. December 2007

12   Glasier, A., Gulmezoglu, A.M., Schmid, G.P., Moreno, C.G., Van Look, P.F. Sexual and reproductive health: a matter of life and death. In The Lancet, Vol. 368, No. 9547 (2007), pp 1595-1607.

13   Drain, P.K., Holmes, K.K., Hughes, J.P., Koutsky, "Determinants of cervical cancer rates in developing Countries. In *International Journal of Cancer*, (2002 Jul 10), 100 (2): 199-205.

14   WHO, UNICEF, UNFPA, World Bank. *Maternal Mortality in 2005.* WHO 2007.

15   Hill, K., Thomas, K., AbouZahr, C., Walker, N., Say, L., Inoue, M., Suzuki, E., on behalf of the Maternal Mortality Working Group. "Estimates of maternal mortality worldwide between 1990 and 2005: an assessment of available data". In *The Lancet*, Vol. 370, No 9595 (2007), pp 1301-1319.

16   UNFPA. *UNFPA Framework for Action on Adolescents and Youth. Opening Doors with Young People: 4 Keys.* New York, UNFPA, 2007.

17   UNFPA. *State of World Population 2005.*

18   UNFPA. Policy for UNFPA Emergency Preparedness, Humanitarian Response and Support for Transition/Recovery. UNFPA, PPM, 2006.

19   WHO. *The World Health Report 2005: Make Every Mother and Child Count.* 2005

20   Van Lerberghe W., De Brouwere V. Of blind alleys and things that have worked: history's lessons on reducing maternal mortality. In: De Brouwere V, Van Lerberghe W, eds. Safe motherhood strategies: a review of the evidence. *Studies in Health Services Organization and Policy*, 17:7–33. Antwerp, ITG Press, 2001.

21   Pathmanathan I, Liljestrand J, Martins JM, Rajapaksa LC, Lissner C, de Silva A et al. Investing in maternal health: learning from Malaysia and Sri Lanka. Washington, DC, World Bank, 2003.

ACKNOWLEDGMENTS

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