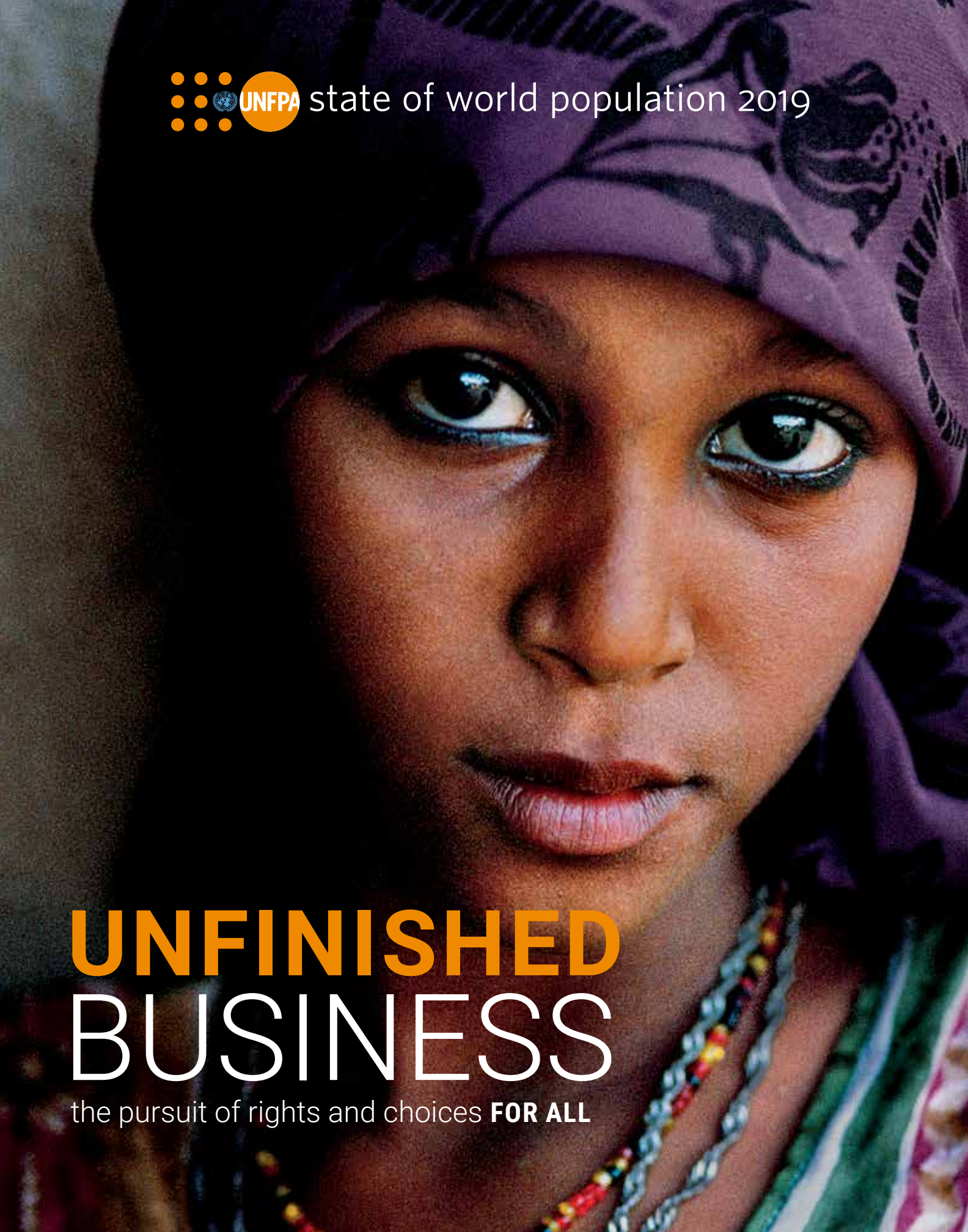
UNFPA state of world population 2019
UNFINISHED
BUSINESS
the pursuit of rights and choices FOR ALL

State of World Population 2019

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EDITOR-IN-CHIEF
Arthur Erken, Director, Division of Communications and Strategic Partnerships

EDITORIAL TEAM
Editor: Richard Kollodge
Editorial associate: Katie Madonia
Digital edition manager: Katie Madonia
Digital edition advisers: Hanno Ranck, Katheline Ruiz
Publication and web design: Prographics, Inc.

RESEARCH ADVISER AND WRITER
Stan Bernstein

UNFPA TECHNICAL ADVISERS
Elizabeth Benomar
Daniel Schensul

LEAD RESEARCHER AND WRITER
Kathleen Mogelgaard

CHAPTER RESEARCHERS AND WRITERS
Jeffrey Edmeades
Gretchen Luchsinger
William A. Ryan
Ann M. Starrs

FEATURE WRITERS
Janet Jensen
Gretchen Luchsinger

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Tefta Shakaj, ALBANIA
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Tsitsina Xavante, BRAZIL
Say Yang, CAMBODIA
Dahab Elsayed and Um Ahmed, EGYPT
Alma Odette Chacón, GUATEMALA
Marta Paula Sanca, GUINEA-BISSAU
Fanie Derismé, HAITI
Rajeshwari Mahalingam, INDIA
Shara Ranasinghe, SRI LANKA
Rasamee, THAILAND
Josephine Kasya, UGANDA

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UNFPA

Ensuring rights and choices for all **since 1969**

UNFPA state of world population 2019

UNFINISHED BUSINESS

the pursuit of rights and choices **FOR ALL**

UNFPA state of world population 2019

Remarkable gains have been made in sexual and reproductive health and rights since 1969, when UNFPA was established. But despite progress, hundreds of millions of women today still face economic, social, institutional and other barriers that prevent them from making their own decisions about whether, when, how often and with whom to become pregnant.

The pursuit of rights and choices is an ongoing one, with new challenges emerging all the time.

Make rights and choices a reality for all

It was 1969. World population reached 3.6 billion, up about 1 billion from only 17 years earlier. Fertility rates worldwide then were about double what they are today. In the least developed countries, fertility was about six births per woman.

Paul Ehrlich's *The Population Bomb,* released the year before, had incited a global panic about "overpopulation," which the author predicted would lead to mass starvation on a "dying planet."

It was in that context that UNFPA was established to advise developing countries about the social and economic implications of population growth and to support national population programmes, which began dispensing contraceptives on an unprecedented scale.

Through these programmes, real reproductive choices became a reality for more and more women in developing countries. And as a result, women started having fewer children. Millions were finally gaining the power to control their own fertility.

Despite the increasing *availability* of contraceptives over the years, hundreds of millions of women today still have no access to them—and to the reproductive choices that come with them. Without *access,* they lack the power to make decisions about their own bodies, including whether or when to become pregnant.

The lack of this power—which influences so many other facets of life, from education to income to safety—leaves women unable to shape their own futures.

Since its creation in 1969, UNFPA has led a multilateral effort to help women in developing countries navigate through an ever-changing landscape of barriers to their reproductive rights. This effort gained new momentum and inspiration in 1994, when 179 governments gathered in Cairo for the International Conference on Population and Development and forged a plan for sustainable development grounded in individual rights and choices and the achievement of sexual and reproductive health for all. That plan, embodied in a Programme of Action, not only re-energized the global reproductive rights movement but also positioned UNFPA as the movement's custodian.

The combined actions of civil society, governments, development institutions and UNFPA over the past 50 years have unlocked opportunities and possibilities for women and girls across the globe. Yet, we still have a long way to go before all women and girls have the power and the means to govern their own bodies and make informed decisions about their sexual and reproductive health.

At the same time, we must push back against forces that would see us return to a time when women had little say in reproductive decisions or, for that matter, in any area of their lives.

The fight for rights and choices must continue until they are a reality for all.

Dr. Natalia Kanem
United Nations Under-Secretary-General
and Executive Director of UNFPA,
the United Nations Population Fund

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THE STRUGGLE FOR **RIGHTS AND CHOICES** IS AN ONGOING ONE

The year 2019 marks two important milestones in the field of reproductive health: 50 years since UNFPA began operations, and 25 years since the landmark International Conference on Population and Development (ICPD) in Cairo.

These two events—the launch of the first United Nations agency dedicated to addressing population growth and the reproductive health needs of the world's people, and the declaration of a global commitment to sexual and reproductive health and reproductive rights—have fundamentally shaped the lives of women and families, and the societies in which they live, in ways measurable and immeasurable, profound and trivial, permanent and fleeting.

Activists, advocates, public health specialists and many others have pushed relentlessly for the transformations we see around us today, but much remains to be done.

What the future holds in terms of changes in population growth, contraceptive use and sexual and reproductive health and rights will both determine and be determined by the ability of women and girls to achieve their full potential as members of their societies. And this will be determined, in no small part, by

how the world takes forward the achievements and addresses the shortfalls of the ICPD to date.

The world in 1969

Fifty years ago around the world, the average woman had 4.9 children, and 35 per cent of married women were using some form of contraceptive method to delay or prevent pregnancy; in the least developed countries, however, the average woman had 6.7 children, and about 2 per cent were using a method of contraception. Abortion was illegal in much of the world, and the women's liberation movement was fighting for equality in access to education, employment opportunities and pay, marriage and divorce, property ownership, and on a range of other fronts. In 1969, the Stonewall Riots in New York

1969 to 2019

UN MILESTONES and World events

RAFAEL SALAS NAMED UNFPA EXECUTIVE DIRECTOR

THE UNITED NATIONS FUND FOR POPULATION ACTIVITIES STARTS OPERATIONS

Nuclear Non-Proliferation Treaty goes into force

GENERAL ASSEMBLY DESIGNATES UNFPA AS LEAD IN POPULATION PROGRAMMES

1969

The Stonewall riots in New York City mark the start of the modern gay rights movement in the United States

First message sent through ARPANET, a precursor to the Internet

Neil Armstrong takes his historic first steps on the Moon

Biologist Robert Geoffrey Edwards reports having fertilized human oocytes in a Petri dish for the first time

USAID Office of Population established

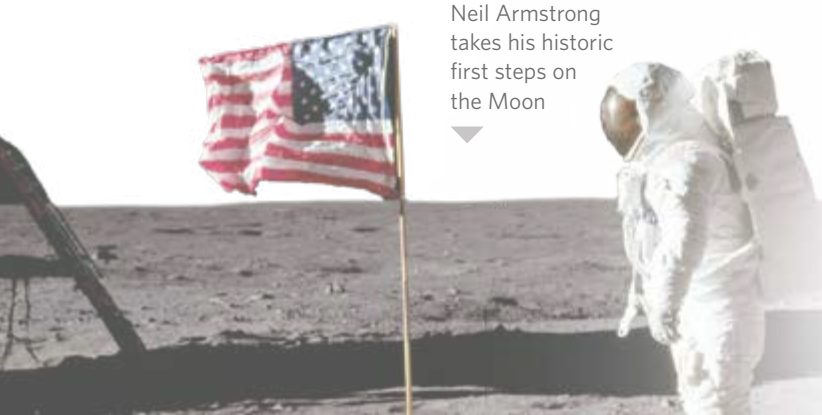
1970

Population Council establishes the International Committee for Contraception Research

1971

Dalkon Shield IUD goes on the market

Sierra Leone becomes a republic



City marked the start of the global gay rights movement; the United States Agency for International Development established an Office of Population; and Ghana adopted its policy for Population Planning for National Progress and Prosperity. A year earlier, at the first United Nations International Conference on Human Rights, in Tehran, delegates had affirmed, for the first time in a global declaration, the basic right of parents "to determine freely and responsibly the number and the spacing of their children" (United Nations, 1968).

By 1969, as a result of public health interventions that were reducing infant and child mortality and prolonging life expectancy, birth rates had outstripped mortality rates in much of the developing world. Concerns that the resulting population

1972

The United States and Soviet Union join 70 other nations in signing an agreement to ban biological warfare

Club of Rome releases *Limits to Growth*

THE UNITED NATIONS PROCLAIMS 10 DECEMBER INTERNATIONAL HUMAN RIGHTS DAY

1973

The bridge in Istanbul that crosses the Bosphorus is completed, connecting the continents of Europe and Asia

The American Psychiatric Association removes homosexuality from its DSM-II

Abortion legalized in the United States

1974

WORLD POPULATION CONFERENCE, BUCHAREST

WORLD POPULATION 4 BILLION

India successfully conducts an underground nuclear test

1975

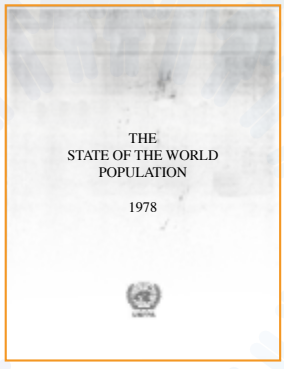
UNITED NATIONS DECLARES OPENING OF DECADE FOR WOMEN

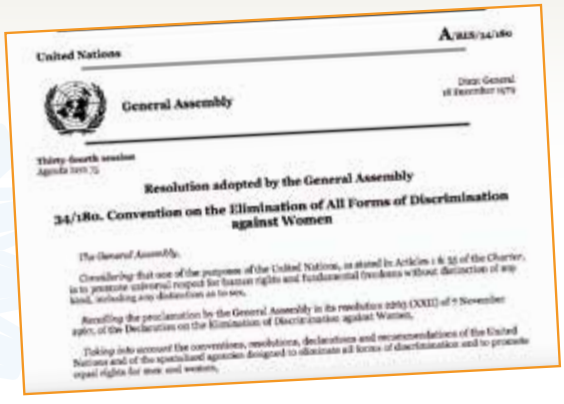
Mozambique and Suriname become independent

Scientist Andrei Sakharov, creator of Soviet Union's hydrogen bomb, is awarded Nobel Peace Prize

growth could harm economic progress and the environment contributed to the desire to better understand and manage human fertility. The establishment of the United Nations Fund for Population Activities, renamed the United Nations Population Fund in 1987, reflected a growing interest in understanding how population dynamics affected social and economic development, and a desire on the part of the United Nations to support action programmes aimed at stabilizing the world's population.

The expanding availability of relatively new and effective contraceptive methods during the 1960s was transformational for women, offering them, for the first time, the ability to reliably prevent unintended pregnancy and new choices in controlling their reproductive





First known outbreak of Ebola virus

1976

UNFPA ISSUES FIRST STATE OF WORLD POPULATION REPORT

1977

Egyptian President Anwar Sadat makes an official visit to Israel

1978

First test tube baby born

THE CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN (CEDAW) IS ADOPTED

1979

First International Year of the Child

lives. But the implications of contraception and fertility regulation for the health, well-being and economic and social lives of individual women and girls were only beginning to be understood. A fuller realization of what they would mean was still to come.

The world in 1994

Twenty-five years ago, when the ICPD was held in Cairo, the average global fertility rate was about three births per woman, and 58.8 per cent of women worldwide were using contraception; in the least developed countries, fertility was about 5.6 children, and 20.2 per cent of married women were using contraception. South Africa held its first multiracial elections and elected Nelson Mandela as President; the Rwandan genocide resulted in the deaths of more than 800,000 men, women and children; civil

UNITED NATIONS ESTABLISHES POPULATION AWARD

Sally Ride becomes the first woman in space aboard Space Shuttle Challenger

1980

Global eradication of smallpox certified by the World Health Organization

1981

Sandra Day O'Connor takes her seat as the first female justice of the US Supreme Court

China's population tops 1 billion

IBM puts its first personal computer on the market, launching operating systems by Microsoft

1982

Doctors perform the first implant of a permanent artificial heart designed by Robert Jarvik

Time magazine's Man of the Year is given for the first time to a non-human, the computer

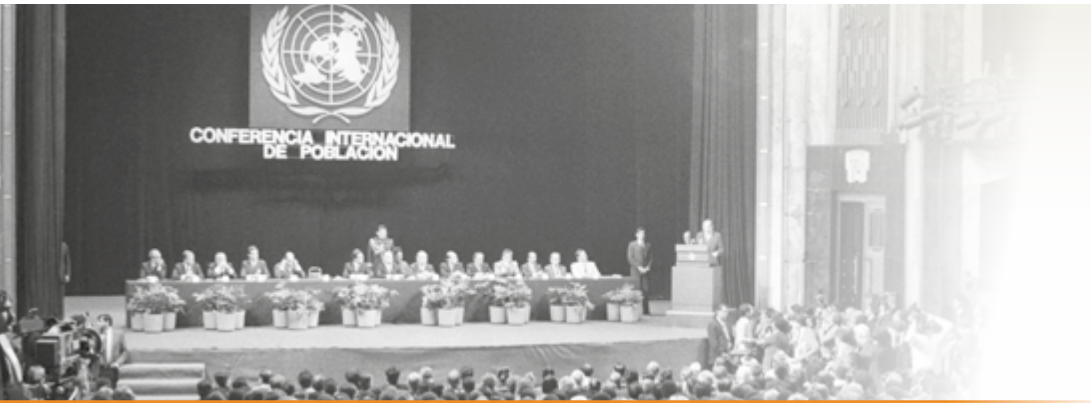
1983

Retrovirus that causes AIDS discovered

Famine in Ethiopia

unions between same-sex partners were legalized in Sweden; and the launch of America Online, or AOL, marked the beginning of easy access to the Internet.

The years preceding the ICPD saw a gradual and accelerating shift: from a primary focus on population issues and fertility reduction to one grounded in the rights of individuals and couples to prevent or delay pregnancy and attain sexual and reproductive health. This shift was largely driven by feminists and advocates for sexual and reproductive health and rights, and was, in part, a response to the abuses that resulted from target-driven "population control" policies of the past. In the 1970s and 1980s, with funding and encouragement from wealthy donor countries and foundations, some countries had rolled out programmes that coerced or forced couples to use contraception



DR. NAFIS SADIK NAMED UNFPA EXECUTIVE DIRECTOR

UNFPA NAME CHANGES TO UNITED NATIONS POPULATION FUND

INTERNATIONAL POPULATION CONFERENCE, MEXICO CITY

Schengen Agreement reached by five member States of the European Economic Community

Space Shuttle Challenger disintegrates, killing its crew of seven

1984

First embryo transfer from one woman to another, resulting in a live birth

1985

The US Food and Drug Administration approves a blood test for HIV

South Africa ends its ban on interracial marriages

1986

Corazon Aquino becomes the first Filipina woman president

First child born to a non-related surrogate mother

1987

Black Monday—stock markets plunge on Wall Street and around the world

WORLD POPULATION **5** BILLION

Safe Motherhood Initiative launched

or limit their family size, or provided monetary or other incentives to convince them to do so.

The ICPD Programme of Action adopted by 179 governments called explicitly for dropping demographic and fertility-control targets from national population and family planning programmes. While still acknowledging that population dynamics merited consideration in policymaking, the Programme of Action issued a clarion call to place women's needs and rights at the centre of population and development policies. What the world needed, governments agreed, was to provide women, couples and families with access to a range of sexual and reproductive health interventions, and to realize social and economic changes that would empower women, respect their rights, and

1988

First World AIDS Day marked on 1 December

1989

Berlin Wall is opened

1990

Nelson Mandela is released from Victor Verster Prison

Namibia becomes independent

Destruction of Berlin Wall begins

1991

Democratic People's Republic of Korea and the Republic of Korea, Estonia, Latvia, Lithuania, the Marshall Islands and Micronesia join the United Nations

Croatia and Slovenia declare independence from Yugoslavia; the Balkans war begins

The Soviet Union dissolves

1992

Peace accord in Mozambique

help move the world towards gender equality.

Advances and setbacks since 1994

The ICPD consensus was a turning point, and a transformative victory for the reproductive rights movement.

By placing individual rights and well-being at the centre of the reproductive health agenda, it set in motion a number of shifts: in research, to explore the factors that influence individual choices and behaviour in relation to contraceptive use or non-use and fertility; in communication, to inform and educate women, men and decision makers about the health, economic and social benefits of reducing fertility and preventing unintended pregnancies; and in service delivery, to underscore the importance of providing a full range of contraceptive methods and ensuring choices for all women.

1993

UNITED NATIONS WORLD CONFERENCE ON HUMAN RIGHTS

The World Health Organization declares tuberculosis a global emergency

1994

INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT, CAIRO

The Rwandan genocide

In South Africa, Nelson Mandela is inaugurated president

1995

THE UNITED NATIONS FOURTH WORLD CONFERENCE ON WOMEN

More than 170 countries agree to extend the Nuclear Non-Proliferation Treaty indefinitely and without conditions

The Dayton Agreement is signed in Paris to end war in Bosnia

The Ebola virus kills 244 in Zaire

1996

Ghanaian diplomat Kofi Annan is elected as Secretary-General of the United Nations

The Bosnian government declares the end of the Siege of Sarajevo

Dolly the sheep, the first mammal to be successfully cloned from an adult cell, is born

The ICPD also recognized that a woman's sexual and reproductive health and well-being encompass not only her access to, and use of, contraception, but many other factors as well: her ability to prevent and manage the complications of unsafe abortion; her capacity to avoid or treat sexually transmitted infections, including HIV; and the care she receives during pregnancy and childbirth. Prevention and management of infertility and reproductive tract cancers were also defined as part of sexual and reproductive health.

The reproductive health needs of adolescents, the ICPD Programme of Action acknowledged, had been largely ignored by existing services. While the ICPD consensus called for special efforts to address these needs, opposition to the provision of comprehensive sexuality education and reproductive health services to adolescents, and disagreements on the issue of parental approval,

Cathy O'Dowd, a South African mountaineer, becomes the first woman to summit Mount Everest from both the north and south sides

MILLENNIUM DEVELOPMENT GOALS ADOPTED

THORAYA AHMED OBAID NAMED UNFPA EXECUTIVE DIRECTOR

1997

Divorce becomes legal in the Republic of Ireland

1998

The US House of Representatives forwards articles of impeachment against President Clinton to the US Senate

1999

WORLD POPULATION **6** BILLION

2000

Historic summit of leaders of the Republic of Korea and the Democratic People's Republic of Korea

2001

The world's first self-contained artificial heart is implanted in Robert Tools in the United States

September 11 attacks at the World Trade Center in New York City

led to convoluted language in the document and, in some cases, to convoluted policies on the ground.

The ICPD coincided with the crest of another public health and rights crisis: the HIV/AIDS epidemic. As concern and activism about the enormous implications of HIV and AIDS ballooned, some donors increased attention and funding to addressing the pandemic and its impact on people, communities and nations, while funding for other aspects of sexual and reproductive health remained mostly stagnant.

Some observers feared that the ICPD's emphasis on individual choice and women's empowerment would not resonate with donors and governments, and that by moving away from a focus on population growth, the community was compromising its ability to mobilize resources and political commitment. Despite such concerns, the ICPD framework held. The commitment

TARGET TO ACHIEVE UNIVERSAL ACCESS TO REPRODUCTIVE HEALTH APPROVED FOR INCLUSION IN MILLENNIUM DEVELOPMENT GOALS

2002

The Organisation of African Unity is disbanded and replaced by the African Union

The Euro is officially introduced in Eurozone countries

EARTH SUMMIT 2002

2003

The Human Genome Project is completed, with 99 per cent of the human genome sequenced to 99.9 per cent accuracy

2004

Brazil launches its first rocket into space

European heads of State sign the **Treaty and Final Act**, establishing the first European Constitution

2005

Angela Merkel, 51, becomes Germany's first female chancellor, and its youngest

Ellen Johnson Sirleaf becomes first democratically elected female head of State in Africa

to universal access to sexual and reproductive health was reaffirmed in 1999 at the ICPD five-year review meeting, where supporters eked out advances on a few key elements, including adolescent sexual and reproductive health, and access to safe abortion where legal, in the face of fierce opposition.

In 2000, however, when the United Nations adopted the Millennium Development Goals (MDGs) setting out global aims and targets for the next 15 years, reproductive health was nowhere to be seen. Perhaps responding to the length and contentiousness of the negotiations at the Fourth World Conference for Women in 1995 and at the ICPD five-year review meeting in 1999, the officials in charge of writing the MDGs opted instead to define a goal on "improving maternal health." Not until 2005 did the sexual and reproductive health community succeed in its quest to add universal

UNITED NATIONS GENERAL ASSEMBLY VOTES TO ESTABLISH THE UNITED NATIONS HUMAN RIGHTS COUNCIL

UNFPA LAUNCHES GLOBAL PROGRAMME TO ENHANCE REPRODUCTIVE HEALTH COMMODITY SECURITY

Surgeons at London's Moorfields Eye Hospital perform the first successful operations using bionic eyes, implanting them into two blind patients

Bolivia declares the right of indigenous people to govern themselves

2006 **2007** **2008** **2009**

Michelle Bachelet is sworn in as Chile's first female president

South Africa's parliament passes a law that legalizes same-sex marriage

UNITED NATIONS GENERAL ASSEMBLY ADOPTS THE DECLARATION ON THE RIGHTS OF INDIGENOUS PEOPLES

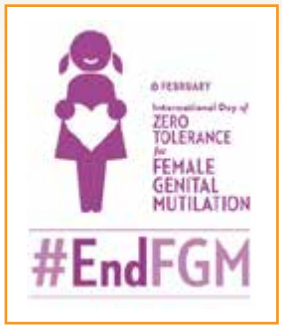
The morning-after pill approved by US Food and Drug Administration for use by 17-year-olds

access to sexual and reproductive health as a target under the maternal health goal.

The initial omission of sexual and reproductive health from the MDGs contributed to the perception that the issue was contentious and problematic, and therefore easier to ignore, at least in global discussions and negotiations. Despite frequently being set aside by the global community, funding and visibility for family planning continued, and at times surged, receiving a strong boost in July 2012 from a global Family Planning Summit, which mobilized major new donor and political commitments and reinvigorated the family planning community.

A new paradigm: 2015 and the Sustainable Development Goals

In September 2015, 193 governments adopted a new global framework to succeed the MDGs.



DR. BABATUNDE OSOTIMEHIN NAMED UNFPA EXECUTIVE DIRECTOR

GENERAL ASSEMBLY ADOPTS RESOLUTION ON PREVENTING FEMALE GENITAL MUTILATION

COMMISSION ON THE STATUS OF WOMEN CALLS ON STATES TO END THE PRACTICE OF CHILD, EARLY AND FORCED MARRIAGE

2010

World Health Organization declares the H1N1 influenza pandemic over

2011

WORLD POPULATION 7 BILLION

The Syrian civil war begins

2012

Typhoon Bopha hits the Philippines

2013

Beijing's level of air pollution is declared to be hazardous to human health

Reflecting the expanded scope of the agenda and the growing complexity of the challenges to be addressed, the 2030 Agenda for Sustainable Development includes 17 Sustainable Development Goals (SDGs) with 169 targets. While the number and proportion of people living in poverty declined between 2000 and 2015, eliminating poverty remains the overriding aim of the new global agenda.

But there are new aspects to old challenges, as well as new challenges, that are explicitly acknowledged and targeted in the SDGs. These include climate change and environmental fragility; a growing number of intractable humanitarian and political crises, and a consequent increase in the number of people living in fragile and unstable settings; and a greater emphasis on the need for domestic financing as well as development aid to build resilience, expand capacity and establish the basis for sustainable economic and social progress.

20-YEAR REVIEW OF PROGRESS IMPLEMENTING ICPD PROGRAMME OF ACTION

SUSTAINABLE DEVELOPMENT GOALS ADOPTED, INCLUDING UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH CARE AND SERVICES

World Health Organization announces an outbreak of the Zika virus

2014

Ebola epidemic in West Africa infects at least 28,616 people and kills at least 11,310 people

276 girls and women in Nigeria are abducted and held hostage

2015

World leaders gather in Paris for historic climate change talks

2016

Unlike the MDGs, the SDGs explicitly recognize sexual and reproductive health as essential to equitable development and women's empowerment, referencing sexual and reproductive health under SDG 3, for health, and again under SDG 5, for gender equality, which also references reproductive rights. As was the case with the ICPD and the MDGs, however, the SDGs do not acknowledge sexual rights. Other central elements of sexual and reproductive health, including maternal and newborn mortality and HIV, were addressed under targets for SDG 3, and gender-based violence and harmful practices under targets for SDG 5. The SDGs also call for achieving universal health coverage, specifically by ensuring access to quality essential health-care services and to safe, effective and affordable medicines and vaccines for all. Overall, the SDGs advance an agenda for all people, as the ICPD continues to do, while emphasizing

DR. NATALIA KANEM APPOINTED UNFPA EXECUTIVE DIRECTOR

UNFPA TURNS 50

2017

Millions of people in 168 countries join the Women's March

The United Nations warns that 20 million people are at risk of starvation and famine in Yemen, Somalia, South Sudan and Nigeria

2018

Global Conference on Primary Health Care declares central role for sexual and reproductive health

PRIMARY HEALTH CARE IS...

2019

25TH ANNIVERSARY OF THE ICPD

ICPD25
International Conference on Population and Development

the importance of equity and addressing the needs of the most vulnerable.

Over the past 25 years, in various review meetings and processes related to the ICPD, some regions of the world have called for recognition of sexual rights. A number of current definitions of sexual rights, including those presented in the 2018 report of the Guttmacher-*Lancet* Commission on sexual and reproductive health and rights, and by the World Health Organization, encompass the rights of people to express their individual sexuality; the rights of adolescents to receive comprehensive sexuality education and sexual and reproductive health services; and the rights of women and girls to be free of gender-based violence and coercion. These rights have been recognized and endorsed by civil society organizations around the world, and acknowledged in various regional documents negotiated and endorsed by governments. No consensus on these rights, however, has been reached by all the Member States of the United Nations in any globally negotiated document.

2019 and beyond

UNFPA's 50th anniversary and ICPD's 25th anniversary present a unique opportunity for the global community to build on the ICPD framework and fully commit to realizing a visionary agenda for sexual and reproductive health and rights, and to reaching those who have been left behind. This agenda must pay attention to population dynamics, recognize the diverse challenges faced by different countries at various stages of development, and ground policies and programmes in respect for, and fulfilment of, human rights and the dignity of the individual.

There is enormous momentum around efforts to achieve the SDGs, including a renewed commitment to "health for all," explicitly recognizing that every human being has a fundamental right to the enjoyment of the highest attainable standard of health, without distinction. The Every Woman Every Child movement, launched by former United Nations Secretary-General Ban Ki-moon in 2010 and now led by Secretary-General António Guterres, brings concerted attention and effort to the SDGs and universal health coverage as they relate to women, girls and adolescents, with sexual and reproductive health and rights as one of its key focus areas.

The pursuit of rights and choices for all is an ongoing one, with new challenges emerging all the time. Over the years, the nature and scope of these obstacles may have changed, but the international community's commitment to overcoming them remains strong.

Millions of women in India join hands to form a 385-mile wall to protest inequality, 2019. © Babus Panachmoodu

© UNFPA/R. Anis

SIX **WOMEN**, SIX DECADES, SIX **JOURNEYS**

Six women who were 10 years old in 1969, when UNFPA was established, and 35 at the time of the International Conference on Population and Development, reflect on marriage, work and family. Did they have the freedom to choose their own paths and shape their own futures?

© UNFPA/R. Anis

Choices were limited

Dahab Elsayed, 60, lives in a marginal neighbourhood of Cairo. She vaguely remembers the excitement in her city when the International Conference on Population and Development (ICPD) took place. But because she was busy working and caring for her family back then, details about the conference and its impact eluded her.

But some of the shifts in attitudes about women and girls she witnessed later in life can be traced to the ICPD, which acknowledged that fulfilling the rights of girls and women, especially their sexual and reproductive choices, is central to development.

"There were no opportunities other than marriage—it was the only future I could foresee."

Dahab

As a girl, growing up in a poor rural family of 15, Dahab's choices were limited, and even an education was out of reach. "There were no opportunities other than marriage—it was the only future I could foresee," she says.

Dahab recalls the day that a woman came to her house and cut her genitals. Dahab had no idea what was happening, but recalls the pain, the blood, and the powder that was applied

to staunch the bleeding. She remembers staying in bed for 15 days to heal. But when she grew older and started a family of her own, she had her own daughter's genitals cut. "It [female genital mutilation] was a must," Dahab says. Her in-laws insisted on it. Marriage prospects depended on it. All the girls were cut back then.

She now believes it is wrong to be subjected to this practice, and her granddaughter has been spared. "Now it is *not* preferable," says Dahab, who learned from a television campaign about the harm female genital mutilation causes, and the fact that the procedure is now illegal.

Dahab had four children in quick succession soon after her marriage. Faced with poverty, and her husband's declining health, the couple decided they had enough children. Because she always did odd jobs—cleaning, laundry, caretaking—she never had health insurance to pay for contraception. But intrauterine devices were subsidized in Egypt, so she started using one.

Her husband, an upholsterer, died 20 years ago. Since then, it has been increasingly difficult for her to make ends meet. Three of her children have medical conditions that prevent them from working. To help support them, and herself, she works at two jobs during the day and cares for an older person at night. She rarely even goes home. Much as she would like to learn to read and write, if she had more time, she would probably use it to earn more money. Soon she will receive a small government pension, but it will not be enough to support her, so she will continue to work. "Women are the ones that work and get the money for the family," she says matter-of-factly.

As Dahab and other 60-year-olds share glimpses of their lives, their dreams and struggles, it becomes apparent how deeply the political and economic circumstances they were born into delineated the course of their lives. Although real choices and options were limited, most of the women found ways to navigate within them, carving out meaningful lives.

The lives and experiences of the women turned out to be very different from what each had envisioned for herself at age 10. Sometimes aspirations were circumscribed by the limited roles that seemed available to females at the time. Other times, they were thwarted by social upheaval. Some lives took unexpected turns, and were successful in ways their 10-year-old selves could not have imagined.

But across their disparate journeys, common threads emerge, many of them directly related to the mandate and work of UNFPA.

Facing a world of limited horizons

Rajeshwari Mahalingam recalls enjoying school in the Indian State of Tamil Nadu, where she was known for her beautiful long curly hair and her participation in dance performances. But no one ever asked her about her dreams or what she would like to do in the future. When she did think about it, her possible roles seemed limited: homemaker, medical worker, teacher.

She entered into an arranged marriage at age 25. She was obliged to wait until all seven of her older siblings were married and her parents were able to find an appropriate match, one that did not require an exorbitant dowry.

After giving birth to two children through caesarean sections, she was told that future deliveries would have to be caesareans as well, and the cost would have been more than her family could have afforded, so she decided to have a tubal ligation. She had already had

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to sell some of her gold jewellery to pay for the delivery of her second child, a daughter.

Most of her friends at that time were having smaller families. They were influenced by family planning campaigns, Rajeshwari says, recalling the popular slogan: "A planned family is a happy family."

She devoted most of her life to caring for her family, although she did take in and care for other children for extra money when times were tough. She invested most of her energy and her dreams in her two children, who are now both college-educated and successful. "I told them stories and read books with emphasis on service and being honest human beings. I longed to see them grow and reach higher," she says.

"I enjoyed motherhood more than anything else. A woman is the light of the house," Rajeshwari says. "A woman contributes to the family, in that way, to the community, country and world."

Over her lifetime, Rajeshwari witnessed big changes in the expectations and possibilities for young women. Before she was married, she was afraid to do much outside the home—her parents did not approve. But her sister, just five years her junior, enjoyed a

"I enjoyed motherhood more than anything else."

Rajeshwari

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greater sense of personal freedom, which allowed her to become a social activist, achieve a master's degree, and work professionally on women's issues.

From deprivation to political action

As a 10-year-old in Uganda, Josephine Kasya admired her teachers: "They were the smartest people—and I said I will become a teacher. Also my dad was a teacher, and I liked him so much. I said, 'I want to be like my dad.'"

But when Josephine was 12, Idi Amin seized power in her country, and years of instability, deprivation and violence followed. Her dream of becoming a teacher never materialized.

After a civil war that ended in 1986, so much of her community was destroyed or lost that she and her new husband, a social worker, moved to his somewhat remote homeland in a verdant, southern part of the country. While less affected by the war, her new community lacked the social infrastructure she was used to. "Life became very different and difficult," she says of that period early in her marriage, during which she raised six children, fetched water from a source a kilometre and a half away, and tended her cows. "I managed to sell some milk to get a little money to buy a few things at home."

But she does not regret those early struggles, she says, because they galvanized her into action. "It is out of that rural set-up that I started convincing women to come together and pool their resources." There too she learned how to partner with other organizations to get things done.

Her leadership skills were noticed, and she was elected to lead, first at a more local level, and later, in 2001, as the Chairperson of

"I demystified the idea that the position was entirely for males and paved the way for other women to take on similar positions in other districts."

Josephine

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a district comprising 250,000 people. Throughout her political career, she has championed community development, education for girls and gender equality, focusing on being a voice for rural women. She became the first woman District Chairperson in Uganda. "I demystified the idea that the position was entirely for males and paved the way for other women to take on similar positions in other districts," she says proudly, adding that in her district a number of other women have taken on decision-making roles.

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When war subverts choices

Say Yang dreamed of going to a good school, studying hard to fulfil her wish to become a teacher. But her dream evaporated when she was 16: soldiers appeared in her community, firing in the air and shouting. She was separated from her family and forced to do backbreaking work. "War destroyed everything," she says. "Even my dreams. Indeed, I didn't dare make a dream. During a war, people don't have even a choice to choose. They do whatever they can to survive."

"During a war, people don't have even a choice to choose. They do whatever they can to survive."

Yang

In Cambodia, when personal freedoms were curtailed under the Khmer Rouge, Yang was forced to marry someone whose name she did not even know in a large collective ceremony. As their names were called out, each couple came forward. They held

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hands and promised to live as husband and wife. Initially, and for several months, she and her husband were so shy that they rarely dared to look directly at or talk to each other.

When rule by the Khmer Rouge ended, Yang and her husband travelled back to her home town to live with her mother. Between 1981 and 1988, she delivered five children, with one dying in infancy and another at age 13. After learning from a neighbour that the hospital in the next town would perform a tubal ligation, she made the arduous and somewhat perilous journey to take advantage of it.

One day in Cambodia, Yang got the good news that she was invited to enrol in teacher training. "However, I just could not make it. I had a child to look after and housework to handle from day to day. I let my husband go instead. We had to balance between family and society."

Championing the rights of women

Until Alma Odette Chacón was 14 years old, she led a relatively uneventful, happy life as the eldest of six children in a family in Guatemala City. Her parents prized education and sent the children to a Jesuit school. When she thought about the future, Alma imagined being a teacher like her mother, or an accountant like her father. What she knew for sure was that she wanted to help others.

Her life changed abruptly the night her mother went to the hospital to deliver her seventh child. She never returned. Even though all her mother's prior deliveries had been normal, this time something went wrong.

Alma's world fell apart. "It was very difficult," she says. "Suddenly you are missing the key piece of the family, with each person going his or her own way." Before her mother's death, Alma had always been at the top of her class, but now couldn't keep up her good grades. Her father was absent much of the time, and eventually her

stepmother threw her out of the house.

A year after Alma's mother died, a 7.5 magnitude earthquake killed or injured 100,000 people near Guatemala City and displaced more than 1 million. Sensitive to the plight of the displaced, Alma found herself helping survivors.

Soon after, she was sponsored by her school to spend a month teaching in an indigenous Quiché community. Those two experiences dealing with marginalized and suffering people—mostly indigenous women—were central to her lifelong commitment to social justice, she says.

In her 20s, fearing arrest for her involvement in politics, she left Guatemala for Mexico, where she sought training in communications. There, she saw a freer way of living and was exposed to feminist ideas. To support herself, she worked in a variety of jobs: cleaning, production assistant and secretary to a centre for human rights, among other things.

"Women now clearly know they have rights and they should be able to decide what goes on with their bodies."

Alma

In the mid-1990s, Alma travelled around Central America and helped organize a regional meeting on the rights of women. This work galvanized her engagement in the women's movement and her understanding of sexual and reproductive health and rights as a central lever to broader development.

She is again living in Guatemala and has worked for several decades now with Terra Viva, a non-profit organization that addresses these issues. Through this lens, she sees big changes in the attitudes of women, especially in indigenous communities: "Women now clearly know they have rights and they should be able to decide what goes on with their bodies."

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A lifetime of helping others

Tefta Shakaj always wanted to study at university to become a doctor, but that was not an option for her in Albania when she was a teenager. "We were obliged to do what we were told," she says. After completing secondary school, however, she did get an opportunity that changed the course of her life: a one-year study programme to become a nurse midwife.

After her training, Tefta was assigned to a remote village that lacked medical facilities, personnel and supplies. Life there was tough on many levels. But she loved caring for newborns and mothers and served with passion—

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delivering babies, providing antenatal care, attending to young children in a paediatric ward. "I have helped a lot because many deliveries took place at home—there were not many centres. I am happy I helped so many women."

In the early 1990s, following the fall of Albania's communist regime, she lived through chaos and shortages of everything, she says. She married and had two children, but would have had more if there had not been so much economic uncertainty at the time. Then, too, her husband got sick, and they

"I am happy I helped so many women."

Tefta

needed money for medical services. Unable to access contraceptives, she became pregnant, and like many women of that era in Eastern Europe, she had an abortion.

There was a positive side to the turmoil of the early 1990s, she says: it spurred an exodus of Albanians to Italy and Greece, exposing people to new ideas and ways of doing things. From those who left Albania, "we started to see another world and other perspectives," she says. "Before that we had only heard that everything outside Albania was bad."

Life is improving in Albania, Tefta says, and she believes that her own daughters and grandchildren will have more choices and opportunities than she had. For one thing, contraceptives are now widely available and free. And for another, her younger daughter has chosen to become a police officer—a sign that old notions of gender equality are changing.

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The lives they lived

All six women are remarkable in the impact they have had on others, whether in their own families or in a wider sphere. But when their lives are viewed across a span of six decades it is also clear the extent to which the women, several of them powerful agents of change in their own families or communities, were also very much affected by larger social, political and economic forces. Compromises were made; aspirations thwarted.

Dahab continues to toil at three jobs, but she says she has accepted her life, and feels content.

Rajeshwari's early love of dance has transformed into her training in a rigorous form of yoga. Her unlived dreams for education are being fulfilled through her children.

Although Yang says her dreams died with the violence she endured during wartime, her close family relationships are central to her life. In addition to caring for her four grandchildren and, from time to time, her ageing mother,

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she recently started up a family laundry business.

Alma continues to find meaning and purpose in her work on women's empowerment, with no plans to retire soon. "There is more to come," she says.

Tefta, who has been struggling with cancer, is determined to see her granddaughter grow up and to stay engaged in life. "I won't let the tumour get the best of me," she says. "I'll continue to help as long as I have energy."

And Josephine in Uganda intends to run for one more term—her fifth—before retiring from public office. But she is not planning to stop doing what she loves. "As years go by, I'm not as strong as I used to be. But I'm very passionate about baking and am planning to train a group of women so they can bake and sell bread."

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RIGHTS AT RISK IN TIMES OF POPULATION GROWTH

It was an era of extraordinary technological advances. Neil A. Armstrong and Edwin Aldrin, Jr., took the first walk on the moon in 1969. Also that year, for the first time, doctors replaced a dying man's heart with a mechanical one. And a human egg was fertilized in a test tube (Edwards and others, 1969).

And by 1969, earlier advances in medical technology, along with stronger public health systems, better nutrition and sanitation, and a global commitment to ending the scourge of infant and child mortality, had started paying off. Worldwide, child death rates plummeted from 215 deaths per 1,000 live births in 1950 to under 160 per 1,000 just 19 years later (United Nations, 2017).

Other medical advances were helping people to live longer. Worldwide, life expectancy in 1969 was about 55 years, up from 47 years in 1950.

Improved child survival rates and longer lives transformed the human condition. But when combined with a global average fertility rate of about five births per woman, they also changed the world's population trajectory.

The world's population in 1969 was growing at about 2 per cent a year. At that rate, world population would double in just 35 years. Never before had population grown so rapidly.

From celebration to concern

Global celebration of public health successes soon gave way to fears of a dystopian future in which too many people competed for ever-dwindling resources. What would such growth mean for global challenges like hunger? What would it mean for areas that were torn by conflict? How could efforts to

grow economies and bring people out of poverty keep up when human numbers were expanding so dramatically? And what could be done about it?

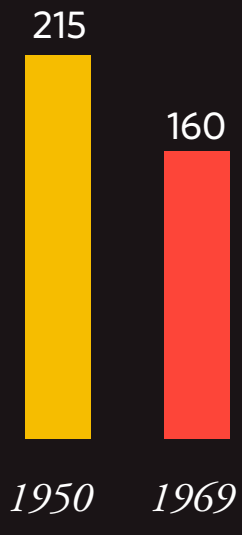
To some, population growth was seen not as a reflection of human progress but as a threat to humanity, a problem that required an urgent solution.

Fears of the consequences of rapid population growth gripped the security community as early as the 1950s. In the United States, President Dwight D. Eisenhower designated retired general William H. Draper to lead a committee to devise coherent strategies for development assistance. Draper's committee flagged what it saw as major concerns related to population growth in various parts of the developing world, primarily linked to food production. "Problems connected with world population growth will be among the most serious to be faced by the younger generation of today," the committee's 1959 report read. "Unless the relationship between the present trends of population growth and food production is reversed, the already difficult task of economic development will become a practical impossibility" (Draper and others, 1959).

To address this challenge, the committee recommended that the United States and other advanced economies provide information and technical assistance to developing countries, at their request, "in the formulation of their plans to deal with the problem of rapid population growth." It also recommended that the United States "increase its assistance to local programs relating to maternal and child welfare."

Several years later, Paul Ehrlich opined in *The Population Bomb* that "Whatever problem you're interested in, you're not going to solve it unless you also solve the population problem. Whatever your cause, it's a lost cause without population control" (Ehrlich,

Worldwide, child death rates plummeted from **215** deaths per 1,000 live births in 1950 to **under 160 per 1,000** just 19 years later



"Problems connected with world population growth will be among the most serious to be faced by the younger generation of today."

Draper Committee

© Mark Tuschman

1968). Ehrlich was interviewed numerous times by Johnny Carson, the host of the popular American late-night television programme *The Tonight Show.* The book became a bestseller, and soon the notion of "overpopulation" and questions about what, if anything, should be done about it were being debated in living rooms, lecture halls and the halls of government worldwide.

A 1972 study commissioned by international think tank the Club of Rome and carried out by researchers at the Massachusetts Institute of Technology further heightened concerns about what continued rapid population growth could mean for society. In their study, *The Limits to Growth*, the researchers elaborated future scenarios based on differing assumptions related to population growth, food production, industrialization, pollution and consumption of non-renewable natural resources (Meadows and others, 1972). The "standard run" model, which was based on a continuation of historic trends from 1900 to 1970, led to "overshoot and collapse," stemming from resource depletion, the collapse of the industrial base (and with it agricultural systems, which have become dependent on industrial inputs), and population growth that is eventually reversed due to increasing death rates from lack of food and health services. Other scenarios based on tweaked assumptions about one or more variables also led to eventual overshoot and collapse. Only one scenario, in which population and industrial capital growth rates stabilize and technological advances support pollution control and

efficient food production, achieved a state of equilibrium that resulted in a "stabilized world."

"If the present growth trends in world population, industrialization, pollution, food production and resource depletion continue unchanged," the researchers concluded, "the limits to growth on this planet will be reached sometime within the next 100 years. The most probable result will be a rather sudden and uncontrollable decline in both population and industrial capacity." The methods and results of the study were widely discussed and debated, spawning further interest in examining the interactions between population growth and other human and natural systems (Nørgård and others, 2010).

From concern to control

Fearing that rapid population growth would reverse development gains, spawn famines, or worse, international and non-governmental organizations and individual governments began to take action.

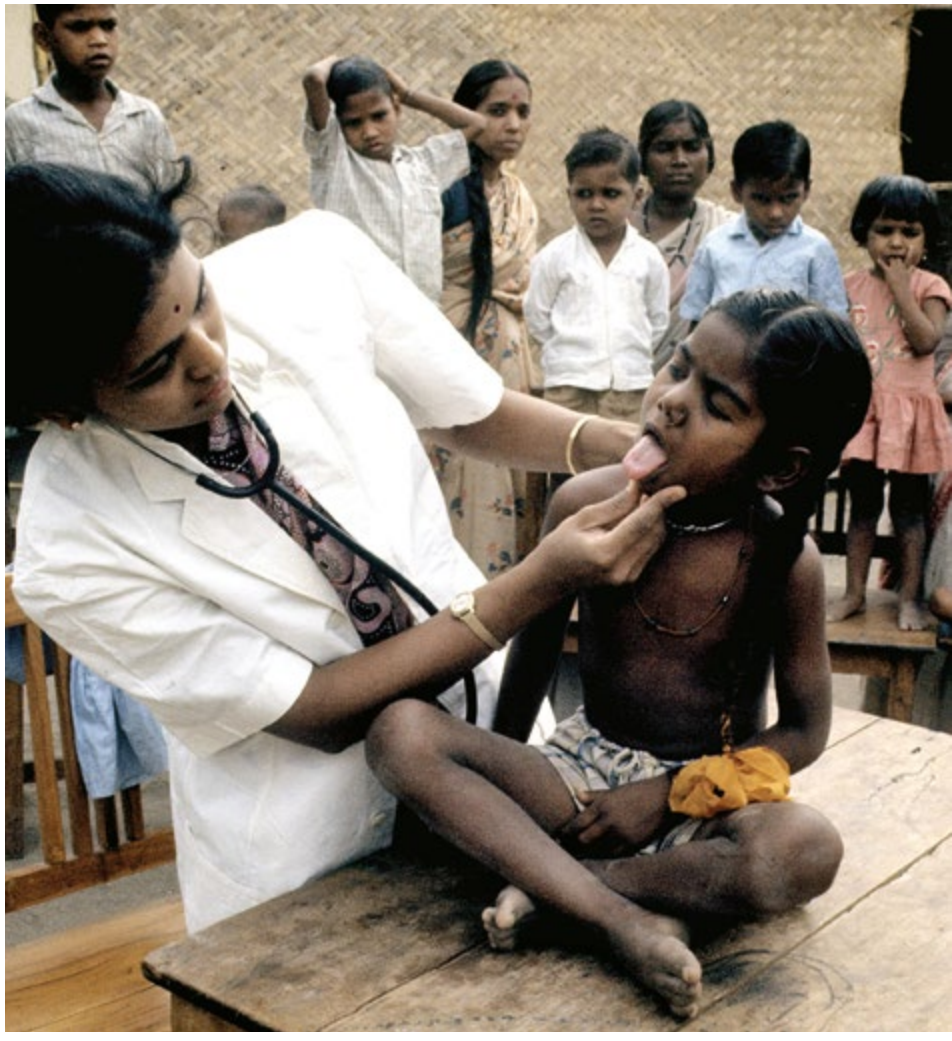
In many places, this action was in the form of examining population trends and seeking to better understand their implications for other societal goals. In other places, action took the form of launching family planning programmes. In some places, action resulted in steps to encourage—or even force—couples and individuals to have fewer or no children, sometimes infringing on rights and choices along the way.

Family planning mural: "Second child after three years," India, 1988. © Raghu Rai/Magnum Photos

Throughout the 1970s and 1980s, many countries adopted population or family planning policies. Often, such policies contained goals or targets linked to demographic outcomes—a target date for achieving population stabilization, for example, or goals related to reduction in fertility rates or increase in the proportion of the population using a modern method of contraception.

Demographic objectives, however, sometimes took precedence over individual rights and choices. Family planning programmes that were voluntary, where individuals had the power to make their own decisions about contraception, were seen by some as inadequate to reduce fertility. "The conditions that cause births to be wanted or unwanted are beyond the control of family planning, hence beyond the control of any nation that relies on family planning alone as its population policy," wrote American sociologist Kingsley Davis in an influential article in 1967 (Davis, 1967). He argued that if population policy were meant to control population growth to the benefit of society, then new directions in population policy—beyond simply providing family planning—would be needed.

Among Davis' recommendations: the postponement of marriage, as well as interventions to encourage the limitation of births within marriage. Such interventions had the potential to erode the protection and promotion of individual rights. For example, financial incentives—such as cash payments, food or household items—were incorporated into some population policies as a strategy to persuade couples to adopt particular family planning methods or limit childbearing (Heil and others, 2012); some population policies also offered housing and lending preferences to families with fewer children (Ross and Isaacs, 1988).



Free child care service offered by family planning programme. India, 1972.
© UN Photo/ILO

Goals to reduce fertility and slow population growth, were, in a number of cases, not aligned with the Programme of Action of the International Conference on Population and Development (ICPD).

Demographic concerns drove many of the innovations in contraceptive technologies in

A young woman examines the "loop" at a family planning centre. East Africa, 1973.
© UN Photo/FAO

the 1950s and 1960s, leading to modern methods including oral contraceptives, intrauterine devices and injectables. But in some cases, demographically motivated population policies led to approaches that limited quality of care and jeopardized the health and rights of individuals.

The first large-scale test of oral contraceptives, for example, took place in 1956 among 200 women living in a housing project in Puerto Rico. The women were given little information about safety and potential side effects, as little was known at the time (Liao and Dollin, 2012). Over time, other concerns have been raised about the practices of agencies, private companies and governments responsible for developing and evaluating contraceptive technologies—including concerns about lack of informed consent, adequate counselling and medical follow-up (United Nations, 2014).

Expanding understanding of trends, enhancing options for individuals

While population growth fears led in a number of cases to policies and programmes that limited or even trampled on rights and choices, the demographic shifts of the twentieth century also inspired new waves of scholarship and global discourse on the ways in which population dynamics influence and are influenced by socioeconomic trends, and how these trends intersected with an emerging human rights agenda.

New institutions emerged to investigate the implications of population growth and potential policy and programmatic responses. In 1952, John D. Rockefeller III convened a meeting under the auspices of the United States National Academy of Sciences to investigate questions related to demographic trends and their consequences. Not long after, he established the Population Council to continue this work. From its early days, the Population Council engaged in pursuits related to building understanding of population trends and their relation to societal goals: one of its first programmes provided support to graduate students for advanced training in demography.

The early work of the Population Council was not purely demographic, however; it

Population growth and economic growth

After an initial grounding in ideological debates, evidence—not political power and support—would be brought to bear on the question of how economic and population growth were related. An important paper by Coale and Hoover (1958) demonstrated that across countries where population growth was very high, economic growth lagged. This correlation did not demonstrate causality, but it was nevertheless used by some to buttress fears of high population growth rates' negative impact on economies.

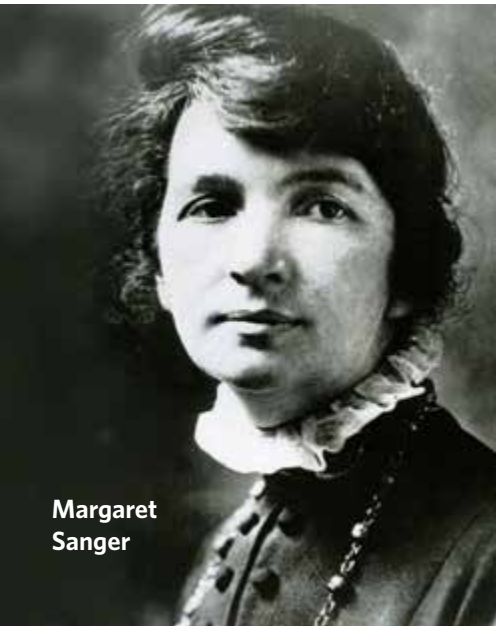
Later studies debunked that notion, however. For example, in 1984, shortly before the International Population Conference in Mexico City, a study commissioned by the United States National Academy of Sciences concluded that population growth was a neutral factor in economic growth. This conclusion came from a comparison of growth rates in population with growth rates in the economy (not in levels of the two). There seemed to be no relation (National Research Council, 1986). This uncertain conclusion and other research reinforced resistance to family planning efforts, at the 1984 conference and beyond.

Since the late 1990s, there has been growing recognition that total aggregate population levels and change do not provide an explanation of the relationship. What is critical is the change in the age structure of populations as births are fewer, later and safer (Bloom and others, 2000 and 2007; Bloom and Canning, 2004), together with the attributes and opportunities of the population, specifically around education (Lutz and others, 2008), health and employment (Joshi and Schultz, 2007). As fertility declines, the proportion of the population that is of working age increases relative to the proportion of the population that is very old and very young. If this period coincides with a broad-based and significant investment in human capital concentrated from youth to adulthood, along with opportunities in the labour market, the result is a boost in economic growth and prosperity for the population. This effect, referred to as the "demographic dividend" or "demographic bonus," does not last indefinitely. As mortality continues to fall, including at older ages, elder dependents become an increasing proportion of the population and the opportunity for a dividend may be attenuated.

This effect, referred to as the "demographic dividend" or "demographic bonus," does not last indefinitely

With growing scholarship on the demographic dividend, population dynamics has re-earned its place in economic policy discussions. This re-emergence has not been free of additional caveats and misunderstandings. The phenomenon is associated with a larger population of youth and adults *relative* to children and older people, not a raw increase in this working age population—so it requires a decline in fertility to reduce the size of following cohorts. Gender issues also need to be included. Working populations increase when women can productively enter the labour force (the same is true of marginalized and excluded populations). Further, ageing is not always associated with a lost window of opportunity. People are born without resources but enter old-age "dependency" with accumulated resources, unless they have been perennially poor. The window of opportunity is also often wrongly assumed to dissipate quickly when dependency reaches its minimum, even though it will still be more favourable than the initial starting point for additional years. This fact reinforces the need for supportive investments over time, initially facilitating and then maintaining the dividend.

also reflected an understanding that demographic trends had individual lives at their foundation. Population Council programmes in social and biomedical research sought to illuminate the context in which individuals made decisions about their reproductive lives, and to investigate contraceptive technologies that could help to expand individuals' options related to sex and childbearing. These issues were of central concern to those working to expand women's options and choices within what was known at the time as the "birth control" movement; indeed, the International Planned Parenthood Federation was established in the same year, under the joint presidency of birth control pioneer Margaret Sanger of the United States and Lady Rama Rau of India (Claeys, 2010).



Margaret Sanger

The Draper Committee's 1959 report was influential in the eventual establishment of the Office of Population at the United States Agency for International Development in 1969, and other developed countries began to establish population programmes as part of their foreign aid strategies. The key feature of these programmes was the provision of family planning information and services. The United States and Sweden soon became leading bilateral donors for family planning programmes throughout the developing world (Robinson and Ross, 2007).

Concerns about rapid population growth also found their way into the United Nations General Assembly, which in 1966 passed resolution 2211 (XXI), titled *Population growth and economic development.* This resolution called on the United Nations "to assist, when requested, in further developing and strengthening national and regional facilities for training, research, information and advisory services in the field of population, bearing in mind the different character of the population problem in each country and region and the needs arising therefrom" (Singh, 2002). The next year, Secretary-General U Thant established a trust fund with a broad mandate to support the development of population policy in countries around the world, and in 1969, that trust fund became UNFPA, with Rafael Salas as its first Executive Director.

UNFPA, along with its peer institutions of that era, helped to launch deeper inquiry into the causes and consequences of population trends. In partnership with the United States Agency for International Development, UNFPA launched the World Fertility Survey to gather and synthesize robust population data. This survey, for the first time, helped to shed light on important questions related to women's lives—including their preferences, choices and needs related to fertility and childbearing.

The Population Council, International Planned Parenthood Federation, United States Agency for International Development and others were founding members of a new population movement, which brought new energy, political will and resources into the exploration of population questions, resulting in the expansion of family planning programmes in the developing world that helped empower individuals to make choices about their reproductive lives. There was, however, growing tension within the movement about whether population growth, at its root, was a problem; and if it was, whether family planning programmes were an appropriate or sufficient solution.

This tension came to the fore at the World Population Conference in Bucharest in 1974. By that time,

CHAMPION OF CHANGE

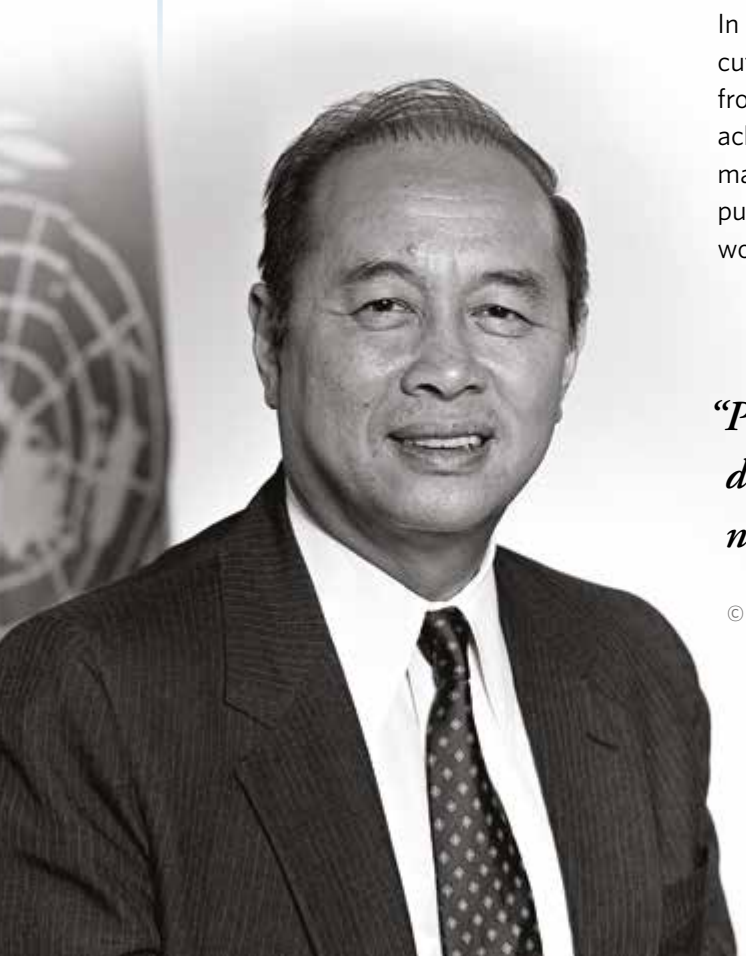
Rafael Salas

Known affectionately as "Mr. Population," Rafael Salas oversaw the birth of UNFPA as its first Executive Director in 1969. Under his leadership, UNFPA grew from a minor body to the world's largest multilateral provider of population assistance. Along the way, global consensus emerged around the integral links between population and development and people's sexual, reproductive and health rights, culminating in the Programme of Action of the International Conference on Population and Development.

"Parents have a basic human right to determine freely and responsibly the number and the spacing of their children," he told participants in the 1968 International Conference on Human Rights. It was a novel statement for the time, especially in Salas' role as conference vice-president.

Salas was widely known for bringing together people who might otherwise remain apart, helping them move past fixed positions of ideology and agree on common concerns. Always, the focus was on realizing the greater good. He led the 1984 International Population Conference in Mexico City and pioneered the work of the United Nations with parliamentarians and religious leaders. He persuaded people at all levels of government to introduce population and poverty links into national development plans.

A man of many talents, Salas was at different points a professor and a poet, the Executive Director of the National Economic Council in his native Philippines, and the general manager of *The Manila Chronicle*. As national coordinator of the Philippine National Rice and Corn Sufficiency Program, he jump-started a "green revolution" that for the first time made the Philippines self-sufficient in rice production.



In 1987, after his tenure as Executive Director of UNFPA was cut short by his untimely death, friends and colleagues gathered from all corners of the globe to say goodbye. As his many achievements were lauded, they agreed they had lost a great man, yet one who had always carried himself as a humble public servant. For his humanity and years of service, he would be remembered as dearly loved.

"Parents have a basic human right to determine freely and responsibly the number and the spacing of their children."

developed countries had already been supporting family planning efforts in developing countries and assisting governments in establishing population policies.

However, not all developing countries welcomed that support; some, in fact, did not see population growth as a challenge in their countries, and were frustrated that the developed world was, by their way of thinking, unduly distracted by the issue. For those whose views were influenced by a Marxist labour theory of value, a larger population meant more labourers and therefore the generation of greater wealth—and attempts to blunt that growth were met with suspicion and resistance. Others believed that more labourers would improve conditions only if the market generated enough employment. As population growth rates often exceeded economic growth rates, the gap would lead to under- and unemployment, with social turmoil as a result.

"Is it owing to overpopulation that unemployment and poverty exist in many countries of the world today? No, absolutely not. It is mainly due to aggression, plunder and exploitation by the imperialists, particularly the superpowers," said Huang Shu-tse, head of the Chinese delegation in Bucharest (Potts and others, 2018). Karan Singh, the Indian Minister of Health and Family Planning, argued that broader social and economic conditions were chiefly

CHAMPION OF CHANGE

Judith Bruce

As an observant adolescent, Judith Bruce realized that unless aggressively challenged, the conventional process of "becoming a woman" meant not only bodily changes but also a loss of freedoms. Young females' choices about sexuality and fertility were constrained not only by insensitive health care but just as forcefully by a lack of an independent "voice" and income.

Even as her generation welcomed modern contraceptives, Bruce questioned the heavy reliance on technical fixes. In her early 20s, she joined a class action case to support a woman's right to choice, and studied how girls' adolescence shaped their ability to lead dignified lives of their choosing.

Her intellectual path followed her lived experience, as she published almost simultaneously on women's social and economic bargaining power in households and on client-centred care. Her "quality of care" framework underpinned a global shift in family planning programmes from stressing numerical targets as the success metric to promoting sustainable and safe use by responding to girls' and women's priorities. This framework contained six elements: ensuring that clients have a choice of among a range of different contraceptive methods appropriate to their needs; exchanging information with clients to ensure informed choices; technical competence of providers; respectful and supportive interpersonal relations; follow-up and continuity mechanisms to address discontinuation rates; and an appropriate constellation of services to ensure that clients receive the range of services they need to address both health needs and their wider social setting.

This framework provided a basis for reorienting a number of planning programmes around the world. Bruce was an architect of the 1994 International Conference on Population and Development's recognition that client-centred reproductive health services and female empowerment strategies were coequal, not competing, goals.

responsible for high fertility, and therefore greater development assistance, not family planning assistance, should be the priority. "Development," he said, "is the best contraceptive" (Potts, 1992).

These conversations contributed to an overall sense of ambivalence about the efficacy of nascent family planning programmes and the relationship between population growth and economic growth more broadly. Indeed, numerous voices raised questions about factors that contribute to fertility decline and hasten the demographic transition in developing countries.

In Bucharest in 1974, John D. Rockefeller III expressed "disappointment at the results of the family planning approach," and urged reappraisal that would move beyond the simple provision of family planning. "In my opinion, if we are to make genuine progress in economic and social development, if we are to make progress in achieving population goals, women increasingly must have greater freedom of choice in determining their roles in society" (Rockefeller, 1978).

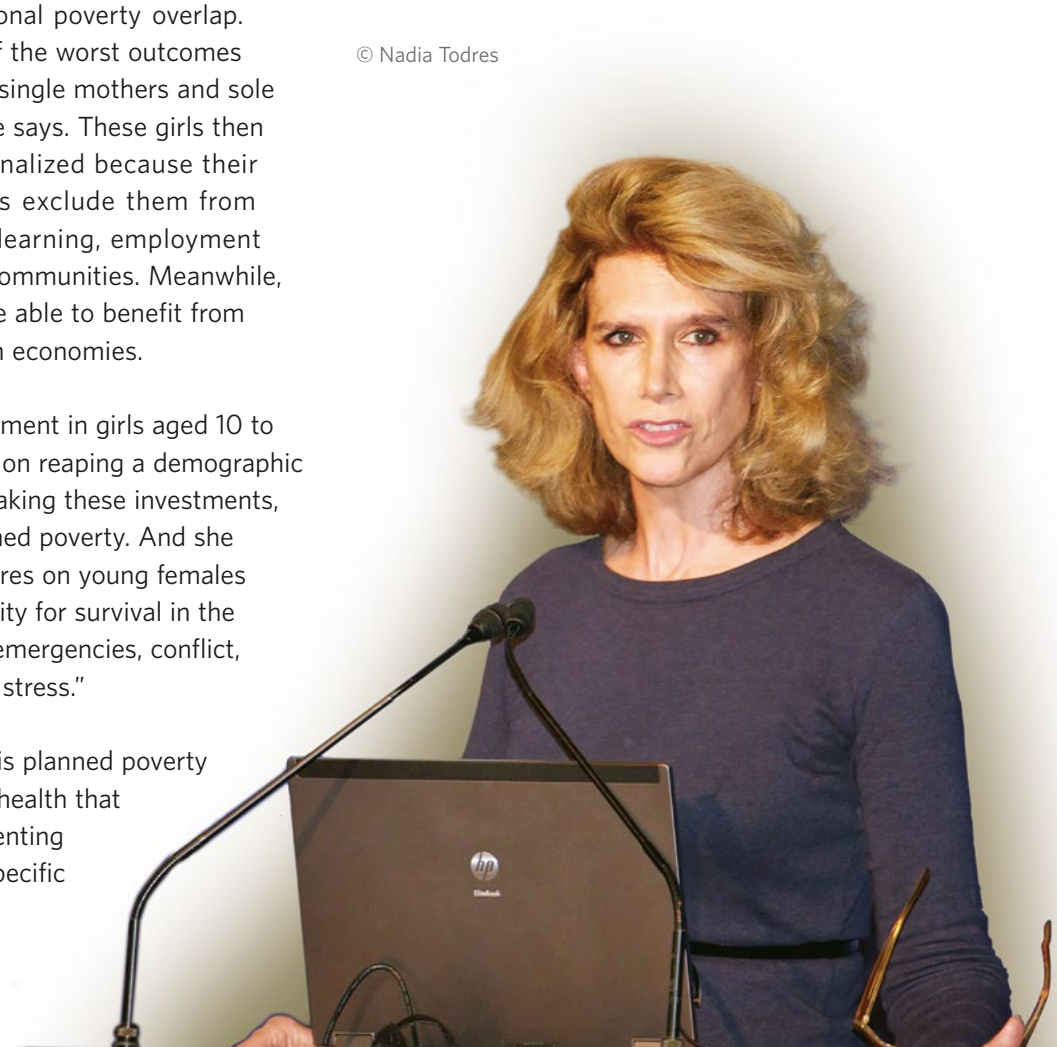
Pushback on narrowly defined population policies

As national population policies continued to expand through the 1980s, fear and mistrust of those promoting demographic goals continued to mount. A growing international women's health movement began to advocate for

Today she calls for using the Sustainable Development Goals to drive investment to hotspots where child marriage, sexual coercion, unmet need, resource scarcity and intergenerational poverty overlap. "Girls at the highest risk of the worst outcomes are most likely to become single mothers and sole household supporters," she says. These girls then become even more marginalized because their household responsibilities exclude them from seizing opportunities for learning, employment and participating in their communities. Meanwhile, their male counterparts are able to benefit from new, technologically driven economies.

"Without aggressive investment in girls aged 10 to 14, countries cannot count on reaping a demographic dividend," she says. Not making these investments, she says, amounts to planned poverty. And she predicts "increasing pressures on young females to trade sexuality and fertility for survival in the face of increasing climate emergencies, conflict, displacement, scarcity and stress."

Bruce calls for reversing this planned poverty and the poor reproductive health that accompanies it by implementing age-, gender-, and place-specific plans for those most likely to be left behind. The starting point for change: the 50 million 10-year-old girls in the poorest countries today.



programmes that ensured not just access to family planning, but a more holistic approach to women's reproductive health, including attention to issues of sexuality and gender relations.

While diverse in many ways, a fundamental message united the women's health movement: the design, implementation and evaluation of women's health programmes should be shaped by a concern for reproductive health and rights, and not by demographic objectives. Women's groups from around the world increasingly called for policies and programmes that treated women as subjects, with their own needs and rights, and not merely as objects to achieve broader societal goals.

A growing number of voices began calling for new research and data about women's needs and preferences related to fertility and family planning, and many argued that these needs and preferences, rather than demographic targets, should serve as the primary guide to population policies and family planning programmes. Indeed, influential research carried out by Sinding and others (1994) showed that in the majority of countries analysed, existing demand for family planning exceeded national targets for contraceptive prevalence rates set by governments; therefore, they argued, population policies with demographic targets should be replaced with objectives expressed in terms of the stated desires of the people served.

Pitching a big tent: the lead-up to the ICPD

Individual and collective goals can be reconciled within the broad umbrella of population policy: this message became the global rallying cry in the preparations for the ICPD, to be held in Cairo in 1994.

As a central organizing institution along with the United Nations Population Division, UNFPA sought to build bridges within a movement that had become increasingly divided. The institutions sought to build on the early foundations of the global population movement, acknowledging that an understanding of population trends is critical to achieving lasting development outcomes, while simultaneously embracing an understanding of the central role of women's lives—and promoting their rights and choices as a basic tenet of population policy.

Under the leadership of UNFPA Executive Director Dr. Nafis Sadik, the ICPD Secretariat guided a process that resulted in a consensus-driven Programme of Action that radically transformed views on how population policies should be developed and implemented in xthe future.

The road to Cairo was long and deliberate. The first preparatory meeting was held in 1991, where, for the first time, "development" became part of the title of an international conference on population, and a draft programme of action was reviewed, debated and accepted by States in subsequent "preparatory committee" meetings.

Alongside the preparatory meetings, the ICPD Secretariat organized expert group meetings to tackle thorny issues like population growth, migration, family planning and health, and population and environment. It organized five regional meetings to ensure broad geographic input and buy-in and, critically, organized numerous formal and informal gatherings of non-governmental organizations, enabling diverse and robust participation from a wide spectrum of interest areas.

The numerous consultations, multiple meetings, and strategic advocacy and engagement of stakeholders paid off. In the final Programme of Action, governments agreed, for the first time, that population policies should include a broad swath of social development considerations. They arrived at a consensus that family planning should be delivered in the context of comprehensive reproductive health care, incorporating efforts to ensure healthy and safe childbearing, prevent sexually transmitted infections, and address related reproductive and sexual health concerns, including gender-based violence and other harmful practices. Women's empowerment and gender equality were lifted up as fundamental elements of population and development policy.

CHAMPION OF CHANGE

Nafis Sadik

Born in 1929, Nafis Sadik grew up in a tumultuous time in history, one that in 1947 saw the birth of her country, Pakistan. It was not a particularly favourable moment to be a girl. But Sadik had a vision that she could change the world for the better. And this she did, by galvanizing people to come together around a wholly new understanding of population and development in 1994.

She challenged convention from the start. She completed a medical degree in obstetrics, served poor rural women and men, and helped shape the first national population policy for Pakistan.

When she joined UNFPA and rose through its ranks to become its second Executive Director in 1987, it marked the first time that a woman headed one of the major voluntarily funded United Nations programmes. She quickly became a passionate advocate for giving women the tools, from information to contraception, to manage their reproductive lives. Travelling the world, she heard women's stories and made them into a relentless crusade for their rights to be healthy and live free from violence.

In the early 1990s, the Secretary-General of the United Nations chose Sadik to lead preparations for the International Conference on Population and Development. It became the largest gathering of governments on the subject in history, and revolutionized the approach to sexual and reproductive health and rights. Under Sadik's persuasive influence, civil society groups took prominent roles at all stages of the process, setting a new norm for activist engagement in international political talks.

"People are at the heart of the process, as agents and beneficiaries."

As the conference began, Sadik stood before delegates and said with typical forthrightness, "Any form of coercion in population policies and programmes is unacceptable. Women and men have the right to choose the size and spacing of their families, and to the information and the means to do so."

"People are at the heart of the process, as agents and beneficiaries," she declared. "We have it in our power to lighten their burdens, remove obstacles in their path and permit them the full flowering of their potential as human beings."

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Underlying this emphasis was a shared understanding that enhancing individual health and rights would contribute to lower fertility and slower population growth. By placing the causes and effects of rapid population growth in the context of human development and social progress, governments and civil society from multiple political, cultural and scholarly viewpoints could join in support of the recommendations (Ashford, 2001).

Unlike outcome documents from previous international population conferences, the Programme of Action contained an openness and sensitivity in its treatment of issues related to sexuality, reproduction and gender relations. It emphasized the crucial links between sexual and reproductive health and rights with almost every other aspect of population and development: urbanization, migration, ageing, changing family structures and the rights of young people. By way of comparison, neither the World Population Plan of Action resulting from the 1974 Bucharest conference nor the recommendations from the 1984 Mexico City conference included the terms "sexual" or "sexuality" (United Nations, 1995).

Taking the lessons forward

The results of the consensus achieved at the ICPD were profound and enduring. Gone were the top-down, demographic targets of the past; today's notions of "population policy" reflect the broad consensus that women's education, empowerment and equality are paramount. The importance of providing family

planning in the context of full sexual and reproductive health care is fully embraced.

That said, many continue to draw attention to the ways in which demographic trends may hinder the achievement of development outcomes. For example, rates of population growth remain high in many areas that are steeped in poverty and conflict, or vulnerable to climate change or natural disaster. At the other end of the spectrum, persistent low fertility and population ageing have raised concerns about economic health and society's ability to provide adequate social safety nets.

Undeniably, population dynamics shape and are shaped by societal conditions. The relationships are complex, multivariate and multidirectional. The lessons of the past have shown that top-down, State-sponsored efforts to engineer or alter demographic trends are a fool's errand: they are instruments too blunt to achieve intended outcomes, they place undue limitations on individual choice, and they risk egregious violation of human rights.

But greater understanding of demographic trends and their relationship to development objectives is needed. The international community has a responsibility to gather and communicate data that shed light on those relationships, while continuing to highlight the primacy of rights and choices in all aspects of life, but particularly in accessing sexual and reproductive health information and services.

CHAPTER HIGHLIGHTS

- The United Nations established UNFPA in 1969, at a time of rapid population growth, to help countries analyse demographic trends and their relationship to economic and social development.
- In the 1970s, governments, non-governmental organizations and development institutions supplied an increasing quantity of reliable, modern contraceptives to empower women to manage their own fertility.
- Achieving demographic targets was the main goal of some early family planning programmes, sometimes compromising the quality of reproductive health services.
- By 1994, when the International Conference on Population and Development (ICPD) took place, a global consensus had emerged that women have a right to make their own decisions about whether, when and how often to become pregnant. The Programme of Action from the ICPD showed that reproductive rights and sustainable development are mutually reinforcing.
- The achievement of rights and choices for all will depend on a continued partnership among civil society, governments, academia and international institutions.
- The success of the United Nations Sustainable Development Goals depends in part on achieving universal access to sexual and reproductive health.

AVAILABLE BUT INACCESSIBLE

The growth of national population programmes and donor funding for them exponentially increased the availability of contraceptives in developing countries in the 1970s and beyond.

The International Planned Parenthood Federation, too, was giving voice to women around the world who were demanding information and services that would enable them to exercise control of their fertility. Top among the goals of the Federation was expanding options for preventing pregnancy. In the 1950s, the most common contraceptive methods were largely controlled by men: the male condom, withdrawal and periodic abstinence. Margaret Sanger, one of the founders of Planned Parenthood, was particularly interested in developing a pill, as easy to take as aspirin, that would enable women to prevent pregnancy. In 1953, she introduced American feminist philanthropist Katharine Dexter McCormick to Dr. Gregory Pincus. McCormick provided financing for Pincus' research into a hormonal oral contraceptive, and by 1960, "the pill" was on the market.

In 1970, the Population Council established the International Committee for Contraception Research to further expand availability of contraceptive options, including long-acting ones, such as implants and injectables.

By 1976, more than 100 governments were providing contraceptive information and services, either directly through government clinics or through non-governmental organizations. The number of countries making modern contraception available had grown to nearly 140 by 1986 and to 160 by 1996 (United Nations, 2013). By 2015, only 6 per cent of governments provided no support for family planning: these governments, however, allowed the private sector to provide family planning services without giving them any material

or financial support (United Nations, 2017a).

As government support for family planning and the number of methods grew, so too did the number of people availing themselves of contraception. Worldwide, the proportion of married or in-union women who reported using a contraceptive almost doubled between 1970 and 2015, from 36 per cent to 64 per cent (United Nations, 2015).

Over the past half century, governments and the international donor community expanded the availability of multiple methods to people everywhere, leading to a broad method mix that is evident today.

More than family planning

As efforts to expand family planning programmes rolled out across the globe, women's issues were moving to centre stage. In 1975, for example, the United Nations declared the opening of the Decade for Women, and multiple international conferences and regional gatherings enabled women across the world to meet, share information and advocate for change. More and more women were demanding agency in their reproductive lives, and such agency, they asserted, extended beyond the simple availability of family planning. For example, in response to sobering new evidence of hundreds of thousands of women dying during pregnancy or childbirth every year, the women's health movement fuelled the launch of the global Safe Motherhood Initiative in 1987. The Initiative aimed to reduce maternal mortality by 50 per cent by 2000 through strengthening community-based health care and developing alarm and transport systems to enable at-risk pregnant women to reach life-saving maternal health services.

Meanwhile, civil society organizations were calling for replacing narrowly focused family planning programmes that prioritized dispensing contraceptives with broader reproductive health care. They argued that the availability of family planning was only one part of the picture—that to ensure rights and choices in people's lives, all people needed and deserved a comprehensive suite of information and services related to sexuality and reproductive health.

So close yet so far

In 1994, the Programme of Action resulting from the International Conference on Population and Development not only acknowledged that family planning and sexual and reproductive health and reproductive rights were intertwined, but also called on States to provide *access* to: antenatal care; safe delivery and postnatal care; treatment of infertility; safe abortion where legal, and management of the consequences of unsafe abortion; treatment of reproductive tract infections and sexually transmitted infections; and information, education and counselling on sexuality, reproductive health and responsible parenthood.

The Programme of Action also affirmed that referral for these services, and for breast cancer and cancers of the reproductive system, should always be available; and that discouragement of harmful practices, such as female genital mutilation, should be an integral component of primary health care (United Nations, 2014a).

The term "access" underscored the point that making reproductive health services *available* was insufficient to enable everyone to enjoy their reproductive rights. Rights are universal, which means that everyone has them. A woman who, for example, is unable to avail herself of family planning services, even when they are available, is denied her right to plan her family. Social, economic and other barriers to access would therefore have to be removed for rights to be fulfilled.

One of the simplest and most basic definitions of "access" is geographic proximity to service-delivery points. Great distances can hamper access, either because affordable transportation options are limited or because the

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opportunity costs for poor women leaving their homes or livelihoods are too high. But distance is only part of the challenge. Sometimes services are available literally around the corner, but they are still inaccessible.

A nearby family planning clinic, for example, may offer services, but a judgemental service provider may refuse to dispense contraceptives to a young person or an unmarried woman. That same clinic may also offer only one or two modern methods of contraception, but not the method preferred by some women. Supplies of contraceptives may be unreliable. There may be laws that block access to services by certain groups, or husbands may forbid their wives from using any form of contraception.

Over time, researchers and practitioners have helped to articulate concepts of access that are multidimensional, recognizing that access is affected by factors at the levels of the individual, community, provider and service-delivery points. Enhanced concepts of access acknowledge the many barriers to individuals' abilities to avail themselves of information and services that enable health, well-being and the realization of rights and choices in their sexual and reproductive lives.

Overcoming barriers to access

In the past half century, great progress has been made in extending access to sexual and reproductive health services and information to people everywhere. But this progress

has been uneven and inequalities persist, both within and between countries—not only for traditional concerns around family planning and maternal health, but for information and services that can enable the realization of the full range of sexual and reproductive health and rights.

Multiple social, institutional, political, geographic and economic forces are at play. Sexual and reproductive health inequalities are deeply affected by income inequality, the quality and reach of health systems, laws and policies, social and cultural norms, and people's exposure to sexuality education.

Income inequality

Within most developing countries today, access to critical sexual and reproductive health care is generally lowest among the poorest 20 per cent of households and highest among the richest 20 per cent (UNFPA, 2017). The relationship between poverty and lack of access is complex: while financial costs of health services and supplies can be a barrier to access in some cases, income is linked to numerous social, institutional, political, geographic and economic forces that can also affect an individual's access.

Women in the poorest households may find themselves with little or no access to sexual and reproductive health care, leading to unintended pregnancies, higher risk of illness or death from pregnancy or childbirth, and the need to give birth on their own, without the assistance of a doctor, nurse or midwife.

For these women, their poor sexual and reproductive health can block opportunities, blunt their potential, and solidify their position at the bottom rung of the economic ladder. Indicators paint a picture of vast differences among wealth quintiles for many critical sexual and reproductive health services (UNFPA, 2017). For example, in the majority of developing countries, the proportion of the demand for family planning that is met through modern contraception, the access to adequate antenatal care, and the likelihood of giving birth with assistance is dramatically lower among the poor than it is among wealthier households (Figures 4.1, 4.2, 4.3).

Over the past 50 years, great strides have been made in

FIGURE 4.1

Proportion of demand for family planning met with modern contraception, by development level, place of residence and wealth quintile, latest year available

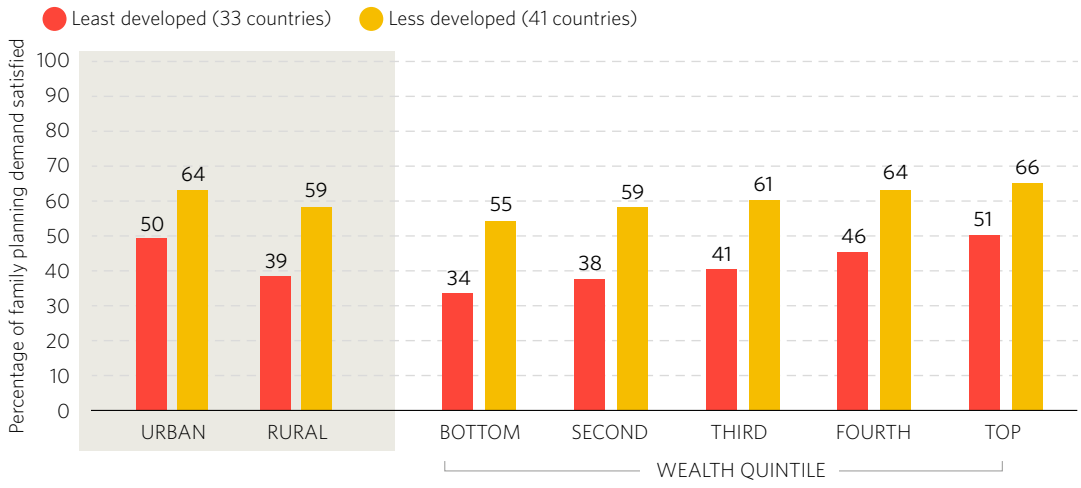


FIGURE 4.2

Proportion of women having four or more antenatal visits, by development level and wealth quintile, latest year available

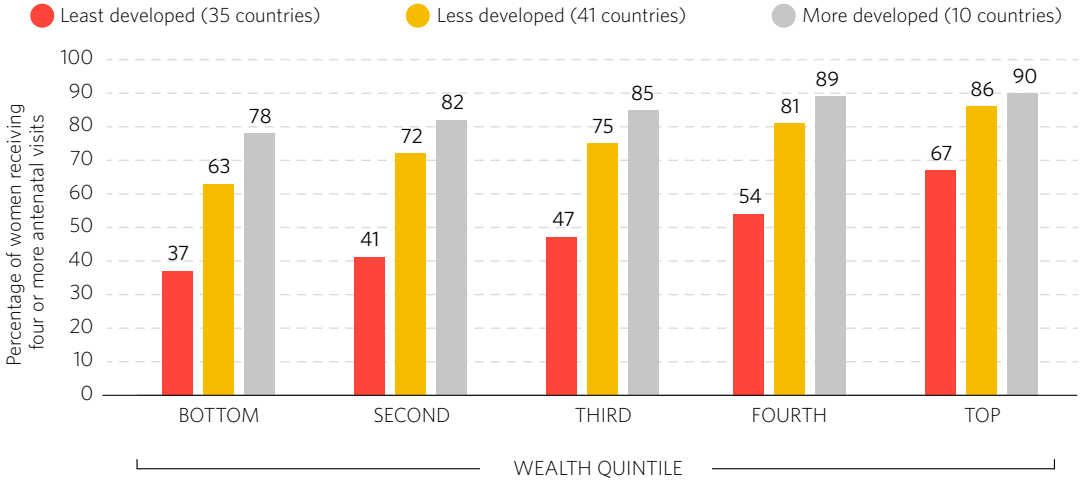
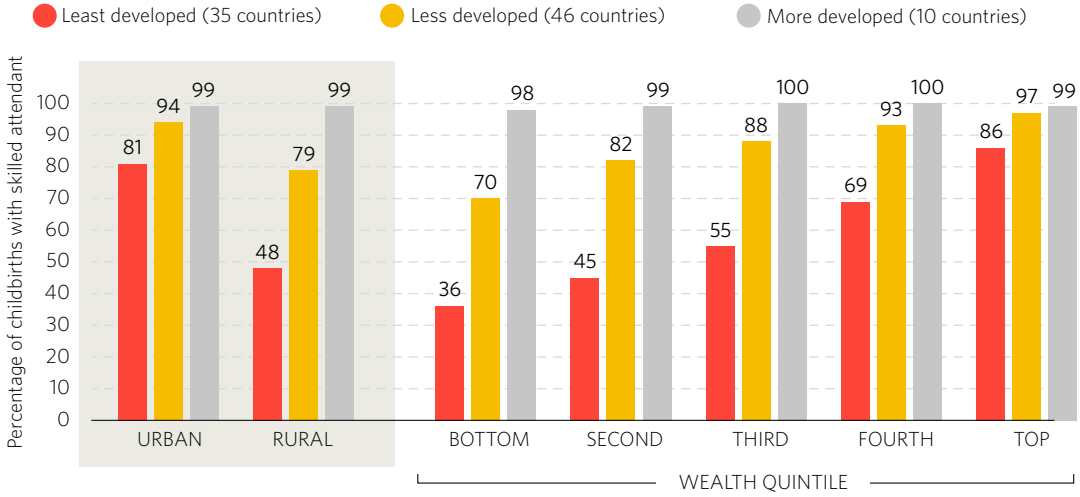


FIGURE 4.3

Proportion of births with skilled attendants, by development level, place of residence and wealth quintile, latest year available



reaching new populations with sexual and reproductive health information and services. Figure 4.4 shows that in many countries, remarkable progress has been made in expanding access to services that have dramatically decreased maternal mortality: globally, the maternal mortality ratio has experienced a decline of nearly 44 per cent, with progress seen in every region (Alkema and others, 2016).

But in many other places, the poorest populations have not yet shared equally in this progress. The vast majority of maternal deaths, for instance, occur in low-resource settings, and poor women with limited access to prenatal care, skilled birth attendance, and emergency obstetric care are more likely to suffer debilitating health impacts and pregnancy-related injury, such as obstetric fistula. Greater effort is needed to advance information and services designed to prioritize the poor and hard to reach.

Examples of such efforts offer hope. In Bangladesh, Bhutan, Cambodia and Thailand, for example, contraceptive prevalence rates are higher among the poorest 20 per cent of the population than they are among the richest 20 per cent. In these and several other countries, concerted efforts to expand family planning coverage to the hardest to reach have led to near-universal access to modern contraception, and near-equitable

UNFPA, 2017

rates of contraceptive prevalence among rich and poor households alike (UNFPA, 2017).

Innovative service-delivery models have helped expand access to the poorest populations. Community-based distribution systems initiated in the 1970s, for example, helped to extend access to poor and rural communities through trained members of the community. While traditionally these efforts were focused on expanding access to contraceptives such as pills and condoms, efforts have been made to expand the service mix to include emergency contraception, birthing kits and misoprostol for the prevention of post-partum haemorrhage (Bongaarts and others, 2012).

More recently, demand-side financing strategies, such as vouchers, have been introduced as a way of giving more decision-making ability to poor clients. In this model, clients can purchase vouchers for specific reproductive products at a subsidized price. The vouchers can be exchanged for services—including services as diverse as information about long-term family planning, and information and services for safe delivery and gender-based violence recovery—at qualified outlets (Bongaarts and others, 2012). Conditional cash transfers have also been introduced as a strategy to incentivize actions and behaviours that contribute to critical health outcomes, such as antenatal health visits, keeping girls in school, or delaying marriage (Bongaarts and others, 2012).

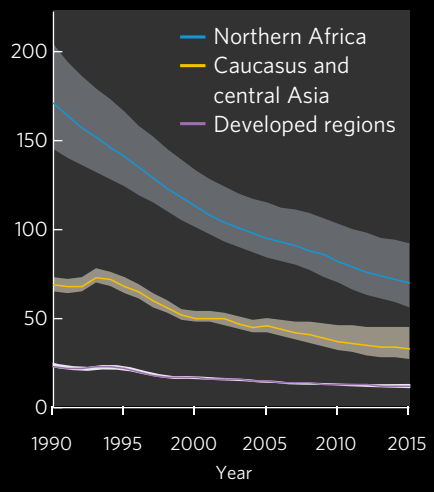
Insufficient facilities, providers and supplies

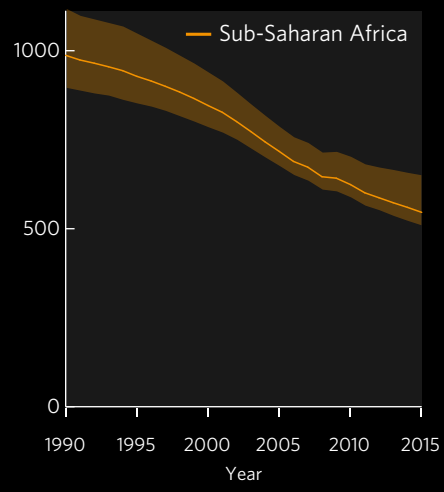
A woman who seeks sexual and reproductive health information and services may find no provider in her community. If she has the means to cover the cost of transportation to a clinic in a neighbouring community, she may arrive only to find that it lacks the proper equipment or supplies for the services she needs. There may be no health service provider, or not enough providers, to see everyone who has turned up that day. If there are enough providers, they may not have the training to offer appropriate information or services, or perhaps

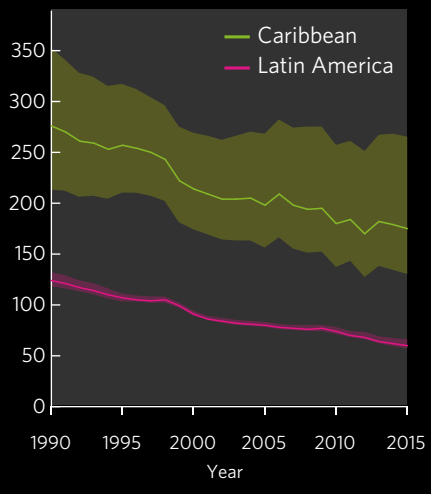
FIGURE 4.4

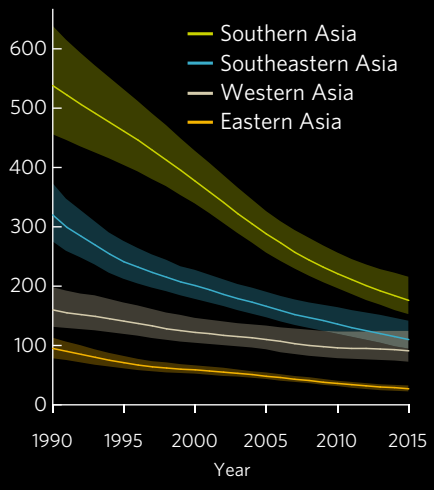
Global and regional estimates of maternal mortality ratio, 1990–2015

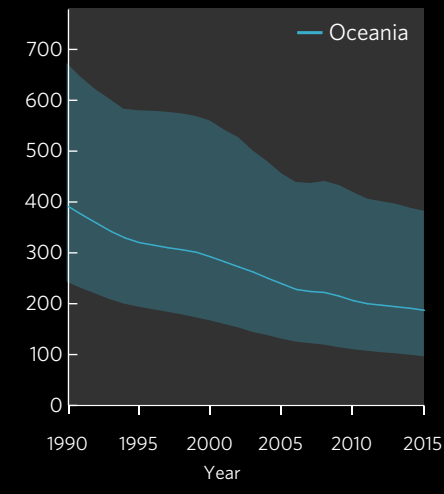
Maternal deaths per 100,000 live births. Shaded areas are 80 per cent uncertainty intervals. Shaded areas in background are comparable.

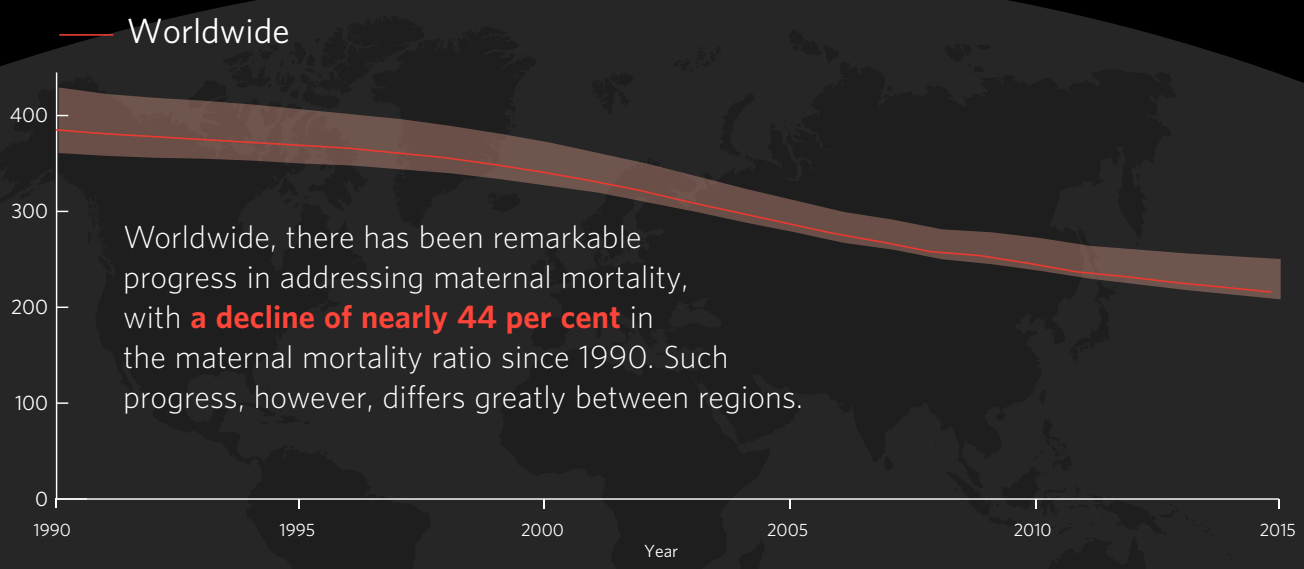












Worldwide, there has been remarkable progress in addressing maternal mortality, with **a decline of nearly 44 per cent** in the maternal mortality ratio since 1990. Such progress, however, differs greatly between regions.

Source: Alkema and others, 2016

The importance of quality

Quality is a critical dimension of access to services. Judith Bruce's seminal work in defining a framework for quality of care outlined six elements that deserve attention from the perspective of a family planning client: choice of methods; information given to clients; technical competence; interpersonal relations; follow-up and continuity mechanisms; and the appropriate constellation of services (Bruce, 1990).

Recognizing that too many women were not benefiting from actions to improve reproductive health, international institutions and nine countries launched the Network for Improving Quality of Care for Maternal, Newborn and Child Health, or the "Quality of Care Network," in 2017. Network members agreed on a vision that every pregnant woman and newborn receives high-quality care throughout pregnancy, childbirth and the postnatal period, a vision that is underpinned by the core values of quality, equity and dignity (WHO, 2018).

The element of quality in all dimensions of sexual and reproductive health is supported by the broad health-care framework known as AAAQ, for *availability, access, acceptability* and *quality,* which has been advanced as a key component of rights in health care by the United Nations Committee on Economic, Social and Cultural Rights (UNCESCR, 2000).

In 1992, the International Planned Parenthood Federation had advanced a "bill of rights" for family planning clients that outlined what individuals seeking family planning should be able to demand if they are receiving high-quality care from providers. These include rights to information, access to services and choice, as well as safety and the right to privacy, confidentiality, maintenance of dignity, comfort, continuity and expression of opinion.

While responsibilities for quality of care are, in principle, distributed through the entirety of a family planning programme, those who are seen as most responsible for ensuring those rights are the individuals who are in direct contact with clients: the providers. Therefore, strategies for quality of care must also recognize that service providers have their own needs, and should be able to expect training, supplies, guidance, back-up, respect, encouragement, feedback and self-expression (Huezo and Diaz, 1993).

The relationship between clients' rights and providers' needs is central to any effort to remove obstacles to quality of care. Promising interventions include those that facilitate a better interaction between clients and providers through means such as training providers in interpersonal communication. Resulting improvements in these dimensions of quality of care are possible without the need for large investments in staff, equipment or supplies (RamaRao and Mohanam, 2003).

"too little, too late" or "too much, too soon"

Limitations on quality of care can have significant implications for maternal health. While more and more women are giving birth in health facilities rather than at home, a lack of adequate staffing, training, infrastructure and commodities can result in poor quality care, known as "too little, too late" or TLTL. The converse also poses challenges: in some regions the rapid increase in the use of facilities for childbirth has been accompanied by widespread over-medicalization of birth, resulting in, for example, overused or unnecessary caesarean sections, or caesarean sections that are provided in unsafe or low-quality conditions, resulting in injury to mother and baby. This phenomenon, known as "too much, too soon" or TMTS, can have the effect of offsetting gains in maternal and perinatal health. For both TLTL and TMTS, improved provider training in respectful care and adherence to best practices can help to strengthen maternal and perinatal outcomes, avoid harm, and reduce health-care costs and inequities (Miller and others, 2016).

may not be able to offer privacy or other measures that would enable her to feel safe and respected.

Research, anecdotal information and reports by civil society have long confirmed the shortcomings of services. A recent review of health facilities in 10 African countries, for example, found overall low levels of readiness when assessing the availability of key supplies and services, including family planning guidelines, staff trained in family planning, blood pressure apparatus, combined oral contraceptives, injectable contraceptives and male condoms (Ali and others, 2018).

More systematic attempts to quantify and monitor overall readiness remain under development. The World Health Organization, in partnership with other organizations, regularly releases guidance notes on standards of good practice for a variety of reproductive health interventions.

A 2017 assessment of 24 countries indicated that family planning services run out of stock of some methods of contraception about three quarters of the time. An average of 78 per cent of primary-level facilities offering three or more methods of contraception had them in stock on the day of assessment; 79 per cent of secondary and tertiary facilities (regional and larger hospitals) offering five or more methods had them in stock (FP2020, 2018). These averages, however, mask wide variations within and between countries.

"Reproductive health commodity security" is achieved when all individuals can have access to affordable, quality supplies, including the contraceptive method of their choice, whenever they

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need them. Towards this goal, a partnership with the Bill & Melinda Gates Foundation and the United Kingdom Department for International Development is expediting the delivery of reproductive health commodities to countries to avoid stock-outs (UNFPA, 2018).

In many places, the number of trained providers is simply insufficient to ensure adequate access to a full range of sexual and reproductive health information and services. The Global Health Workforce Alliance has cited a need for increasing the number of health workers, particularly skilled birth attendants, in developing countries (Campbell and others, 2013). Over all categories of health workers, there was an estimated global shortage of 7.2 million health workers earlier this decade.

The need for trained professionals who can deliver essential sexual and reproductive health services is particularly acute. A recent analysis of 73 low- and middle-income countries found that while more than 92 per cent of the world's maternal and newborn deaths and stillbirths occur within those countries, they are home to only 42 per cent of the world's medical, midwifery and nursing personnel (UNFPA, 2014).

Estimates of outlays for personnel needed to achieve universal coverage levels for key reproductive, maternal, neonatal and child interventions suggest that substantial increases will be needed. To attain levels to meet all unmet need for reproductive, maternal and newborn health worldwide, for example, an estimated 37 per cent increase in funding for personnel to dispense contraception would be required; maternal and newborn health would require increases of about 20 per cent above current levels (Guttmacher Institute, 2017).

These global averages hide significant regional disparities. In the least developed countries, for example, outlays for personnel to address unmet need for contraception alone would need to be 96 per cent higher, and for full maternal and neonatal services coverage, 84 per cent higher. The payoff for such investment would be high: estimates suggest that maternal mortality and recourse to abortion would be reduced by as much as three quarters with full staffing, equipment and system maintenance (Guttmacher Institute, 2017).

The preparedness of providers to offer adequate care has been long appreciated regarding family planning. Insufficient counselling (that which fails to address questions about proper use; to offer advisories about contraindications, side effects and appropriate follow-up, including method switching; or to help in addressing the context of use, including partner concerns) can be an obstacle to contraceptive access, adoption and continuation.

Findings from studies of reasons for unmet need for family planning suggest that the provision of a range of methods and information and counselling to help women select and effectively

use an appropriate method can be critical in overcoming obstacles to contraceptive use. The most commonly reported reasons for non-use include infrequent sex and concerns about side effects or health risks (Sedgh and Hussain, 2014).

Contraception discontinuation is an often ill-addressed dimension of unmet need. A recent analysis of 32 countries indicates that, on average, more than one fifth of episodes of short-term methods (condoms and pills) are stopped within 12 months, despite the user still wanting to prevent pregnancy (FP2020, 2018). Discontinuation rates within one year are lower for long-acting methods: 12 per cent with intrauterine devices and 8 per cent with implants.

Legal barriers

Even in places where there are well-trained providers and facilities are well-stocked and equipped, individuals may face legal barriers that limit their access to information and services. In some places, laws require third-party authorization for women or adolescents to access health services. Elsewhere, laws that criminalize same-sex relationships, sex work and drug use can force people into hiding and prevent them from seeking or receiving the information and services they need.

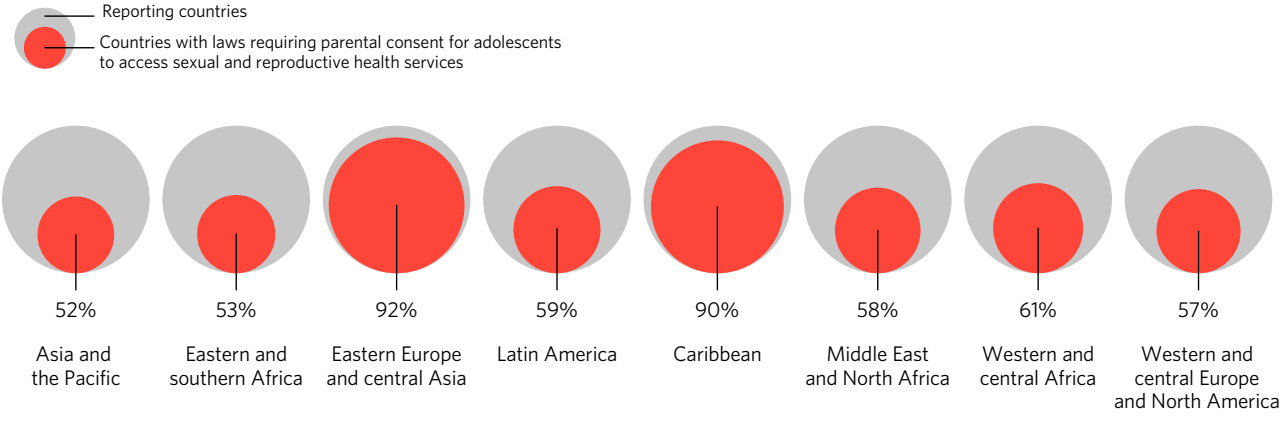
While intended to protect minors, age-of-consent laws for medical services can discourage adolescents from accessing needed services related to their sexual and reproductive health. This can be particularly harmful for adolescent girls, who bear disproportionate social and physical consequences of unintended pregnancies.

In 2017, 68 of 108 countries reporting data to the Joint United Nations Programme on HIV/AIDS (UNAIDS) indicated that they require parental consent for a child under 18 years to access sexual and reproductive health services (Figure 4.5; UNAIDS, 2018). In some settings, health-care providers are legally required to report underage sex or other illegal activities among adolescents (Delany-Moretlwe and others, 2015).

Legislation that bans intercourse between consenting adults of the same sex can interfere with efforts to provide access to services to

FIGURE 4.5 Discouraging adolescents from accessing services

Countries with age of consent laws to access sexual and reproductive health services, 2018



Source: UNAIDS, 2018

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prevent or treat sexually transmitted infections, including HIV. As of 2017, more than 40 countries reporting to UNAIDS stated they have laws specifically criminalizing same-sex sexual intercourse. Among these, two apply the death penalty, and some others may imprison people for life (UNAIDS, 2018). As a consequence, many people fear seeking critical services such as HIV testing.

Laws regarding access to abortion fall along a continuum, from total prohibition to no restrictions. As of 2017, 42 per cent of women of reproductive age live in the 125 countries where access to safe abortion is highly restricted. Of all abortions worldwide, only 55 per cent are safe, relying on a recommended method and administered by a trained provider (Singh and others, 2018).

Evidence suggests that the frequency of abortion is not significantly impacted by legal restrictions: abortion rates in countries with the most restrictive abortion laws are roughly the same as abortion rates in countries with the least restrictive abortion laws. However, the more restrictive the legal setting, the higher the proportion of abortions that are unsafe—ranging from less than 1 per cent in the least restrictive countries to 31 per cent in the most restrictive countries (Singh and others, 2018).

In developing regions combined, except East Asia, an estimated 6.9 million women are treated annually for complications related to abortion. Many more require post-abortion care but are unable to access it (Singh and others, 2018).

Norms, attitudes and practices

Across societies worldwide, expectations dictate that sexual activity and reproduction should take place only among groups with certain characteristics; those characteristics often include individuals who are heterosexual, married, monogamous, able-bodied, not too young, and not too old. In many places, childbearing practices are expected to adhere not to the interests of the individual, but to prevailing norms in families and communities.

Such expectations may result from long-standing attitudes and practices, or prevailing religious beliefs. When a person's sexual and reproductive activities fall outside these expectations, it is likely that it will be more difficult for that person to access information and services to meet their needs.

Adolescents face particular challenges. Despite widespread evidence that many unmarried adolescents are sexually active (Starrs and others, 2018), social norms may preclude or outright prohibit discussions of sexual and reproductive health or sexuality. In addition to legal barriers, challenges to access may come in the form of insufficient sexuality education in schools, or in providers' attitudes and beliefs about the appropriateness of interventions in the context of age or marital status.

Ethnic minorities, indigenous people, sex workers, people with disabilities, the poorest women and girls, and the lesbian, gay, bisexual, transgender and intersex

CHAMPION OF CHANGE

Mechai Viravaidya

Mechai Viravaidya has galvanized a no-holds-barred revolution in Thailand, one fired by the belief that everyone should know how to plan their family and protect their health.

A communications mastermind, Mechai has since the 1960s reached people with messages about condom use through schools and gas stations, in offices and villages, through pig-breeding contests and visits by Avon ladies and ceremonies by Buddhist monks. It was all part of a drive to make contraception an accepted, non-embarrassing feature of everyday life.

"Say the word 'condom.' Make it available. Talk about it," Mechai says. "In fact, what we're teaching is ... the right for you to choose the number of children you want."

While condoms offered a tactile and at times humorous entry point for education, Mechai's aim was always having a wide variety of contraceptives found as easily as "vegetables in the villages." Within a few decades, Thailand had moved a long way towards these goals, and the size of the average Thai family plummeted from 7 children to 1.6.

In the early 1990s, when HIV prevalence was predicted to spike, Mechai persuaded the Government to boost the budget for prevention 50-fold and enlist people from all parts of public service, business and communities to speak out about protection and condom use. Thailand subsequently warded off an estimated 3 million HIV infections, and Viravaidya became known as the "Condom King." Today, "mechai" is slang for condoms.

Viravaidya still leads the largest Thai non-governmental organization, the Population and Community Development Association, which since 1973 has championed rural development and health. Its activities include the Mechai Pattana schools, which embrace principles of equity and fairness in bringing high-quality education—including comprehensive sexuality education—to otherwise marginalized communities. Gender equality is integral to the curriculum. "Women are very, very important in the development process," Mechai says, adding, with a typically memorable flourish, "When you have two brilliant arms, why use only one?"

"Say the word 'condom.' Make it available. Talk about it."

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CHAMPION OF CHANGE

Lebogang Motsumi

When Lebogang Motsumi speaks to other young people about HIV and AIDS, she does so from her own experience. In telling her story, she hopes to inspire other young women and girls to stay in school, stay healthy and make positive choices.

A typical bold Facebook post: "Good morning, my name is Lebogang Brenda Motsumi aka African Queen. I am NOT HIV, I am LIVING with HIV. I am not the virus, the virus lives in me. I am not defined by HIV, but I define HIV."

Almost a decade has passed since Motsumi learned she was HIV-positive. She was only 17 when she was infected by her boyfriend, a well-known singer who later died. Motsumi did not go for testing until a later partner insisted on doing so. A few days after learning she was positive, she made a suicide attempt. A month after that, she found she was pregnant and started taking medication to protect her child.

She also began a remarkable journey, on social media, as an inspirational speaker, and as an HIV activist and coach speaking especially to young people. "My HIV infection helped me find my purpose in life. I realized that I can turn my mess into a message, and use my pain to empower other people."

The African Union has honoured her as a youth hero, and she sits on youth advisory boards for both the Union and UNFPA. She also rallies people as an ambassador for Zazi, a campaign encouraging South African women and girls to "know your strength."

"We will find the cure to HIV," Motsumi declares. "While we try to find a cure, the education and empowerment of people living with HIV is our cure. And prevention for those who are HIV-negative."

"I am not defined by HIV, but I define HIV."

(LGBTI) community face marginalization and stigma that can result in significant barriers to sexual and reproductive health and the realization of rights and choices. Girls and young women with disabilities, for example, are frequently denied the right to make decisions for themselves about their reproductive and sexual health, increasing their risk of sexual violence, unplanned pregnancy and sexually transmitted infections. They may not be seen as needing information about their sexual and reproductive health and rights, and therefore have little knowledge about them, leading to outcomes that further limit their choices and exacerbate marginalization. In one study in Ethiopia, for example, just 35 per cent of young people with disabilities used contraceptives during their first sexual encounter, and 63 per cent had had an unplanned pregnancy (UNFPA, 2018a).

Stigmatization can prevent individuals from seeking services they need and are entitled to. Unmarried women, for example, may be hesitant to seek sexual and reproductive health care, particularly services such as contraception and safe abortion. Levels of unmet need for modern family planning are much higher among single, sexually active women than among married women due to such stigma (Singh and others, 2018).

Stigma not only impacts the choices and decisions of individuals in need of information and services, but can also affect the actions of providers. In places where abortion is broadly legal, for example, persistent stigma about the procedure can affect the willingness of providers to counsel or offer abortions. A recent review found that some providers held negative attitudes towards abortion in most countries in South-East Asia and sub-Saharan Africa, for example, and providers also reported being stigmatized

Access to services for young people with disabilities

Women Enabled International helped develop guidelines for governments, service providers and other stakeholders to meet the sexual and reproductive health needs of young people with disabilities. The guidelines include actions to ensure availability, accessibility, acceptability and quality services, as well as services to prevent or address the impact of gender-based violence:

- Establish disability-sensitive protocols and guidelines for follow-up visits with health-care providers, management of side effects of medication or treatments, and referral guidelines for further assistance when necessary.

- Create accessible informational materials tailored for young people with different types of disabilities and appropriate at different ages that address the types of contraceptive and sexual and reproductive health services available and consider subsidizing such services for low-income young people with disabilities.

- Develop awareness-raising campaigns and educational materials for caregivers and family members of young people with disabilities on sexuality, contraceptive use and the availability of services.

- Ensure that contraceptive information, goods and services are available to young women and men with disabilities. Men and boys should also receive information to help them understand the rights of young women and adolescent girls to use contraceptives.

Sexual and reproductive health and the advent of universal health care

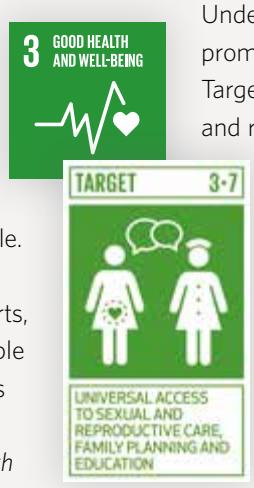
Sexual and reproductive health in general, and family planning in particular, were for decades sidelined in global arenas that took up issues of primary health care.

In 1978, for example, government representatives converged in Kazakhstan for the International Conference on Primary Health Care. The event concluded with the Alma-Ata Declaration, which identified primary health care as the key to attainment of health for all around the globe. But some governments said the goals outlined in the declaration were too broad and therefore unattainable.

A year later, at a gathering of health and policy experts, a consensus emerged on the need to focus on simple but high-impact primary health-care interventions that promised to save lives in developing countries. These interventions, referred to as GOBI, for *growth* monitoring of children, *oral* rehydration, *breastfeeding* and *immunizations*, again failed to address fundamental sexual and reproductive health issues as part of primary health care. But the global health community eventually recognized the importance of other essential primary care interventions, and agreed that family planning should be a priority (as well as female education and food supplementation).

The addition of family planning to the global primary health agenda foreshadowed the Millennium Development Goals (MDGs), which included an objective to reduce maternal mortality worldwide by 75 per cent between 2000 and 2015. In 2005, five years into efforts to achieve the MDGs, the United Nations agreed to add a target to achieve universal access to reproductive health.

Health targets were scattered throughout four of the eight MDGs. But starting in 2015, with the new 2030 Agenda for Sustainable Development and its accompanying 17 Sustainable Development Goals (SDGs), all health-related targets, including ones related to sexual and reproductive health, were included in one Goal. Having all health-related targets in one place reinforced the notion of a continuum of care that includes sex and reproduction—from prevention of pregnancy, to pregnancy, birth, infancy, postnatal care and childhood—and critical water and sanitation factors.



Under this Goal 3—to ensure healthy lives and promote well-being for all at all ages by 2030—Target 3.7 aims for universal access to sexual and reproductive health care and services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Figure 4.6, which shows coverage of health interventions across the continuum of care in the world's poorest countries with the greatest needs, reveals uneven progress in some sexual and reproductive health areas. Coverage, while still suboptimal, is highest around delivery and for schedulable immunizations (UNICEF and WHO, 2017). The times before pregnancy and after a recent birth, prime times for deciding on future pregnancy intentions, remain underserved.

In October 2018, 40 years after the Alma-Ata Declaration, delegates participating in the latest Global Conference on Primary Health Care finally acknowledged the centrality of sexual and reproductive health in primary health care. The declaration from that gathering stated that primary health care "will provide a comprehensive range of services and care, including but not limited to … services that promote, maintain and improve maternal, newborn, child and adolescent health, and mental health and sexual and reproductive health."

The SDG target of universal health coverage includes family planning as a core indicator along with antenatal and delivery care and cervical cancer screening. In recent years, sexual and reproductive health has been consistently included in indicators in global health policymaking.

FIGURE 4.6 Major gaps in coverage

Median national coverage of interventions across the continuum of care among countries, with available data from 2012, from the Countdown to 2030 initiative, which tracks progress in the 81 countries that account for more than 90 per cent of under-five child deaths and 95 per cent of maternal deaths in the world.

a Refers to the prevention and planning of pregnancy and includes the time period prior to a first pregnancy and interpregnancy intervals as well as decision making on whether to ever have a pregnancy.

b Infant and young child feeding indicators serve as a proxy for programme coverage for which measures are not available.

Note: Includes only interventions of relevance to all Countdown countries. Malaria-related indicators that Countdown tracks are not shown.

Source: Immunization rates, World Health Organization (WHO) and United Nations Children's Fund (UNICEF); population using basic drinking-water services and sanitation services, WHO and UNICEF Joint Monitoring Programme for Water Supply and Sanitation; antiretroviral treatment of pregnant women with HIV, UNICEF global database, July 2017, based on 2017 estimates from the Joint United Nations Programme on HIV/AIDS; all other indicators, UNICEF global database, July 2017, based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys and other national surveys.

© UNFPA

by their families, communities, colleagues and policymakers for providing abortions (Rehnström Loi and others, 2015).

Insufficient education about sexuality

Individuals' lack of knowledge can be a barrier to accessing services. Misperceptions or a lack of understanding about sexuality, the human body and development, rights and gender, and power in relationships can stand in the way of people's rights and choices.

Comprehensive sexuality education is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives (UNESCO, 2018).

Initiating age-appropriate comprehensive sexuality education in primary school offers numerous benefits, including helping children to identify and report inappropriate behaviour such as child abuse, and supporting the development of healthy attitudes about their own body and relationships. Comprehensive sexuality education should also be available to those who are not enrolled in school.

Evidence confirms that sexuality education does not hasten sexual activity, but rather has a positive impact on safer sexual behaviours and can delay sexual debut. A UNESCO review for the development of technical guidance on comprehensive sexuality education found that curriculum-based programmes contribute to delayed initiation of sexual intercourse, decreased frequency of sexual intercourse, decreased number of sexual partners, reduced risk-taking, and increased use of condoms and other forms of contraception (UNESCO, 2018). As with all curricula, comprehensive sexuality education must be delivered in accordance with national laws and policies (UNFPA, 2016a).

About 80 per cent of 48 countries covered in a recent study have policies or strategies that support comprehensive sexuality education (UNESCO, 2015).

Towards access for all

Ensuring access to information and services is a priority for the international community. Over time, policymakers, practitioners and advocates have helped to answer the important questions of "access to what?" and "access for whom?" and "what does access really mean in practice?"

Today, there is a consensus around the objective that everyone, everywhere should have access to high-quality information and services for the full range of their sexual and reproductive health needs over the course of their lives. While remarkable progress towards this objective is evident, its full realization remains elusive for many, due to lack of awareness, scant resources, insufficient political will, or underlying gender inequality.

CHAPTER HIGHLIGHTS

- To ensure rights and choices in people's lives, all people need and deserve a comprehensive suite of information and services related to sexual and reproductive health.
- While early programmes focused on expanding the *availability* of contraceptives to women around the world, over time, the concept of access has evolved. Advocates, practitioners and policymakers helped to answer important questions of "access to what?" and "access for whom?" and "what does access really mean in practice?" As our understanding of barriers to access grows, and as new challenges emerge, there is an ongoing need to raise these questions.
- Enhanced concepts of access acknowledge the many barriers to individuals' abilities to avail themselves of information and services that enable health, well-being, and the realization of rights and choices in their sexual and reproductive lives.
- While significant progress has been made in extending access to services and information that enable the realization of the full range of sexual and reproductive health and rights, this progress has been uneven, and inequalities persist. Sexual and reproductive health inequalities are deeply affected by income inequality, the quality and reach of health systems, laws and policies, social and cultural norms, and people's exposure to sexuality education.

THE OBSTACLE UNDERLYING ALL OTHERS

The sexual revolution, fuelled in large part by the advent of reliable and safe contraceptive methods, was well under way in wealthier countries in the 1960s. At that same time, developing countries were undergoing dramatic economic and social changes that fundamentally transformed their societies.

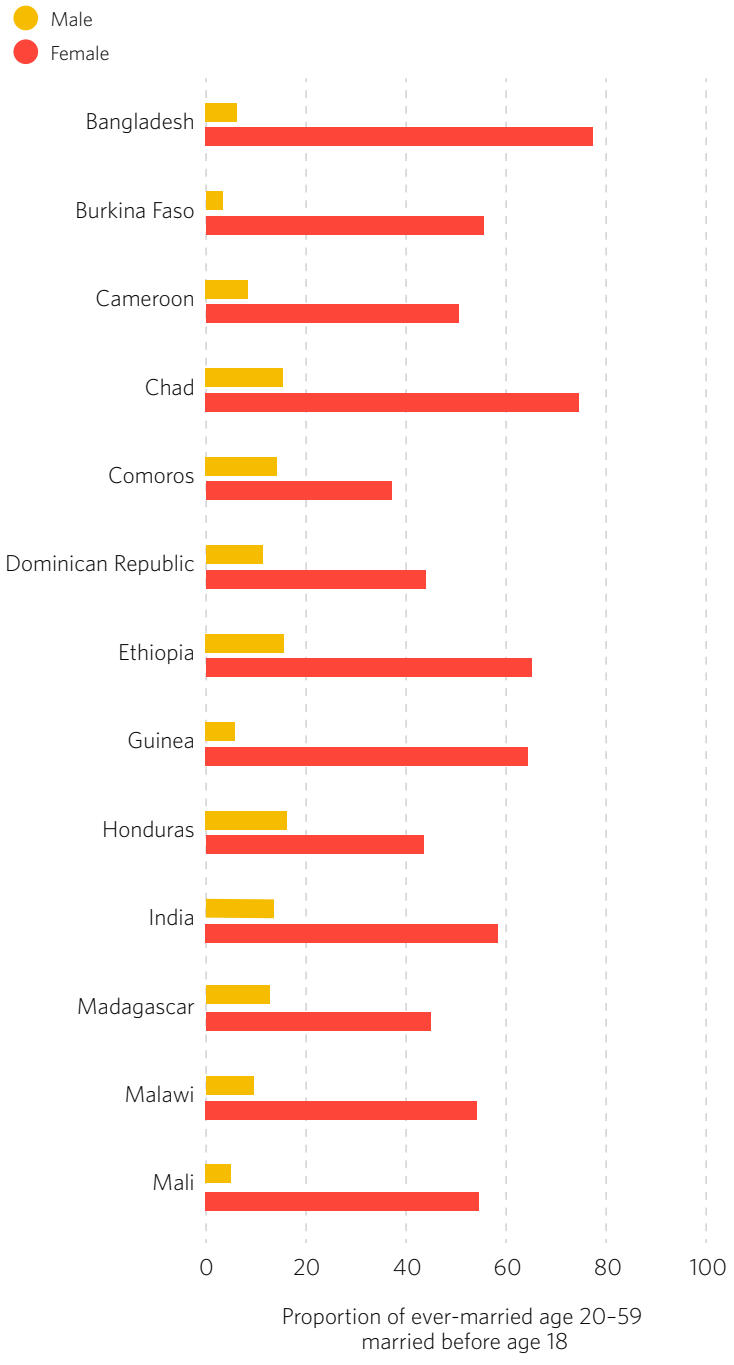
These changes included shifts in attitudes about what men and women could and should be doing in their lives.

At the same time, Ela Bhatt, Sonia Montaño, Gloria Steinem and other feminists around the world were raising awareness about gender inequality and its connection to sexuality, inequality in the family, reproductive rights and sexual violence. This broader vision of gender inequality continues to play a central role in discussions around reproductive rights today.

Of all the obstacles to the achievement and exercise of human rights, including reproductive rights, few have proven to be as challenging to overcome as those based on gender. Gender, the web of expectations and norms within a society that together define what are appropriate male and female behaviours, roles and characteristics, is learned, internalized and reinforced through social interactions with others, thus having a profound influence on every domain of life.

While the expression of gender varies across contexts, in virtually all societies gender has been defined in ways that subordinate women (and those who are gender non-conforming) to men, imbuing definitions of masculinity and femininity with different levels of power and social authority. The net result of these differences in most societies has been a systematic disempowerment of women and non-gender-conforming groups, who find their autonomy and ability to freely make decisions

FIGURE 5.1 The disproportionate burden of child marriage on girls



Source: MacQuarrie and Edmeades, 2015.

for themselves limited across almost every aspect of life. Gender norms wield a particularly large influence in reproductive matters.

Gender influences and is influenced by reproductive rights

Gender inequality limits the ability of women to freely make fundamental decisions about when and with whom to have sex, about the use of contraception or health care, and about whether and when to seek employment or whether to seek higher education. Gender-unequal norms and expectations magnify the negative effects of other impediments to rights and choices. One example is with child marriage, which is overwhelmingly more common for girls than boys (Figure 5.1). When a girl is married, she is less likely to go to, or complete, school or travel freely outside of her home alone; more likely to be subjected to gender-based violence; and less likely to know about her body and rights. Her limited mobility, schooling and knowledge in turn reinforce and perpetuate gender inequality.

Gaining the power to choose

Overall, women today have more control over their reproductive lives than at any point in human history, with profound implications for individuals and societies. For women in particular, being able

to choose how many children to have, and when to have them, has opened the doors to lives not dominated by childbearing and child-rearing and has helped reduce gender inequality.

As levels of reproductive choices have expanded over time around the world, women in most parts of the world have started having fewer children. This trend towards fewer children has had a number of benefits for women in particular, including better health for both themselves and their children, greater educational attainment, increased participation in paid employment, and improvements in how women and girls themselves are viewed and valued by society and within their households (Stoebenau and others, 2013). In many settings, this has formed part of a virtuous circle of empowerment, where greater access to reliable ways of controlling fertility has enabled an expansion of rights in other areas, which in turn has further contributed to their ability to fully exercise their reproductive rights.

The right of both women and men to freely choose the number, timing and spacing of children is now almost universally acknowledged. Ultimately, almost all of the 4.3 billion people of reproductive age around the world today will have had inadequate access to sexual and reproductive health services at some point in their lives (Starrs and others, 2018). And that access is heavily dependent on prevailing gender norms.

Power, voice and choice

In all societies, reproduction is imbued with deep social significance and cultural meaning, playing a critical role in marking the transitions between the stages of life and in building social status and identity. As a result, behaviours associated with reproduction, including the manner in which families are formed and sexual behaviour, are regulated through norms, particularly those related to gender. Such gender norms shape and reinforce social, legal and economic systems.

Patriarchal societies are often characterized by strong and pervasive sexual double standards (Heise and others, forthcoming), where masculinity is defined in ways that reward sexual prowess and where women are rewarded for purity and chastity. These gender-unequal norms and attitudes are often used to rationalize control over women's sexuality and reproduction.

A UN film-maker, editor-and mother-to-be checks her film at UN Headquarters. The symbol for international Women's Year can be seen in the background and on the speaker to the right. New York, 1974. © UN Photo/M. Faust

Concerns over maintaining women's sexual purity underpin a range of harmful practices, such as child marriage and female genital mutilation, and are often used by men as a justification for gender-based violence.

The harmful practices that result from unequal gender norms can further impede access to sexual and reproductive health services and limit a woman's rights and choices in all areas of her life.

Gender-based violence: Violence against women and girls is a human rights violation and public health concern across all countries. One in three women worldwide will experience physical or sexual violence at some point in her lifetime (García-Moreno and others, 2013). The existence and even threat of violence creates an environment where women are subjugated by men in sexual and reproductive health matters and are at increased risk of sexually transmitted infections and unwanted pregnancies.

Child marriage: An estimated 800 million women alive today were married when they were children. Child marriage denies a girl agency and autonomy in her home and in sexual and reproductive decisions, reduces her chance of being educated, undermines her future and blocks her from realizing her full potential in life. Married girls are less likely than adult women to receive adequate medical care during pregnancy, and that lack of care, coupled with the fact that many married girls are not yet physically ready to give birth, presents risks for both mothers and babies. The lack of autonomy that child brides have in terms of being able to make reproductive decisions, combined with the restrictions on mobility that many child brides have, restricts their ability to make reproductive choices freely and their ability to act on those choices by visiting health providers.

Fertility pressure and son preference: Because reproduction is seen as a fundamental part of social ideals of both masculinity and femininity, both men and women can face considerable pressure to prove their fertility early in marital relationships. A similar pattern is also seen in contexts where there is a strong preference for sons, itself a reflection of deeply held and inequitable views of the intrinsic value of men and women. In these contexts, women face extreme pressure to bear sons and may encounter violence, abandonment or stigma for birthing girls instead of boys. Under these circumstances, women have little power, voice or choice and therefore little autonomy.

Gender inequality in law and practice: Laws and policies often reflect broader societal values around gender and can interfere with autonomous decisions about sexual and reproductive health matters. For example, a service provider may be prohibited from dispensing contraception to adolescent girls or unmarried women, or the criminalization of same-sex relations may lead members of the lesbian, gay, bisexual, transgender and intersex (LGBTI) community to avoid seeking sexual and reproductive health services.

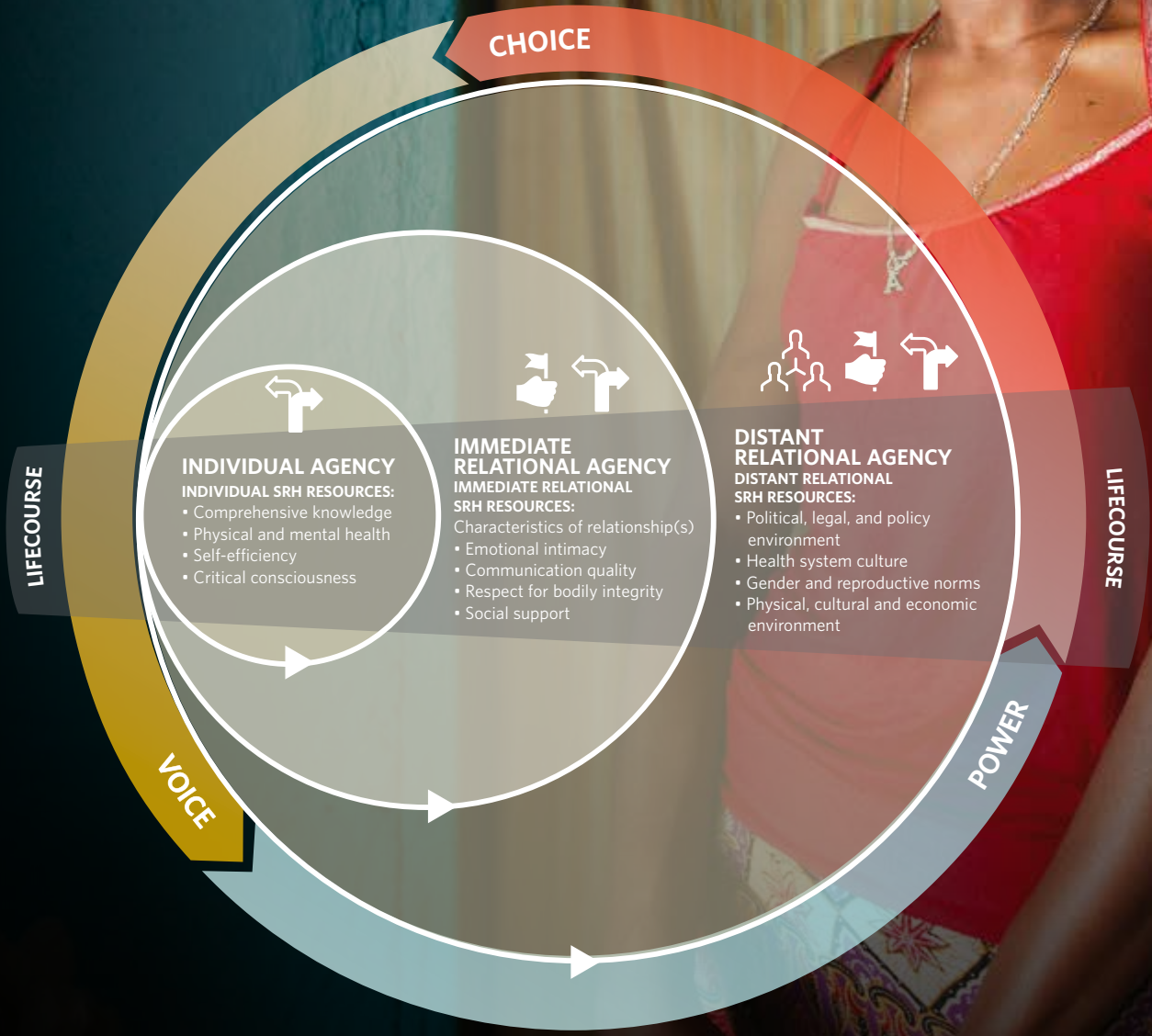
Inherently relational

Sexual and reproductive decisions and the role gender plays in making them are inherently relational in that they involve interactions with others, particularly sexual or romantic partners but also extended family members, community members, or institutions such as clinics and hospitals. Agency is experienced by individuals within these relationships (Figure 5.2).

In particular, three gender-dependent aspects of relationships are important in sexuality and reproductive decisions: the *power* of the individual; *voice*, or the degree to which individuals are able to articulate and advocate for their needs and desires; and the extent to which individuals have real *choices*. Together, power, voice and choice shape the degree of agency an individual has within a relationship, whether interpersonal or with an

FIGURE 5.2

Agency depends on relations to individuals, communities and institutions



Source: Edmeades and others, 2018.

© Michele Crowe

institution or society. For example, a woman may have considerable agency in her immediate relationship with her husband, but have far less in her relationship with her health provider or even her mother-in-law.

Agency is also determined at different levels within each relationship. For example, at the individual level, agency is influenced by factors such as knowledge about sexual and reproductive health and rights, which can enable a person to more effectively advocate for themself and make informed choices. On another level, agency is dependent on factors such as the degree to which a partner respects the other's bodily integrity or the degree to which there is freedom to express views about contraception. At a more distant level, where relationships are with institutions such as health systems or even the economy, agency depends on the responsiveness to individual needs. Within all these relationships, gender norms are key. They can build—or undermine—agency in all aspects of life, but especially in making sexual and reproductive health decisions.

Efforts to expand access to sexual and reproductive health care and empower individuals to exercise their reproductive rights can benefit from an approach that does not just anticipate what *women* need, but that also takes into account that sexual and reproductive health decisions are influenced by *gender* and the way it plays out in relationships, including those with health care systems. Insights into these dynamics can help service providers better respond to the unique needs of each client.

The evolution of gender in family planning

The urgency with which policymakers and donors viewed the question of population growth in the late 1960s meant that many early family planning programmes were mainly about reducing fertility, not about enabling women to realize their right to make decisions about the timing and spacing of pregnancies.

Programmes in the 1960s and 1970s therefore mostly focused on providing contraceptives to women, with little attention paid to the needs or desires of the women and men who might actually use them or to the social and gendered contexts within which reproductive decisions take place.

Some of these early programmes were, at best, blind to gender, and at worst, partly responsible for perpetuating gender inequalities in the name of achieving greater use of contraception and lower fertility. The focus on women, and particularly married women, as the primary targets of family planning programmes served to reinforce existing gender norms that assumed the primary roles of women to be as wives and mothers.

Programmes usually reflected the patriarchal societies in which they operated, with little attention paid to the gender dynamics around reproductive

CHAMPION OF CHANGE

Gita Sen

For 35 years, Indian economist Gita Sen has pushed for feminist thinking to play its rightful role at the centre of national and international commitments to reproductive and sexual health and rights. As a leader of the feminist network Development Alternatives with Women for a New Era, known as DAWN, Sen joins scholars and gender equality advocates in deploying the tools of research and activism to push for gender justice.

"We have to make development work for women and girls," Sen says. "And fight for women's human rights in every way we can."

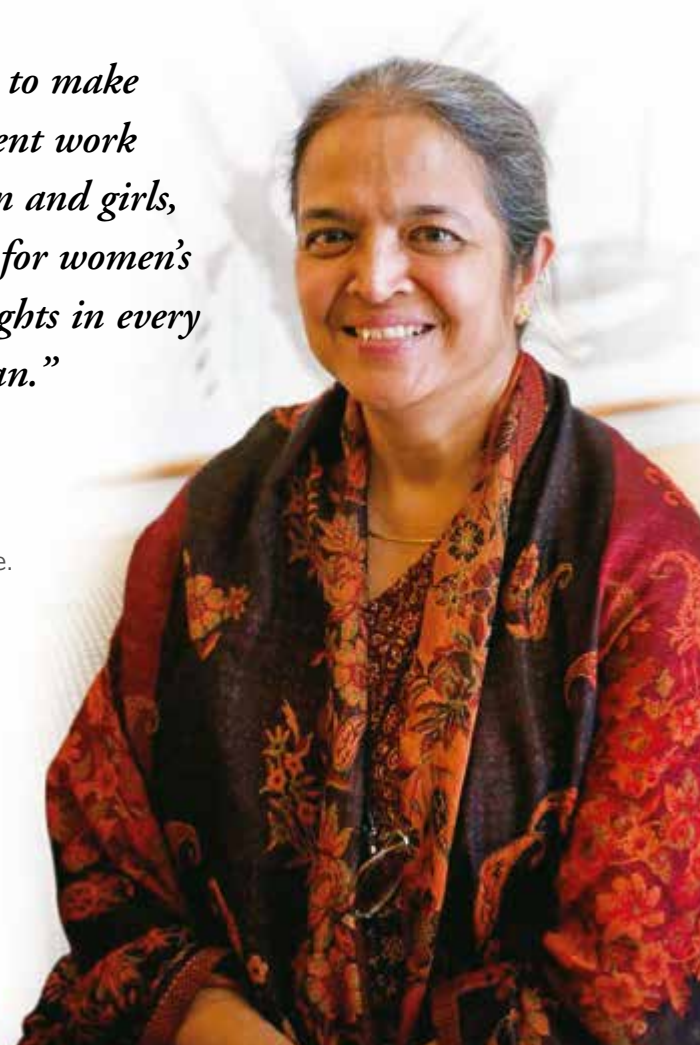
Sen was prominent in mobilizing the global groundswell of civil society that forever shifted understanding of population and development at the 1994 International Conference on Population and Development (ICPD). Before that point, population conferences mostly involved men deliberating population targets. Words like "sex" and "reproduction" were rarely heard. But at the ICPD, they met what Sen calls the "irresistible force of the women's movement." With thousands of activists participating from the global South and North, women's reproductive and sexual health and rights became *the* agenda.

"Twenty-five years later, the world is a much more difficult place for human rights. The backlash against women and feminism has been huge," Sen reflects. "But the fact that the ICPD agenda is still going tells us about the strength of what we achieved."

Sen has long argued that real change for women will only come when women mobilize to break down existing power structures and shift models of development. Among other issues, that means reorienting economies so that they no longer depend on women's unpaid care work or segregation into the worst low-wage jobs. The goal should be much more than an equal share of a "poisoned" pie.

"We have to make development work for women and girls, and fight for women's human rights in every way we can."

About her lifetime commitment to gender equality, she muses, "I think living the life of a woman drives me. I was aware of gender inequality even as a girl, when a lot was about controlling what girls could be and do. The same did not apply to boys. Later, when I could see how the structures of power and inequality work in entire societies and economies—well, there was no going back."



decision-making or the general well-being of women. Meanwhile, little programming was directed towards men, aside from efforts to increase condom use.

By the time of the 1974 World Conference on Population, governments, feminists and others had begun to express frustration with the demographic objectives that had been driving much of the international family planning movement up to that point. The growing evidence of violations of reproductive and human rights, the lack of input from those most directly affected by family planning programmes, as well as the lack of recognition of broader issues of social and economic development in some family planning programmes contributed to significant scepticism in developing countries about the intentions of the international family planning movement. This scepticism resulted in a concerted push by developing countries to adopt a more comprehensive approach to development that included measures to empower women to make their own decisions about the number, timing and spacing of births.

This push gained momentum in the years that followed. The United Nations Decade for Women (1976–1985), for example, coincided broadly with three United Nations world conferences on women (in 1975, 1980 and 1985), the establishment of the United Nations Development Fund for Women (UNIFEM), and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The networks formed along the way provided a foundation for a strong feminist alliance that influenced the direction of the family planning movement for the subsequent two decades.

At the International Conference on Population and Development (ICPD) in 1994, the reproductive rights movement took a great leap forward. The agenda was led by advocates for individual choices and

Gender and vulnerability: adolescents, sexual minorities and people with disabilities

The effect of gendered norms is most directly felt by those groups for whom either control over sexuality and reproductive behaviour is seen as particularly important or those whose behaviour does not conform to prevailing social expectations. The effect on sexual and reproductive health and rights can be profound, with real consequences for their health.

Adolescents

Adolescence is a time of life when the forces of gender socialization, where boys and girls learn how to behave in gendered ways that are acceptable to society, are particularly strong (John and others, 2017). However, it is also a time when individuals have particularly low levels of power, voice and choice in their lives, posing unique challenges to their access to services (Patton and others, 2016). This is particularly true for girls.

Adolescents have special sexual and reproductive health needs. They may lack knowledge about health matters and how to access health care, restricting their ability to prevent both pregnancy and sexually transmitted infections. Social proscriptions against sexual activity among adolescents, particularly for those that are unmarried, increase the social costs and stigma associated with seeking services, heighten fears about loss of confidentiality while accessing services, and place legal restrictions on free access to services. Finally, many adolescents are married as children, a fundamental violation of their rights. These girls, even more than adolescents as a group, have been overlooked for much of the history of the family planning movement, despite their obvious levels of need and relevance to the broader goals of the movement.

Women and young people with disabilities face multiple forms of discrimination including gender-based discrimination.

People with disabilities

Women and young people with disabilities face multiple forms of discrimination including gender-based discrimination. Data disaggregated by disability, sex and age remain scarce but are indispensable for understanding the situation of people with disabilities and informing policies. Evidence from around the world on sexual and gender-based violence and the sexual and reproductive health and rights of women and young people with disabilities reveals that their rights are at serious risk. Young people with disabilities under the age of 18 are almost four times more likely than their peers without disabilities to be victims of abuse, with young people with intellectual disabilities, especially girls, at greatest risk. Girls and young women with disabilities are more likely to experience violence than either their male peers with disabilities or girls and young women without disabilities.

Sexual minorities

LGBTI individuals face additional barriers to sexual and reproductive health information and services. In most societies, where sexual norms dictate heterosexual behaviour with an emphasis on reproduction, these individuals face pervasive stigma and discrimination, often find their sexual practices criminalized, and face high levels of sexual violence (Starrs and others, 2018). As a result, members of LGBTI communities are often reluctant to disclose their sexual orientation or activities to health providers, inhibiting their ability to receive quality care that is reflective of their needs. This population continues to be marginalized within the family planning movement, reflecting both direct prejudice and the perception that reproduction and reproductive matters are not relevant to them.

the full consideration of gender in exercising reproductive rights.

In 2010, the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) was established to help realize the global objective of achieving gender equality and women's empowerment. In 2012, the World Bank focused its annual *World Development Report* specifically on gender inequality, declaring gender to be at the heart of development, and gender equality to have an intrinsic value rather than being a tool to achieve economic growth or other goals (World Bank, 2012). And in 2015, the United Nations endorsed the 2030 Agenda for Sustainable Development and its accompanying 17 Sustainable Development Goals, which include a target for "universal access to sexual and reproductive health and reproductive rights" and greatly expand the number of gender-related indicators used to monitor progress. Goal 5 aims broadly to achieve gender equality and to empower women and girls. It calls for, among other things, the integration of the recommendations of the ICPD Programme of Action in national plans, policies and programmes.

Challenging the status quo: moving towards gender-transformational programmes

Sexual and reproductive health programmes that take into account how gender influences agency in the context of relationships may be better equipped to help women and men exercise their reproductive rights (Edmeades and others, 2018).

Tremendous progress has been made in upholding reproductive rights since 1969. Achieving future success, however, requires directly challenging the linkages between gender and reproduction and the patriarchal social norms that reinforce them. Family planning programmes, for example, have the power to become agents of gender transformation by building understanding around gender in ways that promote greater equality and allow greater freedom in sexual and reproductive choices. A number of promising approaches have been developed that point the way towards achieving these goals.

Achieving full equality must involve engaging directly with men as full, equitable partners in ways that enable them to be both invested in their own health and supportive of women's autonomy (Hook and others, 2018).

Initiatives that have taken this approach include the *Mobilizing Men* programme, which was shown to reduce violence against women in India, Kenya and Uganda (Greig and Jerker, 2012).

Another example is *MenCare*, a programme developed by Promundo and Sonke Gender Justice. It aims to challenge traditional norms around caregiving, encouraging and enabling men to take on roles that are not traditionally considered masculine, with the goal of achieving greater overall well-being, gender equality and health. In a similar vein, the *Ecole des maris,* or husbands' schools, in Niger have found considerable success in encouraging husbands to engage in questions around sexual and reproductive health, both for themselves and for their wives.

While engaging men in the process of gender transformation is critical to the long-term goals of enhancing reproductive rights, it is equally critical to continue empowering women and girls to reach their full potential. Of the changes seen in the past two decades in this regard, perhaps none will have as much impact on gender norms in the long run as the sharp increase in girls who are attending and staying in school. The experience and content of schooling can be a transformative experience for girls in particular, enhancing their understanding of their place in society and how this is shaped; providing them with the skills and information to exercise voice in their relationships with others and negotiate for their own

CHAMPION OF CHANGE

Lise-Marie Dejean

"I grew up in an atmosphere where women's lives were always put aside," Lise-Marie Dejean remembers. "Women were constantly reminded by men and tended to believe that their bodies did not belong to them."

Her voice animated, she continues: "We had to deconstruct the myths and mentalities. We had to help women take care of their bodies and their health."

Widely renowned in Haiti as a defender of women's rights, Dejean, 75, was born not long after the 1934 founding of the country's first feminist organization, which fought for women's rights to education and political participation, including to vote. Dejean remembers going to women's meetings with her mother. But it was not until she became a doctor and started looking at the extremely high maternal mortality rates in Haiti that she fully grasped the magnitude of gender discrimination and the lack of reproductive rights.

Dejean decided to take her medical skills to some of the poorest and most remote regions of Haiti, seeing individual patients and educating midwives to extend available medical services. Later, as the head of a major Haitian women's organization—Solidarite Fanm Ayisyèn or SOFA—she helped open women's clinics in crowded urban slums. An ongoing advocacy plank has been a push to remove criminal penalties for abortion. Illegal, unsafe abortion, Dejean points out, accounts for about a third of the maternal mortality rate. "This is a fight for women's lives," she stresses.

"It's a beautiful gain. When a person is psychologically ready to defend herself as a human being, that's a big victory. She won't get lost. She won't allow anyone to walk over her."

For Haitian women, the 1994 International Conference on Population and Development was a watershed moment. One key outcome was the creation of the first national women's affairs ministry, led by Dejean. She had to overcome death threats and demonstrations to get it running, and even now, constant vigilance is required in the face of regular suggestions to shut it down.

Dejean is undaunted. "Women are beginning to represent themselves as people with rights," she says. "It's a beautiful gain. When a person is psychologically ready to defend herself as a human being, that's a big victory. She won't get lost. She won't allow anyone to walk over her."

CHAMPION OF CHANGE

Sivananthi Thanenthiran

As a younger feminist activist, Sivananthi Thanenthiran used to think that reproductive rights battles had mostly been won in the 1960s. Enough focus had been put on women and their bodies. She chose instead to take part in seminal initiatives like the Women's Candidacy Initiative in her native Malaysia. It backed political candidates running on women's rights issues.

But in 2006, as she worked on a book on reproductive health in Asia, she began looking at numbers and speaking to people, and became outraged.

"It was really shocking to me that these battles were still very alive and present. I needed to do something about it."

Thanenthiran joined activists at the Asian-Pacific Resource and Research Centre for Women (ARROW), eventually becoming the organization's Executive Director. Active in 17 countries, ARROW advocates for the full realization of women's sexual and reproductive health and rights so that they can be equal citizens in all aspects of life.

"You only get what you fight for. We need to put our perspectives out there and forge ahead, fearlessly."

From social media to the halls of international political talks, Thanenthiran has become a prominent voice in systematically tracking gaps in sexual and reproductive rights as well as making links to issues that worsen the shortfalls, such as poverty and climate change. In a fragmented and deeply unequal world, she mobilizes people and policymakers to push back against what she calls the "bargaining" away of social rights amid a struggle over increasingly scarce economic and other resources.

Thanenthiran is proud of young feminists now stepping up to take on the mantle of the movement, including at ARROW. They have inherited a world where gender equality is more widely recognized than it ever has been.

But the battle is far from over, she cautions. Much depends on being bold while remaining united. "You only get what you fight for. We need to put our perspectives out there and forge ahead, fearlessly."

interests; and protecting them from harmful practices such as child marriage. Other programmes, such as the *Abriendo Oportunidades* in Guatemala, implemented by the Population Council, have also found success in helping girls successfully navigate the transition to adulthood, thus literally opening up opportunities that may shape the remainder of their lives.

Comprehensive sexuality education, too, is helping transform gender norms through age-appropriate curricula that provide information about sexuality and reproduction but that also focus on gender and power in relationships. UNESCO and UNFPA support comprehensive sexuality education in schools and through community organizations in dozens of developing countries (Haberland, 2015). Encouraging boys and girls to openly discuss questions around sexuality will result in more communicative partnerships where both partners feel free to share their desires and preferences in a mutually respectful manner, enhancing both the relationships of women and men and improving reproductive outcomes.

Achieving the broader goal of empowerment for all will require the sexual and reproductive health community to make a renewed commitment to building a deeper understanding of the role of gender and how gendered roles and expectations shape social interactions in matters of sexual and reproductive health. Only by addressing these root causes will the field be able to finally claim to have effectively liberated humanity from what Goldberg (2009) describes as the "intertwined tyrannies of culture and biology," an effort that remains one of the most ambitious undertaken in human history.

CHAPTER HIGHLIGHTS

- Of all the obstacles to the achievement and exercise of human rights, including reproductive rights, few have proven to be as challenging to overcome as those based on gender.
- Gender, the web of expectations and norms within a society that together define what are appropriate male and female behaviours, roles and characteristics, is learned, internalized and reinforced through social interactions with others, thus having a profound influence on every domain of life.
- Gender inequality limits the ability of women to freely make fundamental decisions about when and with whom to have sex, about the use of contraception or health care, and about whether and when to seek employment or whether to seek higher education.
- Gender norms constrain the reproductive rights of men by creating strong social pressures to prove fertility, engage in risky behaviours, and have many children.
- Gender-unequal norms and expectations magnify the negative effects of other impediments to rights and choices.
- Sexual and reproductive decisions and the role gender plays in making them are inherently relational in that they involve interactions with others, particularly sexual or romantic partners but also extended family members, community members, or institutions such as clinics and hospitals.
- Reproductive rights cannot be fully realized in the absence of greater gender equality.
- Sexual and reproductive health programmes that take into account how gender influences agency in the context of relationships and seek to promote greater equality are better equipped to help both women and men exercise their reproductive rights.

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WHEN SERVICES COLLAPSE

Since the mid-1990s, governments, aid organizations and international institutions have increasingly delivered services to women and adolescent girls whose choices have been constrained by wars and natural disasters.

In the twenty-first century, as long-running conflicts have proliferated and climate-related disasters have intensified, international consensus on this priority has deepened. States have approved successive commitments to address reproductive health concerns and gender-based violence in crisis settings, and responders have honed expertise on life-saving practices.

A world of trouble

The world today faces unprecedented levels of humanitarian need. Worldwide, some 136 million people were in need of humanitarian aid in 2018; 91 million received aid in 2017 (OCHA, 2018).

Numbers of refugees, migrants and internally displaced people have mounted steadily in recent years. Factors driving the increase include long-running conflicts that stem from and exacerbate countries' fragility; deadly storms related to climate change; and unpredictable events like earthquakes.

The breakdown in security, loss of shelter and disruption of water, food, sanitation and health services all combine to create enduring hardship for people affected by crises. Many are compelled to move and undergo additional suffering during the journey. Others languish in refugee settlements, sometimes for decades.

Every day, more than 500 women and girls in countries with emergency settings die during pregnancy and childbirth, due to the absence of skilled birth attendants or emergency obstetric procedures, and due to unsafe abortions (UNFPA, 2018b).

Insecurity and dislocation increase vulnerabilities to rape, exploitation and HIV acquisition, including among women, adolescent girls and boys, disabled people and individuals identifying as lesbian, gay, bisexual, transgender or intersex.

The causes and severity of displacement vary considerably between and within countries, but it is invariably the least advantaged who suffer hardest and longest. "Poverty


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and inequality, political instability and state fragility, water stress and food insecurity, climate change and environmental degradation, unsustainable development and poor urban planning combine in different ways in different countries to increase people's exposure and vulnerability," according to the Internal Displacement Monitoring Centre. Notably, it states, "low levels of human development correlate strongly with disaster displacement risk" (IDMC, 2018).

Data consolidated by United Nations agencies, the European Commission, governments and non-governmental organizations show that the risk of humanitarian crises and disasters that could overwhelm national response capacities is high in at least 12 countries. (Figure 6.1; IASC and European Commission, 2019).

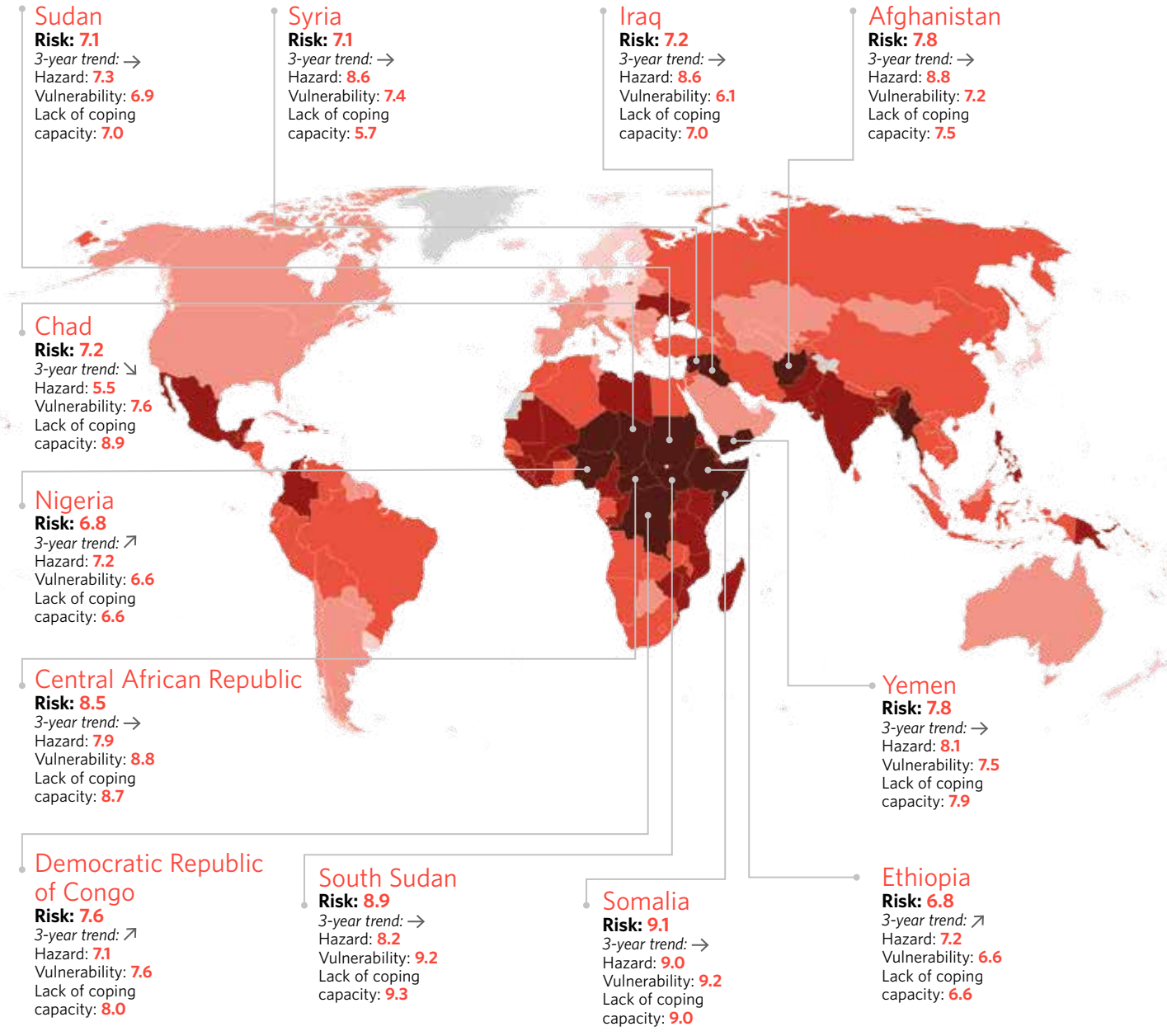
Protracted crises: the new normal

Wars have always impacted civilian populations and frequently produced mass displacements. In 1969, as UNFPA was coming into being, the Biafran War was precipitating a massive famine and humanitarian crisis. In 1994, the year of the International Conference on Population and Development (ICPD), conflict in the former Yugoslavia and civil war in Rwanda involved massive attacks on civilians.

Today, "protracted crises are the new normal," according to the

FIGURE 6.1 Humanitarian crises and disasters could overwhelm countries' response capacity

The 2019 INFORM Global Risk Index is made up of three dimensions—hazards and exposure, vulnerability and lack of coping capacity. This map shows details for the 12 countries with the highest overall risk. Legend is based on the INFORM 2019 Global Risk Index database.



Global Humanitarian Overview 2018 of the United Nations Office for the Coordination of Humanitarian Affairs (OCHA, 2018). Long-term dislocation due to intractable conflicts has driven the unprecedented increase in internally displaced people, refugees and migrants in recent years, creating ever-growing needs for assistance and a mounting challenge for humanitarian actors.

In eight years, the civil war in the Syrian Arab Republic has displaced more than half of the country's population.

At the end of 2017, there were 2.6 million refugees from Afghanistan, 2.4 million from South Sudan, and nearly 1 million from Somalia (UNHCR, 2018).

The world's largest humanitarian crisis today is in Yemen, where war has caused the economy, social services and livelihoods to collapse. Four out of five people, 22 million, are in need, many on the brink of famine (OCHA, 2018).

Around the world, nearly 12 million people were newly displaced by armed conflict, terrorism and communal or political violence in 2017, up from 6.9 million the previous year; 18 million were uprooted by weather-related disasters (IDMC, 2018). At the start of 2018, there were 40.3 million people internally displaced by conflict and 22.5 million refugees—the highest numbers ever seen (IOM, 2017).

Conflict was a major element in 19 of the 21 situations where the United Nations coordinated humanitarian response plans in 2018. Most of these crises have gone on for five years or more; three (in the Democratic Republic of the Congo, Somalia and Sudan) have persisted for over 18 years (OCHA, 2018). The number of forcibly displaced people has risen by over 50 per cent in the past decade.

In 2017, ethnic violence forced 655,500 Rohingya people to flee Myanmar into Bangladesh. In the same year, 2.9 million Syrians, 2.2 million Congolese and 1.4 million Iraqis were newly displaced by conflict (IDMC, 2018).

The effects of protracted internal or external conflict can

persist long after hostilities end. In 2017, the world's largest displaced population— 7.7 million people— were living in Colombia, despite the achievement of a peace deal in 2016.

Extensive conflict often results in a breakdown of authority and economic collapse, necessitating large-scale humanitarian assistance. Security threats to relief workers increase the challenges. Affected people in insecure places of refuge remain vulnerable to new outbreaks of violence and displacement, and each round makes them less resilient (IDMC, 2018).

Those who flee violence are more likely to remain in their own countries than to cross borders. Many long-term displaced people settle among host communities, often in urban areas, straining services and complicating relief efforts.

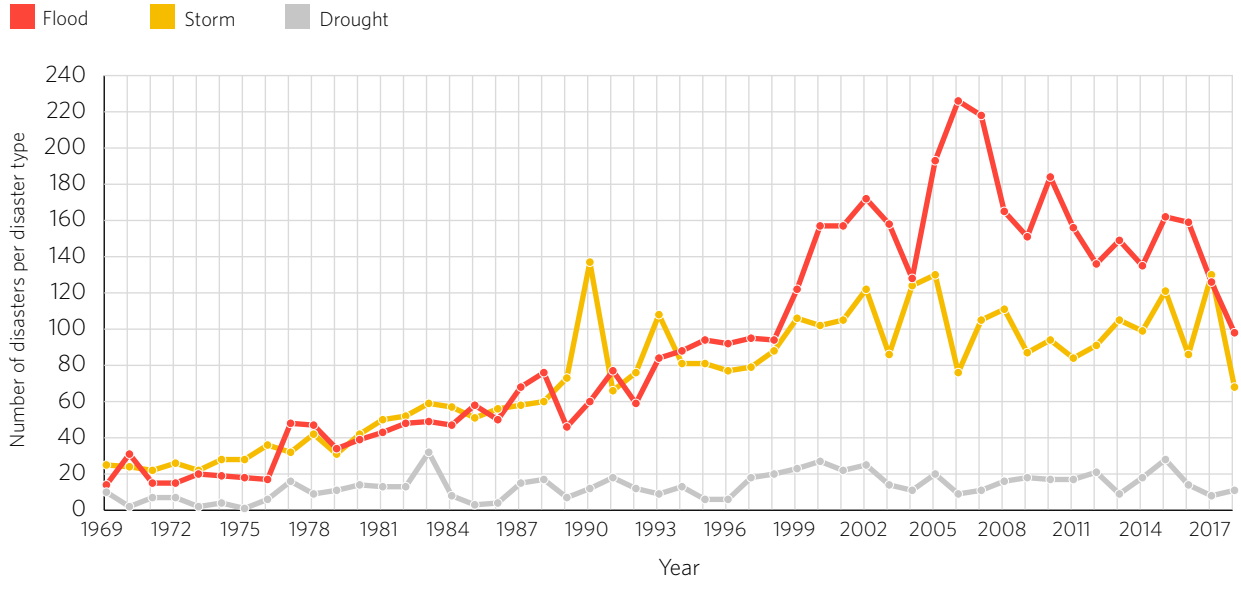
Climate-related disasters

More people are displaced by floods, storms, droughts and wildfires than by conflict, though many of these evacuations are short term. Since 2008, new weather-related displacements worldwide have averaged around 25 million per year; typhoons and hurricanes are a leading cause (Figure 6.2). Small countries and island States in particular face increasing risks of economic and social devastation due to disasters (IOM, 2017).

Poverty and hardship are expected to increase in some areas as global warming increases, contributing to further displacement. Indigenous peoples and local communities dependent on agricultural or coastal livelihoods, particularly in least developed regions, are especially vulnerable.

Climate change is also believed to be a risk factor in outbreaks of infectious diseases like Ebola and Zika, through the spread of disease vectors and competition between humans and animals for dwindling habitat and resources (Deese and Klain, 2017). Epidemics in West Africa and more recently in the Democratic Republic of the Congo have had devastating impacts in communities already incapacitated by conflict.

FIGURE 6.2 Disasters by type, 1969–2017



Source: EM-DAT: The Emergency Events Database – Université catholique de Louvain (UCL) – CRED, D. Guha-Sapir – www.emdat.be, Brussels, Belgium

Millions on the move

Displacement fuelled by conflict and desperation has contributed to a dramatic rise in international and internal migration in recent years. While refugees and internally displaced people are a relatively small percentage of all migrants, they frequently find themselves in highly vulnerable situations and most often need assistance and protection (IOM, 2017).

Migrants displaced by conflict in the Middle East and Africa have endured particular hardship. Thousands have died attempting to cross the Mediterranean. The closure of transit routes in Europe and the resort to smugglers has exposed many migrants to risks of exploitation or human trafficking (IOM, 2017).

Women and adolescents at risk

Every humanitarian crisis—whether due to conflict or natural disaster—causes systems to break down, increasing multiple needs for protection and services. Especially in the initial rush to provide food and shelter, responders may overlook the particular ways a crisis can increase the vulnerability of women and girls and threaten their lives.

Experiencing a natural disaster or fleeing violence can be extremely harrowing for pregnant women and mothers of small children. Trauma and malnutrition are dangerous during pregnancy, and during emergencies many women miscarry or deliver prematurely. The lack of even basic conditions for a clean delivery increases the risk of a fatal infection for both mother and child (UNFPA, 2004). Complications of childbirth in the absence of skilled birth attendants or emergency obstetric care often lead to death or serious injury such as obstetric fistula.

In the world's most densely populated refugee settlement at Cox's Bazar in Bangladesh, only one in five Rohingya mothers gives birth at a health centre, although there are facilities staffed by dozens of trained midwives. Some women are reportedly prevented by their husbands from going outside their makeshift homes; others who have been raped are said to fear stigma and discrimination from the wider community (UNFPA Bangladesh, 2018).

The disruption of family planning is also life-threatening. Sexually active women without access to contraceptives, due to a lack of services or legal restrictions, risk unintended pregnancy and sexually transmitted infections including HIV. Many who become pregnant resort to unsafe abortion, a leading cause of maternal death and injury. Safe abortion services are often minimal or non-existent in crisis settings, even where allowed under the law, and life-saving post-abortion care is often unavailable.

Conditions of displacement and the disruption of families make women and girls susceptible to rape and assault. Adolescent girls, the disabled, and ethnic and sexual minorities may be especially at risk. Recent research indicates that at least one in five refugees or displaced women in complex humanitarian settings have experienced sexual violence, though it is often unreported (Vu and others, 2014). Survivors suffer psychological and physical trauma, as well as unwanted pregnancies and sexually transmitted infections, including HIV.

People with disabilities are particularly vulnerable to sexual violence, and may have more difficulty accessing help after an attack. Men and boys are also at risk, and the norms that discourage women and girls from reporting assaults can be even more of a deterrent to coming forward in their case (IFRC, 2018).

Fear of sexual assault or exploitation and abuse restrict the mobility of many refugee and displaced women. Some families in dire circumstances resort to child marriage, hoping that marrying their daughters off will protect the girls from violence.

CHAMPION OF CHANGE

Nadine Alhraki

Newly married at the age of 21, Nadine Alhraki was studying geography in a university in Damascus, Syria, six years ago. Since then, she has been a refugee. As Syria descended into war and chaos, she and her husband joined 5 million people fleeing their country. Across the border in Jordan, they found safety in the sprawling Za'atari Refugee Camp.

Three days after she arrived, despite wrenching personal upheaval, Alhraki signed on as a volunteer with Questscope, a humanitarian organization that serves young people. A workshop trained her to teach and mentor youth and adolescents on reproductive health. "These are important issues for all people, refugees or not," Alhraki says. "In our own community, we know there is a gap in correct information and young people getting the services they need."

At a Questscope youth centre, Alhraki leads education sessions taking up issues such as safe motherhood for young men and women aged 18–24, and the stages of puberty for those under age 18. Maintaining a friendly atmosphere is part of encouraging interactive discussions around practical questions, such as what to do when your period starts. The sessions often mark the first time that younger camp residents have had any information about reproductive health.

"When people realize they have had the wrong information, and hear the right information and how that can impact their life, it makes a huge change," Alhraki says.

Sessions empower youth to challenge stereotypes, including those related to gender, and to think up and act on their own ideas. In one activity that Alhraki remembers well, young people distributed baby slings to mothers and fathers, along with messages about how husbands can help their wives in caring for children.

"When people realize they have had the wrong information, and hear the right information and how that can impact their life, it makes a huge change."

Now pregnant with her first child, Alhraki is determined to keep helping young residents of Za'atari. But her biggest dream is that her own child will not have to grow up as a refugee. And that he or she will enjoy full access to quality health services and education, and complete awareness of reproductive health.

On the last, she laughs. "Of course, I will teach my child all I know, now that I'm an expert!"

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Developing a response grounded in rights and choices

In the humanitarian response to emergencies around the world, women's needs and vulnerabilities have not always received the same level of attention as the need for food and shelter.

It was only in the 1990s that humanitarian actors adopted a more consistent focus on the rights and needs of crisis-affected women and girls (Chynoweth, 2015). The first edition of the *Handbook for Emergencies* issued by the Office of the United Nations High Commissioner for Refugees (UNHCR) in 1982 had stipulated that primary health care for displaced communities should include "maternal and child care, including family planning." In practice, however, contraceptive services were not typically included in refugee health care (Wulf, 1994).

In 1991, UNHCR issued *Guidelines on the Protection of Refugee Women,* which framed protection concerns within established international norms including the Universal Declaration on Human Rights and the Convention on the Elimination of All Forms of Discrimination Against Women. In addition to "protection against forced return to their countries of origin; security against armed attacks and other forms of violence; protection from unjustified and unduly prolonged detention; a legal status that accords adequate social and economic rights; and access to such basic items as food, shelter, clothing and medical care," it noted, "refugee women and girls have special protection needs that reflect their gender: they need, for example, protection against manipulation, sexual and physical abuse and exploitation, and protection against sexual discrimination in the delivery of goods and services" (UNHCR, 1991).

The Women's Commission for Refugee Women and Children in 1994 published *Refugee Women and Reproductive Health Care: Reassessing Priorities.* This influential report identified critical gaps in care for women, including sex education, family planning, HIV education and prevention, supplies for menstruating women, and services to assist survivors of sexual abuse, rape and forced prostitution (Wulf, 1994).

The transformational ICPD in 1994 elevated global recognition of women's agency with regard to sex and reproduction. In its recommendations on realizing reproductive health and rights, the ICPD Programme of Action included displaced people, refugees and migrants affected by environmental degradation, natural disasters and internal conflicts, and called on States to address the root causes, "especially those related to poverty." It called for protection of people who, "given the forced nature of their movement … often find themselves in particularly vulnerable situations, especially women, who may be subjected to rape and sexual assault in situations of armed conflict." It urged governments "to ensure that internally displaced persons receive … basic health-care services, including reproductive health services and family planning" and to provide refugees with "health services including family planning" (United Nations, 2014a).

In 1999, a five-year review of progress in implementing the Programme of Action elaborated on the need to address protection concerns and ensure the sexual and reproductive health of refugees and displaced people (United Nations, 1999).

Setting standards for reproductive health care

In 1995, some 40 intergovernmental and government agencies and non-governmental organizations involved in relief work formed the Inter-Agency Working Group on Reproductive Health in Refugee Situations, now the Inter-Agency Working Group on Crises. The coalition, spearheaded by UNFPA and UNHCR, developed guidelines for interventions at different phases of crises; on safe motherhood; sexual and gender-based violence; sexually transmitted diseases, including HIV; and family planning. These were elaborated in *Reproductive Health*

While refugees and internally displaced people are a relatively small percentage of all migrants, they frequently find themselves in highly vulnerable situations and most often need assistance and protection.

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in Emergency Situations: An Inter-agency Field Manual (UNHCR, 1999).

The stated cornerstone of the manual was the principle: "Reproductive health care should be available in all situations and be based on the needs and expressed demands of refugees, particularly women, with full respect for the various religious and ethical values and cultural backgrounds of the refugees while also conforming with universally recognized international human rights."

Over the years, the Inter-Agency Working Group on Crises has been instrumental in pressing for the inclusion of sexual and reproductive health concerns in all crisis response, and in providing technical standards for service delivery and evidence for policymakers. The coalition has grown to include 20 steering committee member agencies and has a network of over 2,000 members from 450 agencies.

Essential services in a crisis

In its field manual, the working group delineated an influential "minimum initial service package" of activities most crucial to preventing mortality and morbidity. These apply in all emergencies, and should be implemented by trained staff at the start of any crisis.

The objectives are to: identify a lead agency to coordinate reproductive health activities and support partners; prevent sexual violence, and provide medical and psychosocial care for survivors; reduce HIV transmission, with safe blood transfusion and free condoms; prevent maternal and newborn deaths, through emergency services, full-time referrals and clean delivery kits; prevent unintended pregnancies, with a range of contraceptive methods and information; and transition to comprehensive sexual and reproductive health services as soon as possible.

Advocacy by working group partners has led to broad adoption of the service package. It is now included in the Sphere Standards, widely adopted principles for humanitarian responders; in the life-saving criteria of the United

Nations Central Emergency Response Fund for prioritizing early action in disasters; and in health guidance from the Inter-Agency Standing Committee, which coordinates relief work by United Nations agencies and non-governmental organizations (IASC, 2009).

The 2018 revision of the field manual now identifies preventing unintended pregnancy—by providing both long- and short-acting contraceptive methods, information and counselling—as a distinct, life-saving objective rather than an element of maternal health. Control of fertility is also recognized as enabling women and girls to engage in education, protection, life skills and livelihoods. Safe abortion care, where legal, is included as a separate priority. The manual also provides more guidance on the transition from emergency to comprehensive sexual and reproductive health services, adds a logistics chapter, and places greater emphasis on gender-based violence.

Importantly, the 2018 manual emphasizes that providing comprehensive sexual and reproductive health services for crisis-affected populations is a human rights imperative aligned with international rights obligations and guidance from numerous political bodies.

The United Nations World Humanitarian Summit in Istanbul in 2016 adopted the Agenda for Humanity. As part of its core commitments to achieve gender equality, it called for "universal access to sexual and reproductive health and reproductive rights," and a "coordinated global approach to prevent and respond to gender-based violence in crisis contexts." States made numerous commitments to implement and fund sexual and reproductive health activities.

Responding to sexual violence

In parallel to the growing emphasis on ensuring the sexual and reproductive health of women in emergencies, humanitarian actors have focused increasingly on sexual violence and its consequences, particularly during conflict. The horrific, widespread use of rape as a weapon of war in the 1990s in the former Yugoslavia, Rwanda, Sierra Leone and Liberia, and in the Democratic Republic of the Congo after 1998, prompted the international community to respond.

The 1995 Beijing Declaration and Platform for Action adopted at the Fourth World Conference on Women called for measures to address the "close link between massive violations of human rights, especially in the form of genocide, ethnic cleansing, systematic rape of women in war situations and refugee flows and other displacements, and the fact that refugee, displaced and returnee women may be subject to particular human rights abuse" (United Nations, 1995a).

The 1998 Rome Statute establishing the International Criminal Court defined rape and sexual violence committed in systematic attacks against civilian populations as crimes against humanity and war crimes (ICC, 1998).

In 2000, the United Nations Security Council adopted resolution 1325 calling for increased women's participation in conflict prevention and the promotion of peace and security. The resolution called on "all parties to armed conflict to take special measures to protect women and girls from gender-based violence, particularly rape and other forms of sexual abuse."

Security Council resolution 1820, adopted in 2008, declared that "women and girls are particularly targeted by the use of sexual violence, including as a tactic of war to humiliate, dominate, instil fear in, disperse and/or forcibly relocate civilian members of a community or ethnic group." The resolution called sexual violence a threat to security and an impediment to restoring peace, and said that post-conflict reconstruction and recovery efforts need to pay special attention to the effects of sexual violence. The

Council elaborated on these issues in subsequent resolutions.

Over the same period, organizations involved in relief work have increasingly prioritized preventing sexual violence and responding to the needs of survivors, a core objective of the minimum initial service package. The revised field manual of the Inter-Agency Working Group defines gender-based violence as including rape, sexual exploitation and abuse, forced prostitution, trafficking, forced early marriage, female genital mutilation, honour killing, domestic and intimate partner violence, harm based on sexual orientation or gender identity, and elder abuse. It offers guidance on establishing safe spaces for survivors within health facilities, providing appropriate clinical care, and referring survivors to psychosocial and legal services.

Global compacts on migrants and refugees

The United Nations General Assembly hosted the Summit on Refugees and Migrants, the first of its kind, in 2016. The aim was to develop a blueprint for a more responsible, predictable system for responding to migration.

In its New York Declaration, the Assembly affirmed that the United Nations 2030 Agenda for Sustainable Development promise to "leave no one behind" includes refugees, internally displaced people and migrants. Member States pledged to "ensure a people-centred, sensitive, humane, dignified, gender-responsive and prompt reception for all persons arriving in our countries" and protect their human rights and to increase diplomacy aimed at early prevention of crises. They committed to "mainstream a gender perspective" in migration policies, to "combat gender-based violence," and to "provide access to sexual and reproductive health-care services" to those affected by crises (United Nations, 2016).

The summit kicked off negotiations to develop two more-extensive agreements: the Global Compact on Refugees, which the General Assembly endorsed in

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its 2018 session; and the Global Compact for Safe, Orderly and Regular Migration, adopted at an intergovernmental conference in Marrakech, Morocco, in December 2018. Both compacts have commitments to combating gender-based violence. Neither document, however, explicitly mentions sexual and reproductive health care (United Nations, 2018 and 2018a).

UNFPA responding in emergencies

In line with its mandate set forth in the ICPD Programme of Action, UNFPA focuses on the sexual and reproductive health and rights of women and girls, even in crises and emergencies.

UNFPA has advocated for including reproductive health interventions as a life-saving component of international assistance in all crises and has been instrumental in developing standards that today underpin the work of responding to reproductive health needs and gender-based violence in a wide range of settings. It has helped recovering countries integrate reproductive health as they rebuild their health systems. And it is helping countries prepare to face future crises.

Before crisis strikes, and throughout prolonged emergencies, UNFPA, in partnership with governments and local civil society organizations, helps build capacities in health systems, by stocking critical supplies, strengthening supply-chain management, and training national staff in storing, transporting and using reproductive health supplies.

When an earthquake hit Nepal in 2015, responders were able to quickly deploy medical supplies pre-positioned in strategic locations. Warehouses in Fiji and Australia stand ready to serve the disaster-vulnerable Pacific Islands (UNFPA, 2018c). In South Sudan, where few health facilities are functional, five supply hubs stock post-rape kits and reproductive health supplies (UNFPA, 2018c).

Worldwide, UNFPA is the main provider of reproductive health-related supplies and equipment packaged and ready for distribution for different situations and levels of service. Family planning kits, for example, contain condoms, oral and injectable contraceptives, and intrauterine devices. Maternal and neonatal health kits include medical equipment and supplies essential for clinical delivery assistance and basic and comprehensive emergency obstetric care. Other kits contain supplies for treating sexually transmitted infections, managing miscarriages, and performing blood transfusions.

UNFPA gives priority in crisis situations to meeting the sexual and reproductive health and protection needs of adolescent girls. UNFPA and Save the Children in 2009 published a toolkit on responding to adolescents' needs through the minimum initial service package (UNFPA, 2009).

In its humanitarian interventions, UNFPA sets up dedicated spaces for girls, offering livelihood skills, health information and referral to services. Where needed, it also supports mobile clinics and outreach teams providing health services and supplies, including

contraceptives. Adolescents are consulted and participate in the response, distributing dignity kits, collecting data and communicating with peers (UNFPA, 2016).

UNFPA also coordinates gender-based violence prevention, risk mitigation and response in many humanitarian settings. It trains health workers to sensitively and confidentially provide quality, life-saving services including post-rape treatment, and distributes clinical supplies—including for emergency contraception and HIV post-exposure prophylaxis—to health centres and mobile clinics.

Building resilience

Ensuring the sexual and reproductive health and rights and the safety of women and girls in crises is now a well-established global priority. But real success in this effort is bound up with meeting the Sustainable Development Goals for 2030. Societies need to be made more resilient to prevent, confront and recover from violence and disasters. That calls for more resources, smarter solutions and better international collaboration to address multiple factors underlying the exponential growth in humanitarian needs. Growing inequality, prolonged conflicts, climate change and demographic developments (population growth, migration, urbanization and ageing) all make it harder to overcome the mounting challenges.

And well beyond crisis-response demands, vast investments and greater commitment are needed for sustainable development, peacebuilding, addressing climate change, and disaster risk reduction.

As a 2016 United Nations Secretary-General's expert panel on humanitarian financing noted: "The best way to deal with growing humanitarian needs is to address their root causes … Because development is the best resilience-builder of all… the world's scarce resources of official development assistance (ODA) should be used where it matters most—in situations of fragility" (United Nations, 2016a).

CHAPTER HIGHLIGHTS

- Every humanitarian crisis—whether due to conflict or natural disaster—causes systems to break down, increasing multiple needs for protection and services. Especially in the initial rush to provide food and shelter, responders may overlook the particular ways a crisis can increase the vulnerability of women and girls and threaten their lives.
- Experiencing a natural disaster or fleeing violence can be extremely harrowing for pregnant women and mothers of small children. Trauma and malnutrition are dangerous during pregnancy, and during emergencies many women miscarry or deliver prematurely.
- Every day, more than 500 women and girls in countries with emergency settings die during pregnancy and childbirth, due to the absence of skilled birth attendants or emergency obstetric procedures, and to unsafe abortions.
- Since the mid-1990s, governments, aid organizations and international institutions are increasingly delivering services to women and adolescent girls whose choices have been constrained by wars and natural disasters.
- The transformational International Conference on Population and Development in 1994 elevated global recognition of women's agency with regard to sex and reproduction. In its recommendations on realizing reproductive health and rights, the conference's Programme of Action included displaced people, refugees and migrants affected by environmental degradation, natural disasters and internal conflicts.

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INSTITUTIONS AND FUNDING TO ENSURE RIGHTS AND CHOICES

In 1969, few countries had population policies or institutions to implement them (Nizamuddin, 2002). But as global attention to population issues took root, more and more countries sought to better understand and address the interactions between population dynamics and development.

By 1976, 40 countries had policies to lower fertility; by 1986, that number had grown to 54, and by 1996, 82 (United Nations, 2015a).

Some countries put their ministries of health in charge of narrowly focused programmes to deliver contraceptives. Others established independent family planning boards or population commissions to rapidly translate donor funding into services. And in many other countries, governments collaborated with civil society organizations to deliver contraceptives, particularly to underserved populations.

Over time, institutions have had to adapt to be able to meet the growing needs for a broader range of sexual and reproductive health services and to enable women to exercise their reproductive rights.

Early constraints

Some early family planning programmes housed within ministries of health delivered services mainly through urban clinics and hospitals. Weak infrastructure sometimes made it difficult to extend services to remote areas. And even in urban areas, under-resourced facilities and a lack of trained personnel meant that large swathes of the population in a given country had limited or no access to quality contraceptive services.

Further, because Western donors covered many of the costs of dispensing contraception at that time, services often reflected donor preferences and, in the process, sometimes failed to respond to women's needs. Some donors were committed to building more clinics, while others preferred to fund distribution schemes that operated outside of health ministries'


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infrastructure, and still others funded mainly research and demonstration projects (Robinson and Ross, 2007).

Coordination was a particular challenge in early population programmes. Different national institutions had responsibility for different aspects of implementing population policies: ministries of health dealt with clinical service delivery; central statistical offices were responsible for censuses and surveys; ministries of education handled school and training institution curricula; ministries of information were responsible for public education campaigns; and ministries of planning or finance allocated funds. In some places, population planning units or national population commissions helped to coordinate the multiple facets of population policy, but often capacity to lead such efforts was low. The diffuse administration of programmes complicated delivery of the services and information women needed to exercise their reproductive rights.

Another constraint in the early days of family planning programmes was a paucity of data to guide the formulation of programmes or monitor the impact of initiatives. In the 1970s, the United States Agency for International Development helped to set up numerous central statistics agencies, and since then, the scope and quality of epidemiological and behavioural data on sexual and reproductive

health from developing countries have improved dramatically.

However, gaps remain in the collection and analysis of data for some events, outcomes and morbidities, such as abortion, interpersonal violence, sexually transmitted infections, obstetric fistula, incontinence, pain with intercourse and sexual dysfunction.

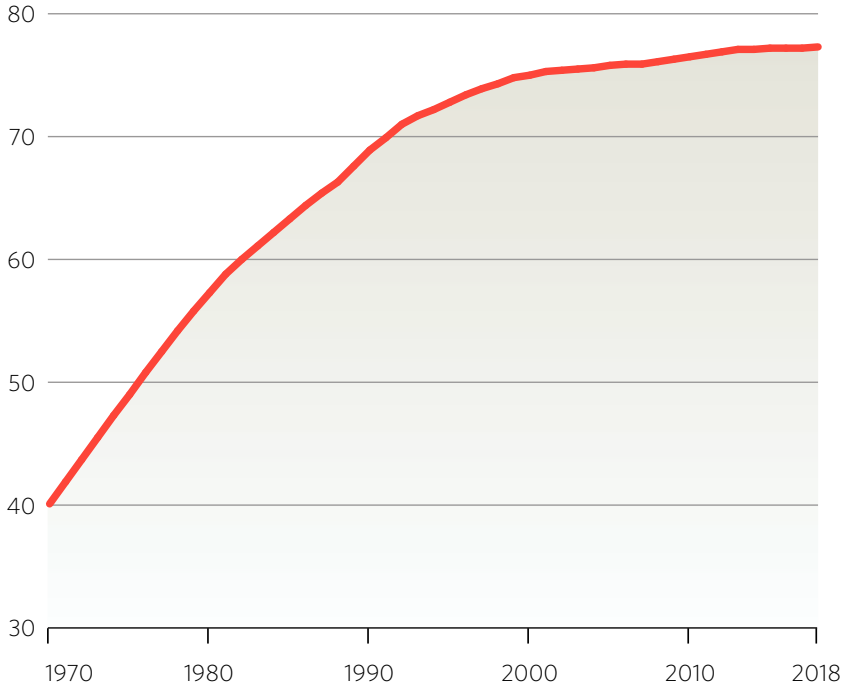
Gradual progress

The reach of family planning programmes expanded slowly in the 1970s and then more rapidly in the following decades. In developing regions in 1970, for example, an estimated 40 per cent of demand for family planning was met with a modern method (Figure 7.1). That percentage climbed to 57 per cent in 1980, 69 per cent in 1990, 75 per cent by 2000, and is about 77 per cent today (United Nations, 2018b).

This progress reflects a gradual expansion in the "level of effort" that governments put into their family planning programmes. In 1972, researchers devised measures of programme effort, and since that time, have applied them periodically in most developing countries. The Family Planning Program Effort Index is based on a questionnaire that relates to 30 measures of level of effort in four categories: policies, services, evaluation and method access. The effort index score is drawn from questionnaire responses from independent, informed observers, and is assessed separately from outcomes, such as contraceptive use or fertility change.

When this index was first assessed for 23 national programmes in 1972, countries were fairly evenly distributed across a continuum from low to high effort. By 1989, however, many countries' effort scores had climbed, with low-effort countries beginning to resemble those in middle- and high-effort categories (Robinson and Ross, 2007). This progress in family planning effort, however, is only one part of the picture, and gradually, population policies began to encompass more than family planning.

FIGURE 7.1 Demand for family planning met through modern methods of contraception: percentage of women who are married or in a union, 1970 to 2018



By 1976,

40 countries had policies to lower fertility; by 1986, that number had grown to 54, and by 1996, 82.

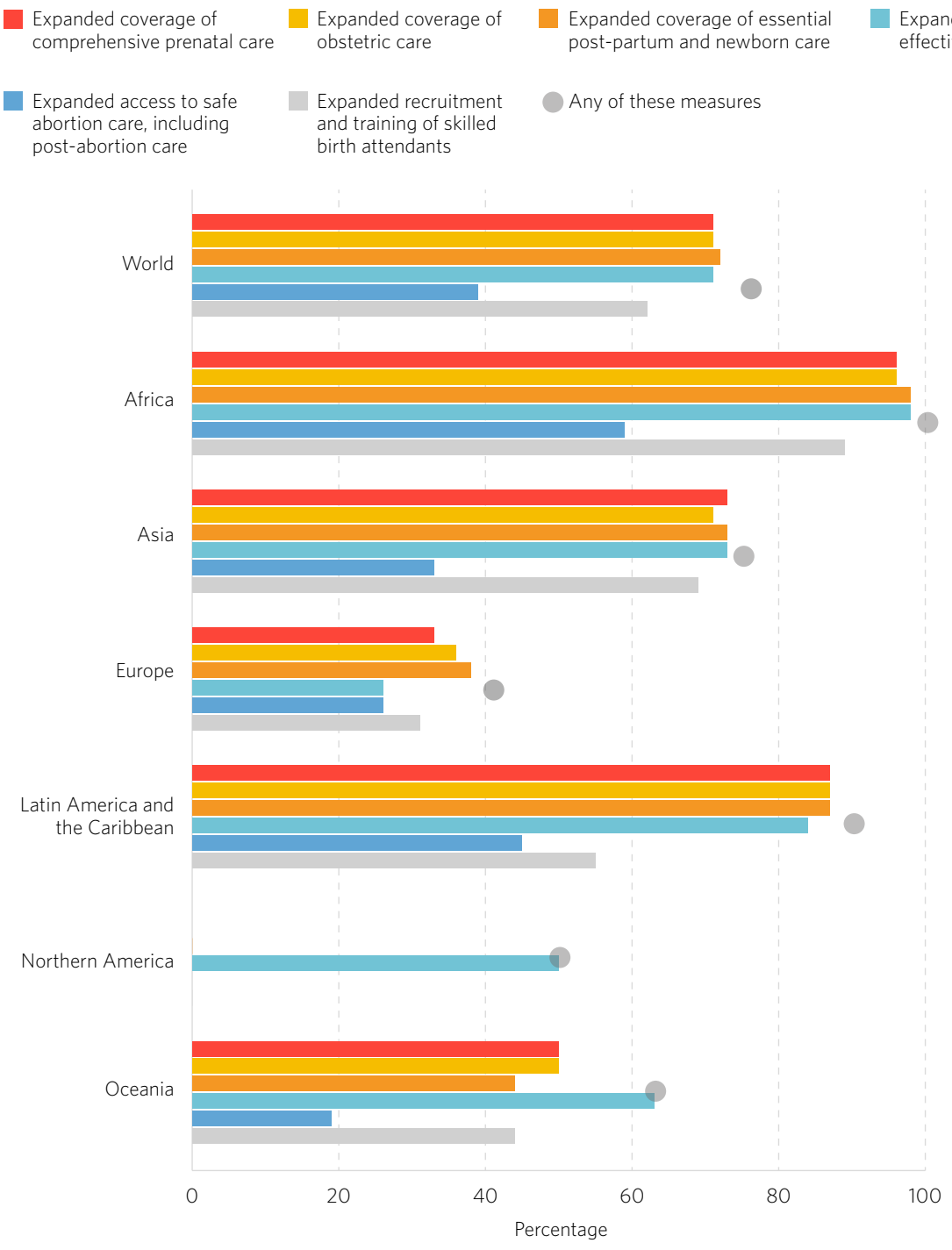
Population policies: moving beyond fertility reduction

The groundbreaking consensus achieved at the International Conference on Population and Development (ICPD) in 1994 helped to generate momentum for the creation and renewal of institutions. Over time, more national population policies and strategies broadened beyond their narrow focus on family planning for the purposes of fertility reduction to encompass the new global agenda for sexual and reproductive health and women's empowerment.

For example, as of 2015, 76 per cent of governments had adopted one or more policy measures in the previous five years to reduce the number of newborn or maternal deaths, and more than 70 per cent of governments had expanded the coverage of essential post-partum and newborn care, comprehensive prenatal care, or obstetric care (United Nations, 2017a). In addition, 62 per cent of governments around the world had adopted a policy to expand recruitment and training of skilled birth attendants, and 39 per cent had expanded access to safe abortion care, including post-abortion care (Figure 7.2).

In a global survey of progress in implementing the recommendations of the Programme of Action of the ICPD, governments provided information about the establishment of various institutions "to address issues related to the interaction between population and development." The findings suggested that, compared with other themes of the ICPD, such as education and migration, there was greater relative growth in government institutions to address gender equality, adolescents and youth, and population and sustainable development since the 1990s (United Nations, 2014).

FIGURE 7.2 Percentage of governments having adopted policy measures in the past five years to address newborn or maternal mortality, by region, 2015



Source: United Nations, 2017a.
Note: based on 190 countries with available data.

These new institutions are most effective in advancing rights and choices when they fully embrace the needs and perspectives of potential clients. The Programme of Action emphasized the need to involve those directly affected, particularly people who were historically excluded due to discrimination, coercion or violence, in developing laws, policies and practices. Such involvement serves to empower individuals, especially women and girls, to more fully exercise their rights.

The growing value of partnerships

Throughout the 1970s and 1980s, partnerships within the realm of population and development expanded, diversified and contributed to much of the success in advancing population and development objectives (Weerakoon, 2002).

The Programme of Action recognized this evolution, noting that it was no longer unusual for governments and multilateral organizations to work closely with national and international non-governmental organizations and the private sector (United Nations, 2014a).

The ambitious and expansive goals of the Programme of Action are in large part an outcome of civil society mobilization, and not surprisingly, since 1994, a broad range of civil society organizations and other non-governmental stakeholders have increasingly mobilized to shape global, regional and national policy and accountability frameworks on sexual and reproductive health (United Nations, 2014). This trend has taken place in the context of greater diffusion of authority and leadership in governance structures, and a corresponding recognition of the value that comes with participation and partnership among national and local governments, civil society, as well as non-State actors.

Through the late 1980s and early 1990s, a wave of government decentralization initiatives offered opportunities for civil society participation in local planning, decision-making, and monitoring and evaluation of sexual and reproductive health services. However, decentralization also brought challenges related to lack of clarity in how different institutions related to each other and to district health authorities, as well as problems related to commodity flows and procurement and disbursal of equipment and supplies (Maceira, 2005).

With this evolution, the participation of intended beneficiaries of the Programme of Action has been enhanced over the past 20 years, as wide networks of civil society and non-governmental organizations have been formally recognized and integrated in planning and implementation (United Nations, 2014).

The Reproductive Health Supplies Coalition, for example, brings together civil society organizations alongside multilateral and bilateral organizations, private foundations, governments and private sector representatives with the goal of ensuring that all people in low- and middle-income countries can access and use affordable, high-quality contraceptives and other reproductive health supplies. And the Family Planning 2020 initiative has engaged civil society in setting strategies to achieve its goal of providing 120 million more women and girls in the world's poorest countries with access to voluntary family planning information, contraceptives and services by 2020.

Similarly, the private sector has taken on a larger role in programme planning and implementation. The Programme of Action recognized the critical role the private, for-profit sector could play, and called on governments and non-governmental organizations to intensify their cooperation with the private sector in population and development programmes, particularly in such areas as the production and delivery of high-quality contraceptive commodities and the delivery of services with appropriate information and education (United Nations, 2014a). A worldwide field inquiry in 1998 found that the private sector in many countries had begun to take a

CHAMPION OF CHANGE

Michelle Bachelet

She has been a doctor, a survivor of political torture, a defence minister and one of the world's most notable woman politicians. Twice elected President of Chile, Michelle Bachelet has championed gender equality and sexual and reproductive rights, overseeing transformative changes in Chilean legislation for women and girls.

Bachelet became the first ever woman President of Chile in 2006, quickly fulfilling a campaign promise to have a cabinet comprising equal numbers of men and women ministers. She drew on long-standing relationships with the Chilean women's movement to bring feminists into the Government, who joined ranks with her in advancing reforms on core issues of reproductive rights.

She successfully pushed to scale up protections for survivors of domestic violence, stop workplace discrimination, make the pension system fairer to women, and improve childcare for low-income mothers. When a conservative coalition stood in the way of her plan to expand access to emergency contraception, Bachelet appealed to a supportive public and the bill was fast-tracked and approved. In 2017, towards the end of her second term as President, Bachelet propelled another landmark change as the Chilean Congress ended a 28-year blanket ban on abortion.

"I was determined to carry out the kind of social, economic and political reforms that I believed were necessary to make people's lives better," Bachelet says. "We had the courage to put Chile in motion, and with it, we have seen Chile change."

In 2018, Bachelet became the United Nations High Commissioner for Human Rights, vowing to draw on a lifetime of experiences to promote human rights for all. "Those who defend human rights and the victims look up to the High Commissioner and hope that we are there to defend and support them," Bachelet says. "And I'll do everything on my side to make sure that we do so."

No more so than for women and girls. "Building a more equitable and just world, that guarantees the rights of women and girls, is more than a challenge," says Bachelet, who also served as UN Women's first Executive Director. "It's a necessity and an obligation."

"I was determined to carry out the kind of social, economic and political reforms that I believed were necessary to make people's lives better."

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more active role in operating clinics and initiating social marketing programmes (Weerakoon, 2002).

With the growing diversity of partnerships and actors, the Programme of Action called on recipient governments to strengthen national coordination mechanisms to ensure efficient and effective cooperation in population and development. The Programme of Action noted the need for clarification of responsibilities assigned to development partners, based on consideration of comparative advantages and national development priorities, and called on the international community to assist recipient governments in undertaking these coordination efforts (United Nations, 2014a). While retaining their national priorities, donor countries have supported increased collaboration and harmonization within the United Nations and within national processes as part of United Nations' reform and through new network initiatives.

Challenges in estimating and tracking funding

Estimating funding needs and tracking financial flows for sexual and reproductive health services is a critical aspect of effectively advancing the rights and choices of people in need. Such efforts provide information and transparency that enable donors to coordinate efforts, planners to identify priorities and gaps, and advocates to keep donors and governments accountable to their commitments.

But estimating and tracking finance has been a challenging exercise since the earliest days of population policies. In the 1960s and 1970s, finance for sexual and reproductive health fell into various budgetary categories. Financing for maternal and child health and treatment of sexually transmitted infections, for example, was categorized within broader health funding, while "population" funding was heavily concentrated on financing

CHAMPION OF CHANGE

Enkhjargal Davaasuren

Across Mongolia, people used to avoid mention of the violence that erupted within their homes. In the communist era, the penalties were so severe that many women were reluctant to report even serious crimes. In 1990, a democratic revolution took place, but in its wake, the court system stopped recognizing domestic violence and marital rape as criminal offences.

For Enkhjargal Davaasuren, that was never acceptable. As a girl, her union activist mother held numerous sessions at home where women organized for their rights at work, but also helped each other stop abuse. Davaasuren went off to law school as another way to stand up for women's rights.

As a young lawyer, she founded the National Centre Against Violence and kickstarted a campaign to pass a new law criminalizing domestic violence. For two decades, she and her team of committed activists persistently called on politicians to take action. It took until 2016, but their dedication paid off when the Mongolian Parliament criminalized domestic violence for the first time in the country's history as a democracy. A new law ensures that the one in three Mongolian women who will experience some form of domestic violence in their lifetimes can seek safety and protection.

"In a male-dominated, patriarchal society such as Mongolia, women don't realize how strong they can be."

Davaasuren has faced death threats and criticism of "importing ideas from abroad" in her quest for change. But she has never backed down. The National Centre sponsors a team of lawyers to provide free legal representation for survivors of abuse and established shelters across the country where women and girls can seek refuge and assistance. Awareness has spread, with more women seeking assistance, and a palpable sense of public outrage has stirred through high-profile media coverage of cases of abuse.

"We will never rest in our advocacy efforts," Davaasuren states. "In a male-dominated, patriarchal society such as Mongolia, women don't realize how strong they can be."

She advises: "Be strong, but more importantly, be collectively strong. Women must work together to achieve social change. The challenges are systemic, the solutions collective."

contraceptive services, with some devoted to the collection and analysis of demographic survey data. In various studies, both health and population expenditures were often lumped together as "health sector" funding, and historic data on financing for specific interventions are not easily parsed out.

Tracking efforts starting in the 1970s shed light on trends, and particularly on the ways in which the donor community ramped up support for health and population activities. Disbursements from multilateral and bilateral agencies for the health sector totalled nearly $900 million (in 1990 dollars) in 1972; this grew to $2.7 billion by 1980 and $3.9 billion by 1990. Of this, assistance for "population activities" increased slowly during the 1970s and 1980s. Total population assistance grew to $936 million in 1990, almost 20 per cent of the total external assistance for the health sector. Bilateral donors accounted for 60 per cent of this population assistance, United Nations agencies for 22 per cent, the development banks for 13 per cent, and private sources for 5 per cent (Michaud and Murray, 1994).

By 1994, systems for estimating and tracking financing for sexual and reproductive health services had become much more sophisticated. The Programme of

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Action itself included estimated costs for implementing core recommendations in the areas of family planning; reproductive health; treatment and prevention of sexually transmitted infections, including HIV; and basic research. The international community agreed then to a "costed package," estimating that $17 billion would be needed in 2000, $18.5 billion in 2005, $20.5 billion in 2010 and $21.7 billion in 2015.

Governments agreed that two thirds of the required amount would be mobilized by developing countries themselves, and one third was to come from the international community.

Growing needs, growing costs

A number of organizations and programmes have begun tracking costs and donor assistance for reproductive, maternal, neonatal and child health. For example, the Family Planning 2020 initiative tracks financing for family planning globally; the Partnership for Maternal, Newborn and Child Health tracks financial commitments to the Global Strategy for Women's and Children's Health; and the Guttmacher Institute reports funding and spending gaps for a suite of reproductive health services.

These estimating and tracking mechanisms reveal progress and persistent challenges in the financing landscape since 1994. The number of donors has steadily increased, and donor efforts have increasingly been shaped by the growing engagement of civil society and the private sector (United Nations, 2014).

However, globally, resources for addressing sexual and reproductive health needs remain insufficient, and donor trends are heading in the wrong direction. Disbursements of official development assistance from developed to developing countries for sexual and reproductive health climbed rapidly after the ICPD in 1994, and peaked in 2011 at just over $5 per woman of reproductive age in the developing world. By 2016, however, this figure had dropped by 60 cents per woman, to $4.40. When all sources of overseas funding are considered, including official development assistance and private grants, assistance for sexual and reproductive health amounted to $6.22 per woman of reproductive age in 2016. While significant, even these higher figures remain low when compared with needs.

The central role of domestic finance

While difficult to measure, it is clear that financial resources from developing countries as a whole, including funding from governments, national non-governmental organizations and private expenditures, account for the majority of funding that supports population activities (UNFPA, 2014a).

Many developing country governments have made progress in aligning domestic objectives and budgets with Programme of Action goals. But ongoing financial crises in developing countries and countries in transition can affect abilities to maintain momentum. Further, opposition to population programmes on religious and cultural grounds has been an obstacle to resource mobilization in some places (Cohen and Abrams, 2002).

Many countries, especially the least developed ones, are not able to generate the necessary resources to fully meet the sexual and reproductive health needs of their citizens. Most developing countries rely on donor assistance to finance and maintain population programmes (UNFPA, 2014a). This challenges developing countries' abilities to plan and budget over sustained time frames, since donor funds can vary from year to year, putting the stability of national sexual and reproductive health programmes at risk of sudden cuts.

Moreover, private consumers in developing countries take on a heavy burden of sexual and reproductive health costs through out-of-pocket expenses. This has important implications with regard to access to critical services for the poorest and most marginalized populations. In places where men control a family's discretionary income, for example, women may face additional challenges in paying for their own sexual and reproductive health needs (Starrs and others, 2018). The burden of out-of-pocket expenses can also create challenges for initiatives aimed at reducing poverty and income inequality in the developing world (United Nations, 2014).

Innovative financing approaches are supporting and incentivizing developing country governments to prioritize and sustain investments in under-resourced areas such as health and nutrition. The Global Financing Facility, for example, was launched in 2015 and encourages governments to increase domestic spending in alignment with health and nutrition dimensions of the Sustainable Development Goals (SDGs). Similarly, the Bill & Melinda Gates Foundation supports governments that have committed to the Family Planning 2020 goal of reducing the unmet need for family planning and are developing and implementing country-specific plans to expand family planning access.

Growing attention to aid effectiveness

The launch of the Millennium Development Goals (MDGs) in 2000 ushered in an era of increased attention to aid effectiveness, prompted in part by frustrations of developing country governments over problems of unequal aid partnerships and the loss of their ability to effectively plan, coordinate and lead the development process in their own countries.

In the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, Member States of the African Union committed to increasing health spending to at least 15 per cent of the national budget, and called upon donor countries to scale up support accordingly. The outcomes of the High Level Forums on Aid Effectiveness (the Paris Declaration on Aid Effectiveness of 2005, the Accra Agenda for Action of 2008 and the Busan Partnership for Effective Development Cooperation of 2011) strengthened commitments to deliver aid more effectively, with an emphasis on capacity development and national ownership and execution (United Nations, 2014).

This growing attention to aid effectiveness has been reflected in the development of structures for donor coordination, and greater acknowledgement of country leadership and mutual accountability in these collaborations (United Nations, 2014). A joint World Health Organization-UNFPA study of the implications of changes in the aid environment for sexual and reproductive health found a growing focus on sector-wide approaches and poverty reduction strategies, as well as on strategizing to achieve the MDGs. The study also found that secure, predictable funding for sexual and reproductive health remained a challenge (WHO and UNFPA, 2011).

Advancing universal health coverage

With the advent of the SDGs in 2015, increasing attention has been focused on attaining universal health coverage, which is at the centre of SDG 3. The concept of universal health coverage embodies several principles, including the provision of high-quality services to improve

CHAMPION OF CHANGE

Chea Chantum

Heading up the population and development directorate in Cambodia's Ministry of Planning, Chea Chantum has been instrumental in his country's efforts to put ICPD commitments at the core of progressive national policies on population, ageing and a range of other issues.

Under his watch, Cambodia significantly scaled up investment in family planning. A country that only a few decades ago was mired in conflict can now point to sharp declines in fertility rates, comparable to those in much more advanced countries, as well as improved maternal health.

"We have stressed the right to have children but at the same time urged couples to think about their own well-being and that of their family," he says "So much can be done through education and awareness."

Cambodia is in the process of introducing comprehensive sexuality education as part of the national curriculum from grades 5 to 12, building on the back of Chea's persistent call to respect the sexual and reproductive rights of adolescents and youth. He also helped drive the creation of a national health equity fund that provides free health care to poor citizens across the country.

A civil servant for almost 30 years, Chea started his career as a police officer before going on to get degrees in rural development and public management. It was while spending time in rural areas that he began to see the inextricable links between population and development.

"At first, I did not understand the importance of population," he recalls. "Now I know that population is the main thing for development. That motivates me to do everything I can to understand what people need to improve their well-being."

"It is not enough just to provide a few services," he stresses. "We have to include all people in our development. If we don't have people, we have nothing. Only people can make our country continue to move forward."

"We have stressed the right to have children but at the same time urged couples to think about their own well-being and that of their family."

health and equity in access to health services without the risk of financial hardship.

As embodied in the SDGs' theme of "leaving no one behind," the concept of universal health coverage also encourages "progressive realization," the idea that prioritization should be given to health-system reforms that address inequities from the outset, benefiting less advantaged individuals to an equal or greater degree than those who are more advantaged, and that every country can make progress, regardless of its starting point (Starrs and others, 2018).

Universal health coverage envisions a health service package that is successively expanded, and increasing the share of costs that are covered through pooled funding or insurance schemes, so that out-of-pocket expenses are reduced. The concept also emphasizes the many intersectoral links between the SDGs, recognizing that prospects for achieving health goals will be enhanced with progress in addressing the multiple social and environmental determinants of health (Stenberg and others, 2017). Sexual and reproductive health outcomes have been improved through various innovative financing schemes such as voucher programmes, conditional cash transfers, social insurance programmes and performance-based monitoring (USAID, 2014). Such innovative interventions can be effectively adapted for other settings (Starrs and others, 2018).

In support of these objectives, multilateral institutions have come together to launch a collective process to accelerate progress towards the SDGs. The Global Action Plan for Healthy Lives and Well-being for All aims to accelerate impact in countries, while reinforcing domestic decision-making, promoting rights-based, equitable responses that leave no one behind, and enhancing learning among countries and institutions. Coordinated by the World Health Organization, the initiative unites the work of 11 health-oriented multilateral institutions. The group will finalize the action plan to be delivered in September 2019 at the United Nations General Assembly (WHO, 2018a).

Together, these initiatives are setting the stage for institutions that are better equipped and sustainably funded to expand access to information and high-quality services that can enable women to exercise their reproductive rights.

CHAPTER HIGHLIGHTS

- Over time, the policies and programmes of governments and other sexual and reproductive health service providers have evolved in response to growing understanding of sexual and reproductive health. Institutions need to continuously adapt to be able to meet the growing needs for a broader range of sexual and reproductive health services and to extend rights and choices to all people everywhere.
- The participation of national and local governments, civil society and the private sector has helped to shape the ambitious goals of the International Conference on Population and Development (ICPD) and the Sustainable Development Goals (SDGs); partnerships among these actors have been central to progress towards these goals, and will be critical in their achievement.
- Estimating funding needs and tracking financial flows for sexual and reproductive health services is a critical aspect of advancing the rights and choices of people in need. Globally, resources for addressing sexual and reproductive health remain insufficient, and donor trends are heading in the wrong direction. Many developing country governments have made progress in aligning domestic objectives and budgets with ICPD Programme of Action goals, but ongoing financial crises affect abilities to maintain this momentum.
- Attaining universal health coverage is at the centre of SDG 3. Such coverage includes the provision of high-quality services to improve health and equity in access to health services without the risk of financial hardship. The advent of initiatives to promote universal health coverage offers opportunities to advance institutions that are better equipped and sustainably funded to expand access to information and high-quality services that enable rights and choices for all.


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REALIZING RIGHTS AND CHOICES FOR ALL: IF NOT NOW, WHEN?

A woman who is 60 years old was born when sexual and reproductive rights and choices were more constrained. It was hard for many to obtain contraception, and relatively easy to die giving birth. But by the time she was 10, change had begun, producing steady gains.

Some changes benefited her, but many more accrued to the next generation, the women who were 10 when the International Conference on Population and Development (ICPD) took place. Yet even for them, progress today is incomplete. Now aged 35, they have more rights and more choices, but not all that have been promised.

Can we do better for a girl who is 10 today? If history is a guide, the answer is yes, if we put people first and leave no one behind.

Many remarkable advances in expanding sexual and reproductive health and rights have been championed by governments, civil society and international organizations over the past 50 years. In 1994, the ICPD offered a visionary global commitment to these rights and choices, and an unprecedented consensus on the essential ties between women's empowerment and development. Twenty-five years later, the ICPD vision remains a high point of human aspiration, reflected now across the 2030 Agenda for Sustainable Development and its 17 Sustainable Development Goals (SDGs).

Looking forward, however, some old problems remain. And new ones have emerged. As a measure of the task ahead, UNFPA and its many partners have issued a clarion call for three zeros by 2030: there should be no unmet need for contraception, no preventable maternal deaths, and no violence or harmful practices against women and girls.

A girl who is 10 today deserves a world where everyone enjoys all of their rights and can live the lives they choose.

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A transformative vision: from the past, for the future

In the late 1960s, population growth was feared, conceived as a ticking time bomb to urgently defuse through aggressive, at times coercive, family planning programmes. By the time of the ICPD, consensus had emerged that people have a right to control their bodies and their sexual and reproductive lives. When they realize this right, they often make choices that benefit themselves, and support broader social, economic and even environmental well-being. Today, the 2030 Agenda recognizes that sustainable development hinges on universal quality health services, including sexual and reproductive health care, as well as the achievement of gender equality and the realization of reproductive rights.

Gains are fragile in an often unstable and troubled world, however. Some people are surging ahead, but many are left very far behind. Epidemics, conflict and climate change undercut advances and impede rights and choices. Shrinking populations in some countries have opened the door to new forms of population policies aimed at pushing people to have children, while in other places, fears about population growth have re-emerged. Other demographic shifts such as migration, in many cases reflecting deep-seated inequalities and crises, have fanned intolerance. Poverty remains profound and intractable even in many countries that as a whole are better off. Conservatism and fundamentalism could block progress and reverse what has been attained.

Putting people first

For all countries, making the most of existing gains, overcoming obstacles and embracing a better future, including the one envisioned in the 2030 Agenda, starts with acting on the commitments of the ICPD. These include putting people first by upholding their sexual and reproductive health and rights as well as the right to development for both current and future generations.

National legal systems can make explicit commitments to these rights, and shed remaining discriminatory provisions, such as barriers to access services and contraception for young people, unmarried people, migrants,

people of diverse sexual orientation and gender identity, and others. These commitments can then be translated into practice through well-designed population and development policies that prioritize reaching people who have the fewest choices and face the greatest shortfalls in realizing their rights.

Recognizing the complex interactions between sustainable development and population dynamics, population issues should also cut across broader development plans and investments, and be part of the integrated approach to development now embodied by the 2030 Agenda. These efforts should reflect the full range of factors that influence sexual and reproductive health and rights, including education, work, housing and food security.

Countries concerned about shrinking populations can act to ensure that essential sexual and reproductive health services are readily available to all. They may also need to do more to advance the reach of family-friendly policies to help people exercise their rights to start or expand a family, such as paid parental leave for men and women, tax breaks for families, flexible work arrangements and affordable housing. Countries with a greater share of people entering the workforce can boost productivity and make more of potential demographic dividends by ensuring that younger people can access quality, comprehensive essential health services as well as quality education, and have opportunities to move into decent work.

Within national health policies, sexual and reproductive health should move from an often peripheral role to a central one, matching its impact on overall health and well-being and the importance individuals and couples give it. This could include guiding a move towards the recent Astana Declaration definition of primary health care as integrating preventative, curative, sexual and reproductive, and mental health services (WHO and UNICEF, 2018). National sexual and reproductive rights "check-ups" could assess whether laws, policies, budgets, services, awareness campaigns and other activities are aligned with these rights.

Rights and choices across the life cycle

Significant shifts in population patterns in recent years, particularly across different age groups, have led to greater appreciation of the value of taking a life cycle approach in planning and policymaking. Public services and other interventions should reach people at the start of life and continue to be available at each subsequent stage, building on each other through old age.

This helps countries realize rights for people at all stages of life and maximize high-impact investments. Children and young people will have the health and education they need to become capable working adults. Adults will have the decent work and family planning support needed to productively contribute to the economy, care for their dependants and prepare for older age. Older people can draw on accumulated resources and sustain their quality of life, and continue contributing to their families and communities. A life cycle approach can help reduce age-related inequalities, and guide choices about resource consumption to balance the needs of current and future generations.

Social protection systems with a minimum safety net of benefits should be available to people at all stages of life, ensuring that people can maintain a level of dignity, choice and well-being in line with their rights. Employment policies need to keep up with rapid shifts in labour markets that undercut job stability and quality, such as through a continuum of essential health and social security benefits, and commitments to lifelong learning.

An unfinished agenda: access to quality services

Over 50 years, understanding of the nature of sexual and reproductive health services has steadily evolved. A near-exclusive focus on contraception widened to the ICPD call for universal access to a full range of services related to sexual and reproductive health care. Universal health coverage is now a major emphasis of SDG 3 on health and well-being for all.

A universal package of services

The highest unmet needs for sexual and reproductive health services are among marginalized groups, including minority ethnic groups; young people; unmarried people; lesbian, gay, bisexual, transgender and intersex (LGBTI) people; people with disabilities; and the rural and urban poor. Among poorer women, not only is the unmet need for contraception more pronounced, but maternal mortality rates are markedly higher.

Low-quality care, insufficient facilities and supplies, discriminatory laws and dismissive treatment by service providers are among the barriers still preventing women and girls from accessing services. Reaching and fully realizing the rights of long-excluded groups can be difficult and expensive, but must be a central priority in finishing the ICPD agenda and achieving the 2030 Agenda. Services not only need to physically reach these groups, but also be tailored to the needs they express, confidential, and free of judgement or coercion.

All health systems should define and deliver an essential package of universally available, integrated, high-quality sexual and reproductive health care services, at primary and referral levels. The ICPD defines these as comprising family planning; services related to pregnancy, sexually transmitted infections, infertility and safe abortion where legal; and referrals for reproductive system cancers. In general, integrated services do more to respond to multiple needs, such as when contraceptive counselling is provided before and after birth.

Weak maternal and child health programmes need to improve, supported by related programmes in nutrition, food security and women's empowerment. Through a Maternal Health Thematic Fund, for example, UNFPA helps countries with particularly high burdens of maternal mortality through proven interventions such as training for midwives and the inclusion of comprehensive sexual and reproductive health care in emergency obstetric and newborn care facilities.

There is also a need for more concerted efforts to end taboos and misinformation around menstruation and strengthen facilities and services for managing menstrual hygiene, given consequences that range from interrupted education to untreated health problems.

Many countries can do much more to uphold rights and choices for all by removing barriers to services and information for people with diverse sexual and gender orientations. Dismantling these could start with training and sensitizing health-care workers to avoid discrimination and meet special needs.

Making links to end violence

Major gaps remain in preventing and responding to gender-based violence, a globally pervasive violation of rights. Shelter systems, despite dedicated efforts by women's organizations, are still marginal or non-existent in many places. Integrated service models can be introduced or scaled up to help women readily access the combination of health, judicial, psychosocial, employment and other forms of support required to find safety and restart their lives. Successful experiences in training police units and judicial officials to respond to the special circumstances around gender-based violence could be more widely shared and replicated.

Stronger links could be forged between reproductive health services, initiatives to prevent and protect against gender-based violence and economic empowerment programmes for women. These links could be as basic as screening and referral systems, so that women seeking family planning services, for example, are asked about other needs and risks, and referred as appropriate to additional resources.

Accountability starts with service users

One major reason for deficits in service quality, beyond low resource levels, relates to the lack of accountability and responsiveness

to service users. Stronger health information management systems, as well as efforts to systematically record and analyse all maternal deaths to identify shortfalls in care, would empower countries to monitor progress and confirm that services are reaching the furthest behind first. A positive trend has been the adoption of minimum standards and complaint procedures. Where health care is being privatized, regulations should reflect these standards and require private providers to respect the sexual and reproductive health and rights of all users.

Involving women's groups and other representatives of service users in policy and service decisions can also go far in improving the quality of care. Systems that could be further developed include those that send a simple follow-up survey to mobile phones asking service users to weigh in directly on the quality of care. The results could be used to assess the performance of care providers. This kind of approach can both improve services and encourage their use.

Including adolescents

Adolescents as a group have consistently lacked access to sexual and reproductive health services, despite ICPD commitments to deliver them. Legal norms and long-standing norms still stand in the way. New issues have emerged from the Internet, which offers a flood of information, correct or otherwise, along with risks such as cyberbullying and sex trafficking.

Adolescents have the right to be educated and empowered to make choices and protect themselves. This right can be supported by measures such as age-appropriate comprehensive sexuality education, integrated in school curricula and reaching all students, and capable of reaching girls and boys who are not in school. Such programmes should provide information, but to achieve the most significant outcomes, should also aim to improve

self-esteem, build understanding of human rights and positive gender norms, and develop decision-making and communication skills (Starrs and others, 2018).

Facing fertility challenges

As many as 180 million couples worldwide are potentially affected by infertility, with consequences that can include psychological distress, intimate partner violence and social stigma (Starrs and others, 2018). Important drivers of infertility include the shifts in work and family that have driven a growing number of women to postpone childbearing until later ages when they may face fertility challenges. Ill health and lack of access to care during first pregnancies can also result in the inability to have additional children.

For those with resources, assisted reproductive technology such as in vitro fertilization is available. Given the universal character of reproductive rights and the principle of universal health care, however, such options need to be delinked from the ability to pay. Expanding access requires having appropriate ethical guidelines and medical standards in place, reducing prohibitive costs, and broadening capacities to obtain technology across countries at diverse stages of development. More could also be done to raise awareness about preventing and addressing infertility, and in some countries to reform laws on infertility treatment, adoption and surrogacy in line with sexual and reproductive rights.

A growing reproductive cancer burden

In all countries, cancer burdens are expanding, with a particularly pronounced jump in low- and middle-income countries as people live longer. Other risks relate to lower levels of physical activity from modern jobs. Prostate, breast, cervical and other forms of reproductive cancer constitute a significant share of the cancer burden (American Cancer Society, 2016). Routine screening should be expanded as integral to primary medical care, including through established techniques and the exploration of new ones such as genetic testing, which are beginning to decline in cost. In line with a rights-based approach, part of accelerating access may include reviewing intellectual property processes and hastening the speed with which technology meeting a public good moves from development to broad use.

One demonstrated tool for prevention is the vaccine for the human papillomavirus or HPV, which causes most cases of cervical cancer. It is now routinely administered to girls aged 9–13 in 55 countries. Other countries should consider moving towards adoption, particularly with a new dosing schedule that has reduced cost.

Factoring in ageing

The ICPD pointed to the fact that the distinct reproductive and sexual health issues of older women and men are often inadequately addressed. With growing numbers of older people in more and more countries, health systems will need to take up issues around sexual functioning, risks around HIV and sexually transmitted infections, and reproductive cancer risks that rise with age.

More attention to mental health

Despite the stipulation in the ICPD that "everyone has the right to the enjoyment of the highest attainable standard of physical and mental health," the latter remains a poor cousin to the former in attention and resources. Yet mental health issues can have a significant impact on rights and choices.

Ante- and postnatal depression remain common problems worldwide, for example. Unintended pregnancies are linked to longer-term depressive episodes. Continuing unmet need for family planning, side effects of contraceptive use, and power imbalances in relationships, including violent responses to unintended pregnancies, are

among the factors posing mental health risks to women and girls. Suicide is now a major cause of death for adolescent women.

At a minimum, reproductive health services should have providers trained on these issues, and screening and referral processes in place to detect and respond to them (WHO, 2009). These efforts should operate with respect for human rights, and dignity, and make efforts to reduce the pronounced stigma that often remains around mental health.

Fundamentals: empowerment and equality

The ICPD drew historic attention to women's fundamental right to make choices about their bodies. This is a right that underpins many others—to learn, to work, to move freely in public and private spaces, to enjoy free time. Since 1994, in every part of the world, women and girls have streamed into education and the workforce. On balance, they are healthier and better equipped to plan their families.

Still, women are paid less, do more than their fair share of unpaid care work, and have yet to crack parity in most decision-making positions, from corporate boards to parliaments. Gender-based violence goes unpunished; harmful traditions result in the mutilation and marriage of girls.

Challenging gender norms

Discriminatory gender norms remain among the most significant drags on progress for women and girls, appearing in every area of life. They dictate a second-class status, impeding rights and limiting choices. High-quality comprehensive sexual and reproductive health information and services must be extended to all women. But actual access and use may also depend on a husband's willingness to let his wife leave the house, the messages sent by mass media, community standards around sex and fertility, or the words of religious or other figures of authority. Empowerment is often used as a blanket term to indicate that women have the right to choose, but in reality there are many factors related to a woman's own means, her status in her household, and the broader social, economic and political environment that reduce the options she can choose from.

Sexual and reproductive health services should become more effective in responding to the realities of gender roles and norms. Many remain top-down providers. A mode of respectful engagement, grounded in two-way communication and free of judgement, would help individuals think through and define their sexual and reproductive health goals, and understand how they can achieve them. Service providers should be trained to avoid gender-discriminatory norms and behaviours, many of which still go unquestioned. They could learn to ask about and assist with, directly or through referrals, discriminatory barriers that might arise once a woman leaves a health facility.

Broader social awareness and behaviour change campaigns can support shifts towards more positive, broadly accepted norms. Measures are still needed to end gender stereotyping in schools, including those that track girls and boys into some forms of study over others. Work with the media should aim at reducing often rampant gender stereotyping, and raising the still limited visibility of women's voices and perspectives. Successful experiences in working with religious leaders, who can have a profound influence in communities and households, should be better understood and replicated.

Ending all harmful practices

Some of the most insidious gender norms result in harmful practices such as child and forced marriage, female genital mutilation and son preference. These need to be entirely eliminated, starting with clear legal statutes backed by implementation. Some progress has been made in working within communities to explain the harm that these practices impose and build consensus around

CHAMPION OF CHANGE

Lilianne Ploumen

The 2017 imposition of a United States policy restricting funding for reproductive health services did nothing to silence Lilianne Ploumen. In fact, it inspired her to speak out. The parliamentarian and then Dutch Minister of Foreign Trade and Development Cooperation called on women around the world to send their own message: no one decides about women's bodies except women themselves.

The SheDecides movement was born. First there was a hashtag, and then a pledging conference that raised $200 million from governments, foundations and philanthropists. A crowdfunding platform was created. Over 50,000 people have signed a manifesto committing themselves to ensuring that "she decides," while national ministers in France and South Africa are among 40 prominent champions dedicated to spurring momentum.

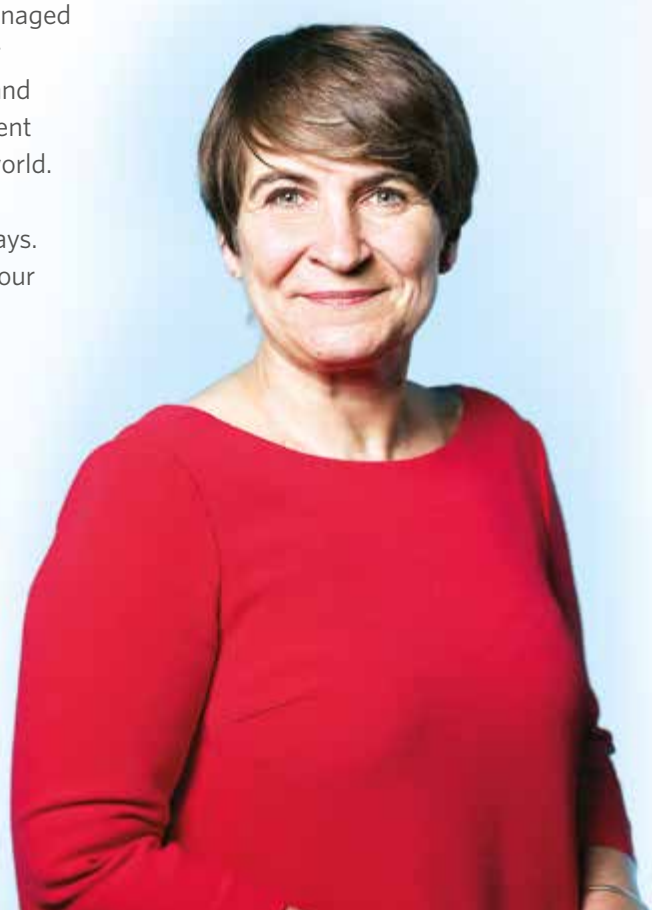
"Brave, tireless and brilliant organizations and individuals have been working on matters concerning girls' and women's bodily autonomy and comprehensive health care for decades. And suddenly, the rest of the world was paying attention," Ploumen says. "[We are] embracing a new energy and a new language that brings more and more people, from all walks of life, on board to embrace the idea of SheDecides."

All told, Ploumen estimates that at least $600 million a year will have to be raised to make up for losses imposed by the so-called gag rule, a policy decision in the United States to shut off funding for organizations that, with their own funds, provide abortion counselling or referrals, or that advocate to decriminalize abortion or expand abortion services, even where legal.

A former community outreach worker in Rotterdam, Ploumen led Mama Cash, a fund for advancing women's rights, and managed the international programmes at Cordaid, a major provider of relief and development assistance. She has seen first-hand the mix of norms, values, laws, codes and habits that prevent women from being who they can be—everywhere in the world.

"These written and unwritten rules have to change," she says. "And here is where I ask everyone to stand up and make your voice heard, be in solidarity, call on your governments and organize for change!"

"[We are] embracing a new energy and a new language that brings more and more people, from all walks of life, on board."



abandonment, including through a joint programme of UNFPA and the United Nations Children's Fund in a number of countries with high rates of female genital mutilation (UNFPA and UNICEF, 2018).

Proactive championing of the rights and potential of girls could shift tendencies to treat them primarily as a burden or source of household labour. Where girls can remain in school, including through measures such as targeted cash transfer schemes, and eventually move into decent work, they realize their rights, and parents and communities begin to see their capabilities and promise.

Engaging men

Most reproductive health programmes have focused heavily on women and girls, for the justifiable reason that reproduction takes place in their bodies, and they are still significantly behind men and boys in exercising rights and choices. Yet men and boys must be better engaged, both to enlist them in advancing gender equality and to respond to their rights and specific needs.

A growing number of interventions support men as active agents in reproductive processes. These include couples' counselling to foster communication and resolve conflict, and comprehensive sexuality education that stresses women's empowerment and men's roles and obligations. Other initiatives have worked with groups of men to redefine harmful masculine norms, and broken down patterns contributing to gender-based violence. Parental leave for men brings them into childcaring from the beginning, and should be more widely available. The many benefits of male involvement before and after delivery include reduced odds of antenatal and post-partum depression, and improved use of postnatal care (Starrs and others, 2018).

Sexual and reproductive health programmes in many instances need to explicitly reach out to men as clients, including in family planning and the prevention of sexually transmitted infections. Investment should increase in male contraceptive methods as well as services responding to issues such as male sexual dysfunction and reproductive cancers. Specific forms of outreach and counselling may need to be developed in contexts where men avoid seeking health care for reasons such as the fear of appearing weak, or because they think that clinics are mainly for women and children.

Equalizing up

For far too many women, economies are failing to deliver, in ways that compromise their sexual and reproductive rights and choices. They hold a disproportionate share of poorly paid, insecure jobs, for example, and have less access to social protection. New models of inclusive growth should be gender-equitable and emphasize "equalizing up," including through eliminating gender gaps in unemployment and increasing decent work for both women and men, but with a higher rate of expansion for women (Elson and Fontana, 2019).

Everywhere in the world, even in countries that have moved a

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significant way towards gender equality, women carry a greater burden of unpaid care work that unfairly diminishes time for paid work and leisure. Globally, women comprise 40 per cent of the formal workforce, but do between 2 and 10 times more caregiving and domestic work than men (Starrs and others, 2018). For many women, having a child still requires leaving the workforce, remaining outside it longer than they would like, or simply struggling to keep up. Some pay steep costs in terms of income and health.

Affordable housing, clean energy, safe public transport, clean water and sanitation, and health, education and childcare services can all reduce women's unpaid work (Starrs and others, 2018). Much better evidence is needed in measuring time use as the basis for defining investments in services and infrastructure that contribute to gender equality and reach the furthest behind first. Costing exercises could define the extent to which services and infrastructure weigh on the public purse, and deliver returns such as through productive employment and higher tax revenues (UN Women, 2018). Another element entails encouraging men to do their fair share.

Beyond the imperative of realizing women's rights, a growing number of countries have started to realize that "equalizing up" can deliver an extra momentum to

demographic transition, yielding a women's demographic dividend. Well-educated, healthy women who realize their reproductive rights and choices can make a significant contribution to a productive, thriving economy.

Continuity in times of crisis

From intractable conflicts to climate-related disasters, today's world is prone to crises that regularly constrain rights and choices. The ICPD called for protecting people forced to move or in vulnerable situations, including through sexual and reproductive health services.

Crisis must not put rights and choices on hold. Yet financial support has consistently lagged behind acute needs. For a pregnant woman fleeing catastrophe, skilled medical care can be as essential to her life and that of her child as food and shelter.

Reproductive rights and choices must become integral to all international responses to crisis. All humanitarian actors, public or private, from governments or non-governmental groups, should apply the minimum standards for services to stop and respond to sexual violence, reduce HIV transmission, and prevent maternal and newborn death and illness. Comprehensive sexual and reproductive health care should be provided as soon as conditions allow.

Pursuing opportunities

Crises, while never wanted, can open opportunities to improve rights and choices. More could be made of these, such as through programmes that may be the first chance people have to learn about sexual and reproductive health, challenge gender norms or seek refuge from gender-based violence. Amid the disruption, women and girls may explore new roles, such as through job training. More could be done to boost investment in psychosocial services and mental health, since gaps can quickly lead to risky sexual and other behaviours, ill health and gender-based violence, among other consequences.

Being prepared

Not all crises can be avoided. Being prepared means putting in place plans to manage disasters and mitigate risks. Where supplies

CHAMPION OF CHANGE

Sheshkala Pandey

Sheshkala Pandey was supposed to get married in eighth grade. But instead, the 19-year-old is today attending college, mentoring other girls, and recently received a national honour, the Unsung Hero Award.

Such developments could not have been readily predicted when Pandey was born. In her impoverished community in southern Nepal, girls have traditionally been married off as young as possible, despite a legal minimum age of 18. With no chance to finish their education, for many, marriage is the entry point to a lifetime of continued poverty and disempowerment.

Pandey was determined that this would not be her fate. When the subject of marriage first came up in her family, she burst into tears. Then she created a business plan, borrowed money from her brother and set up a small business making handicrafts to sell in a local market. She earned enough to manage her school tuition fees, a cost that often pressures family finances enough for parents to withdraw girls from school and push them towards marriage.

For Pandey, change in her own life was only a starting point. Today, when she is not studying for her university degree, she teaches in a local boarding school to support herself. She also heads a 30-member Girls' Circle, which mobilizes against harmful practices such as child marriage and sexual abuse and calls for girls to stay in school. When members hear that a child marriage is about to take place, they intervene to stop it, even in one case interrupting a wedding ceremony.

"We have to change the society, so why get disturbed by obstacles on our way?"

"I encourage [girls] to be bold to withstand all sorts of untoward violence against them," Pandey says, adding matter-of-factly: "We have to change the society, so why get disturbed by obstacles on our way?"

Pandey's courage in showing the way forward has meant that more girls in her community are now staying in school. Mothers come to ask her how their own daughters can become like her. She is the harbinger of a new norm, one where a girl should be treasured and encouraged, not discarded through child marriage.

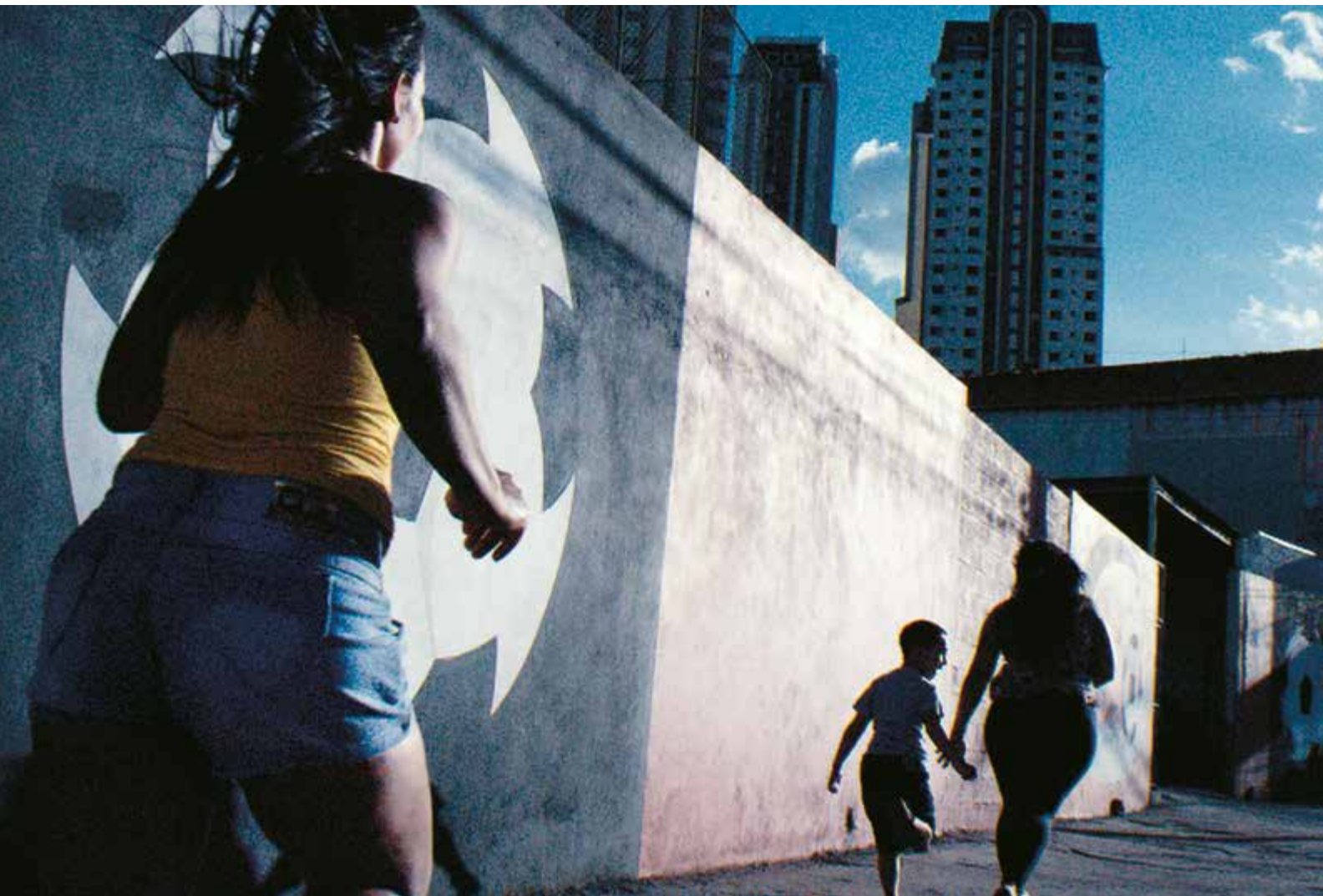
are pre-positioned to respond to disasters, they should by default include contraceptives, safe delivery kits and other essentials for reproductive health. Integrated service models can anticipate personnel and measures required to maintain continuity. All of these efforts should be backed by expanded disaster risk financing, which is often inadequate. One promising practice is to convene national risk boards that develop guidance from the pooled expertise of insurance supervisors, disaster management agencies and relevant ministries, including those working on health and gender equality.

Building resilience

Some of the best disaster-proofing comes when people are resilient and have means to protect themselves. Strong health-care systems with a full array of sexual and reproductive health services can reduce vulnerability and improve the choices people are equipped to make. Universally accessible social protection programmes can sustain health, education and income, three pillars of resilience for people on the margins. They can determine if and how well people survive a crisis, inform choices about whether to stay or flee, and support eventual transition away from external humanitarian assistance.

Accelerate action to complete the ICPD agenda

To finish the unfinished business of the ICPD and to move realistically towards realizing the 2030 Agenda and the SDGs as well as the three zeros—no unmet need for contraception, no preventable maternal deaths, and no violence or harmful practices against women and girls—most countries can build on the foundation of recent achievements. Many countries now have basic institutions and policies



in place related to population and reproductive health, but need to reach those furthest behind, improve service quality and respond to emerging shifts in demographics and development. They will need to plan strategically, based on correct evidence, which is still often lacking, and appropriate investments, which have grown but remain insufficient.

Getting the right institutions

Realizing rights and choices will not be achieved by working issue by issue. Health systems as a whole need to be strengthened to offer people the full array of essential services they need over a lifetime. A recent study published by *The Lancet* estimated costs for most countries to meet the health targets of the SDGs, predicting that about three quarters of additional investments would need to go towards health-systems' strengthening, such as for expanded health workforces and facilities (Stenberg and others, 2017). In many developing countries, despite moves towards decentralizing health and other public systems, significant work remains in improving subnational capacities, ensuring adequate financing and responding flexibly to needs that vary across locations.

Recognizing the integrated nature of the SDGs, a national vision for universal health coverage would draw strong links to the diverse determinants of health, and sexual and reproductive health in particular. These include a clean environment, which supports health during pregnancy and may reduce reproductive cancer risks. Decent work helps women plan their families by offering higher levels of income and autonomy. Education equips young people to make informed and healthy choices. As is already the case in some countries, national mechanisms that bring together people working in different arenas can develop deeper understanding of how different issues interact and build on each other.

Since the ICPD, greater accountability for rights and choices has emerged through the wide involvement of civil society and non-governmental groups in policy and planning. Many have been supported by UNFPA. Engagement continues to evolve, such as through the Reproductive Health Supplies Coalition and Family Planning 2020. Among other challenges, these groups could draw attention to the sexual and reproductive health services that do not feature in the SDG targets and indicators, given the risk that these will rank low in government policy and investment choices.

In some cases, expanded networking and capacity-building may be a priority to involve a broader cross section of civil society and non-governmental groups, not just those with a national or international presence, but those from smaller communities and marginalized groups. The participation of youth, the elderly, LGBTI people, people with disabilities, and indigenous and other minority communities could advance in many cases. There should be attention to multiple levels of diversity, such as young women from poor backgrounds.

Other forms of accountability might come through the deliberate inclusion of sexual and reproductive health and rights in the oversight responsibilities of national human rights institutions and through parliamentary reviews. Judicial system capacities could be further developed to reduce discriminatory legal practices, which persist even when laws are aligned with human rights standards.

Finding the money

Tracking financing for ICPD commitments has proven challenging, albeit with strong indications that funding remains insufficient. The ICPD stipulated that two thirds of the required amount would be mobilized by developing countries themselves, and one third from the international community.

In terms of funding priorities, publicly funded health services

CHAMPION OF CHANGE

Dany Stolbunov

Dany Stolbunov, now 20, admired and trusted his doctor in Ukraine enough to confide in him that he wanted to go to medical school. He hoped for affirmation of his dreams. Instead, he met rejection. "You can't be a doctor," his doctor said. "You have HIV."

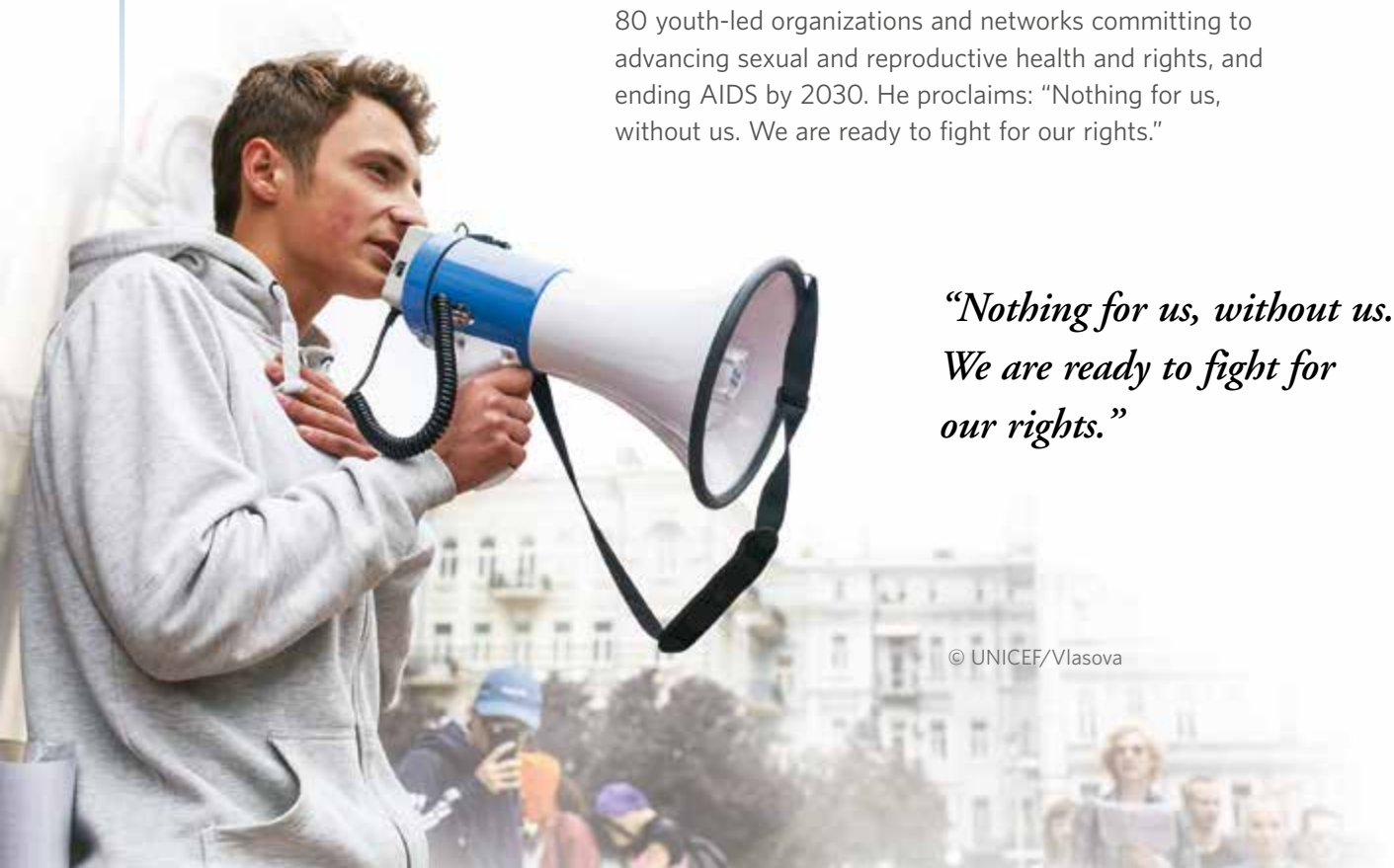
Born with HIV, Stolbunov learned he had the virus at age 8, when his father died of AIDS. As he grew up, he saw first-hand the stigma that still persists around HIV and AIDS even among people in health-care systems who are supposed to be on the front lines of treatment. As a young adult, he became determined to advocate for less discriminatory care.

"We are the first generation born with HIV who are growing up and can openly speak about it," he told people attending the 2018 International AIDS Conference, the largest global gathering on a health-care concern.

As a leader of the Ukrainian organization *Teenergizer*!, Stolbunov performed at the conference in a documentary theatre production, "Don't Tell Anyone." It showcases what it means to live with HIV in Eastern Europe and calls for listening to the voices of young people living with HIV.

Created by adolescents for adolescents, *Teenergizer*! advocates for every teenager to realize their full potential and rights, and for ending all forms of discrimination, including those against people living with HIV. Young people are still not seen as a priority in accessing even basic information about HIV, even though globally, HIV is a leading cause of death among people aged 10–19.

Stolbunov also co-chairs The Pact, a coalition of more than 80 youth-led organizations and networks committing to advancing sexual and reproductive health and rights, and ending AIDS by 2030. He proclaims: "Nothing for us, without us. We are ready to fight for our rights."



"Nothing for us, without us. We are ready to fight for our rights."

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generally offer maternal, newborn and child health care as well as family planning, albeit to a lesser degree. HIV/AIDS services have received significant donor finance in endemic areas, while far fewer domestic or international funds have gone towards services to address, for example, infertility, reproductive cancers and sexual violence (Starrs and others, 2018). Evening out distribution would be an important element in rolling out a universal package of essential sexual and reproductive health services.

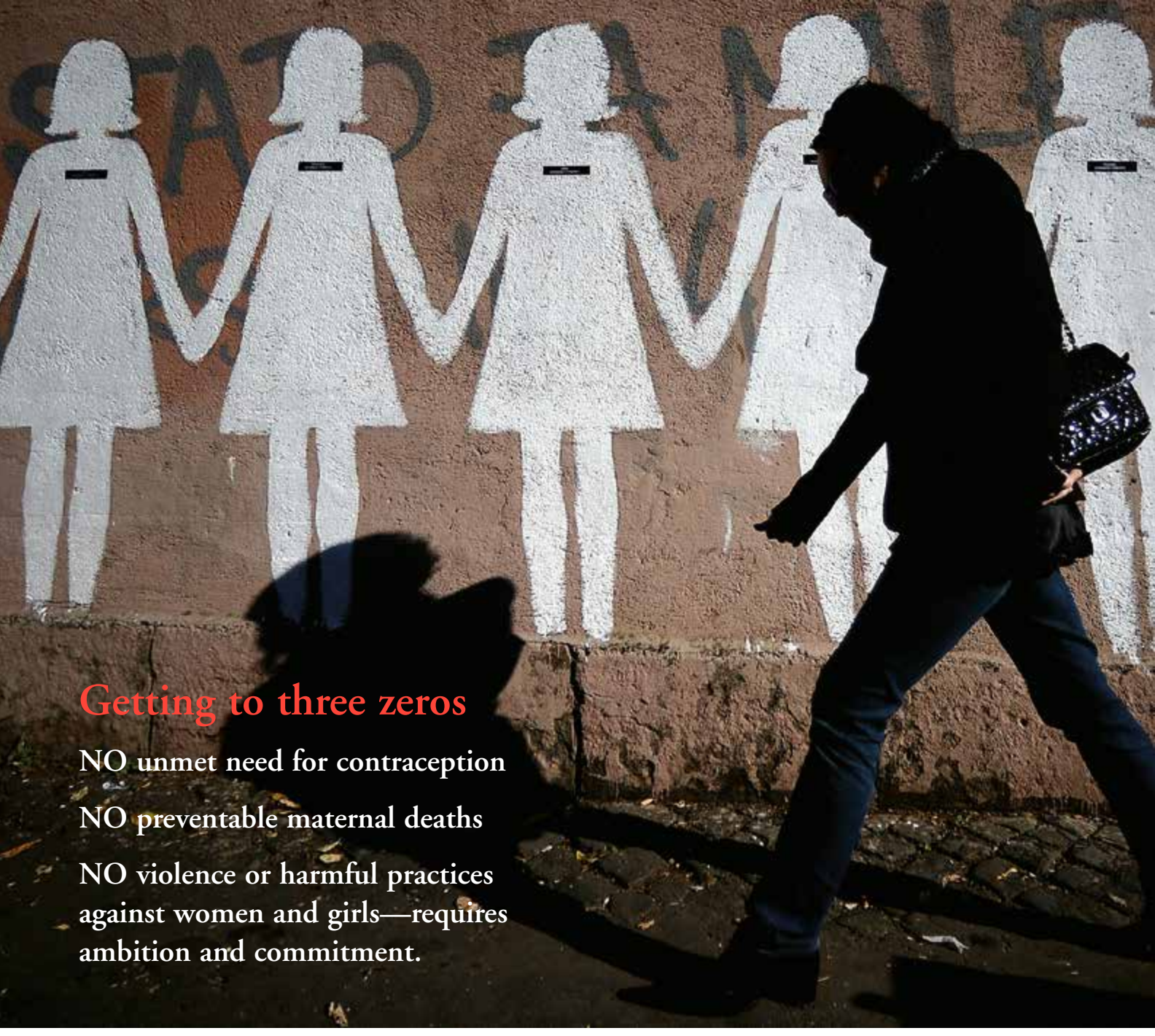
One study estimated that for most countries to meet all the health targets of the SDGs, up to $371 billion is needed per year by 2030, rising from an initial $134 billion per year (Stenberg and others, 2017). Among other outcomes, this would cut maternal mortality nearly in half, avert 400 million unplanned births, and prevent 10.8 million deaths from HIV/AIDS.

Middle-income countries are well equipped to self-finance the investment required and even be more ambitious, the study concluded. Low-income countries will face a financing gap and will continue to need external financial support, but even the poorest can aim for some level of universal health coverage. All countries will need to prioritize investments in line with the principle of equity and reaching the furthest behind first, and according to commitments to human rights. Developing countries that have successfully financed expanded services have taken measures including using tax revenues to subsidize target populations, increasing enrolment in government health insurance, and decreasing out-of-pocket spending by households while boosting the government's share of total health expenditures (Starrs and others, 2018).

A rights-based approach to budgeting can guide choices and may define new priorities, such as increasing allocations for universal access to a full array of contraceptives in the poorest communities, and adjusting tax policy in a progressive fashion to generate revenue to expand services.

Currently, 100 million people a year fall into poverty because of health costs (Starrs and others, 2018). Pooled funding or insurance schemes can be steps towards reducing out-of-pocket expenses. Voucher programmes, performance-based financing, social insurance programmes, and conditional cash transfers to families have improved sexual and reproductive health in a wide range of settings (Starrs and others, 2018). In some countries, there may be a rationale to privatize health services, but this should not be done in ways that impose costs that poorer and younger people may not be able to afford, resulting in losses to their rights.

Beyond domestic finance, a variety of external factors constrain



Getting to three zeros

NO unmet need for contraception

NO preventable maternal deaths

NO violence or harmful practices against women and girls—requires ambition and commitment.

funds for health care and should be addressed, starting with the fulfilment of global commitments to official development assistance and humanitarian aid. Other critical challenges include debt servicing that contradicts human rights by imposing onerous spending restrictions on essential services.

Measuring the situation

Policies, programmes and investments to fully realize reproductive rights and choices need to be grounded in the right evidence. Data gathering has improved since the ICPD. Yet gaps remain in coverage and capacity for data collection and analysis. Surveys often remain a stopgap for

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the lack of effective administrative sources such as civil registration systems.

Many countries struggle with a lack of disaggregated data, making it impossible to accurately understand and respond to what is happening in marginalized communities, for instance, or to assess differences by region or between urban, peri-urban and rural areas. Data on reproductive health often focus on married women of reproductive age, without sufficient consideration for single women, younger and older people, or LGBTI people. Only about one third of all countries and territories have reliable data on maternal mortality (UN Women, 2018). Other major gaps involve measuring financial resources dedicated to sexual and reproductive health and rights, the scope of unpaid care work, the surveillance of sexually transmitted infections, and the extent of gender-based violence. Intersections among multiple forms of discrimination are poorly tracked, as are changes in population age structure, despite their profound impact on development.

The emphasis on monitoring in the 2030 Agenda provides opportunities to close these gaps, particularly since monitoring progress towards the ICPD contributes directly to core aims of the SDGs. Upcoming rounds of censuses starting in 2020 can be oriented around updating and disaggregating data in the context of the 2030 Agenda, applying new technologies and developing innovations. Increasingly, technology offers options to improve data collection, such as through the use of geospatial information or handheld electronic devices. Modelling tools available in open source software offer new options to apply data in assessing interactions across different dimensions of population, sexual and reproductive health and rights, and sustainable development.

Getting to three zeros

Over the past 50 years, change has worked its way through people's lives and across generations. Many women today have better lives than their mothers, and can hope for even more for their daughters. That hope rests largely on realizing sexual and reproductive rights and choices for everyone. Getting to three zeros—no unmet need for contraception, no preventable maternal deaths, and no violence or harmful practices against women and girls—requires ambition and commitment. Many obstacles lie ahead along a path that is neither straightforward nor uncontested. But people have already gone far in claiming their rights and choices, and will continue to do so. History is on their side.

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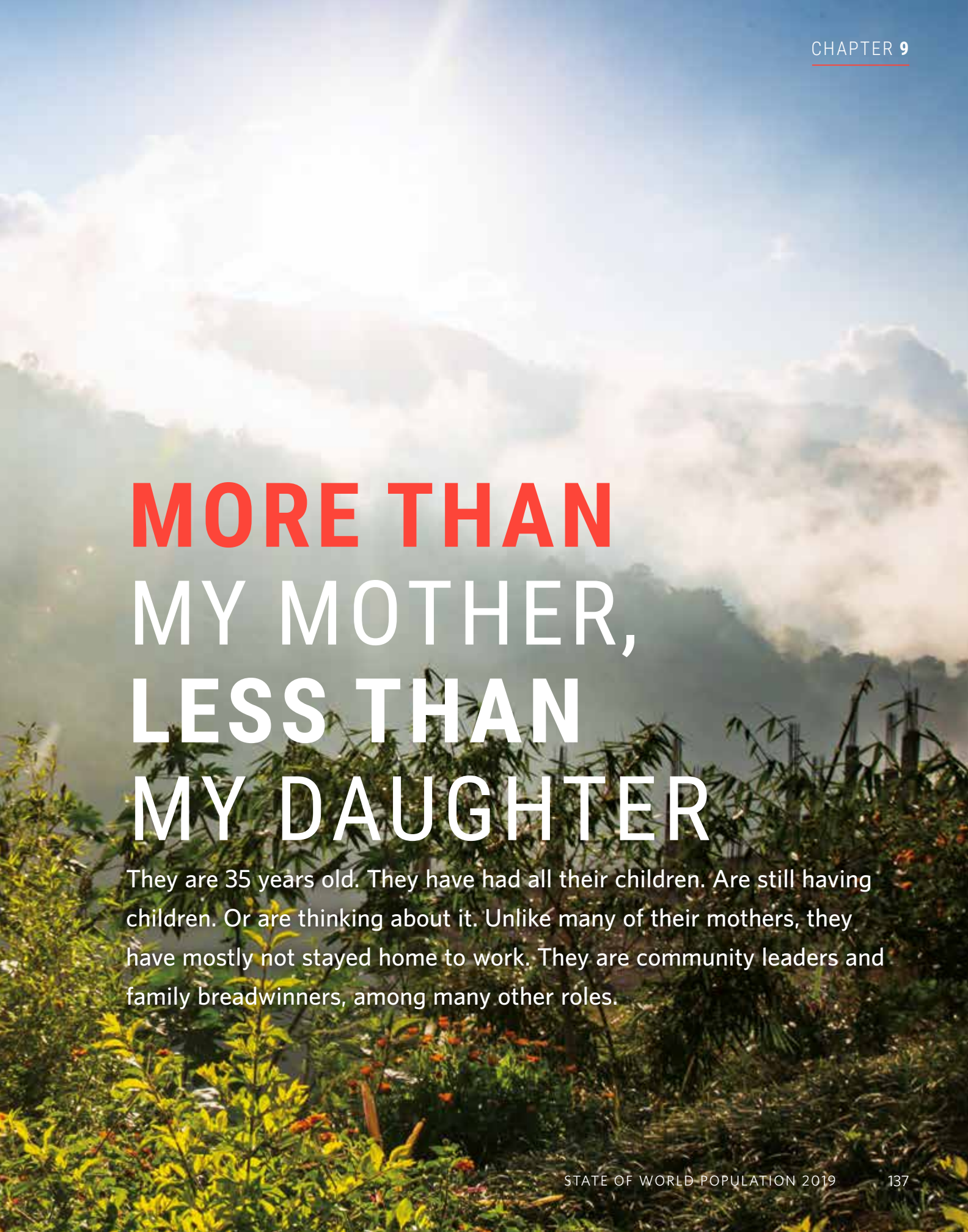

MORE THAN MY MOTHER, LESS THAN MY DAUGHTER

They are 35 years old. They have had all their children. Are still having children. Or are thinking about it. Unlike many of their mothers, they have mostly not stayed home to work. They are community leaders and family breadwinners, among many other roles.

Many have dreamed dreams that never occurred to their mothers. They have services and chances to earn an income that have allowed them to claim some of their reproductive rights and choices. Some of these became available as a result of the International Conference on Population and Development (ICPD), which happened when they were just 10 years old.

But especially for women at the low, sharp end of the economy, rights and choices have been partially realized at best. The constraints are many: limited education, the absence of decent work, the rising cost of health care. Even those in higher-level jobs can still face steep financial penalties related to childbearing and caring.

Has the world kept its promises to the post-Cairo generation? Not entirely. Not yet.

These 35-year-old women are hopeful and courageous. They believe that the future will be better for their children. For now, though, their experiences tell a story of how far we have come and just how much more needs to be done.

"I have experiences and know things, but a diploma would recognize what I can do."

Fanie

Haiti: lost chances for education

Fanie Derismé was born high in the mountains outside the capital of Haiti, Port-au-Prince, and was one of 13 children crammed into a three-room house. Her parents had a thriving garden to feed the family, and her mother was renowned as a butcher.

But the pressures of a large family encouraged a decision to take Fanie out of school at age 10 so that she could work in the home of a cousin in the city. The hope was that she would find opportunities to continue her education. Those dreams soon faded in the exhaustion of time-consuming household chores, and in a second family, regular abuse.

By 20, Fanie had fallen in love and was pregnant. That had not been the plan, but no one had ever told her anything

more than it might be dangerous to get "too close" to a man. At the six-month mark, her boyfriend left her for another woman, and Fanie had her son on her own. Today, he is 15 and in school, but Fanie is under constant stress to make ends meet. She cleans homes for income, and wishes she had taken her own schooling more seriously so that she could have pursued her dream of becoming a cook, maybe opening a small restaurant.

"I have experiences and know things, but a diploma would recognize what I can do," she says. "I have had to accept so much, like living in other people's houses, doing all the work and constant humiliation. I hope my son will learn and become somebody, and live much better than I have."

She would like another child but is concerned about costs and the lack of a stable relationship. "I do not want to be with a man, have a child, see it doesn't work, and be alone in carrying out all the responsibilities," she says. "Only with two incomes would I be in a position to sustain a child."

For now, she relies on condoms to avoid pregnancy, but they have become expensive; public clinics do not always freely provide them as was once the case.

Other pressures come from her sisters, who have many more children and expect her to help them out. One sister gave two children to an international organization that promised to educate them and return them at age 18, but they never came back. No one knows where they are.

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"I have not seen the changes that people talk about."

Um Ahmed

Egypt: a struggle for income and health

Born in a poor neighbourhood of Cairo, the birthplace of the ICPD Programme of Action, Um Ahmed says simply, "I have not seen the changes people talk about." Poverty ended her education after primary school. Until she married at 27, she toiled in odd jobs as a seamstress and domestic helper, scraping together enough money for the household furnishings that a bride is expected to bring to a new union.

There were two pregnancies in quick succession, ending in two premature births and the deaths of her children. Surgery in a public hospital helped her carry a third pregnancy long enough for her son Ahmed, now 6, to make it into the world.

Along the way, Um Ahmed learned that years of working long hours for little pay had taken a permanent toll. She contracted a virus that can complicate pregnancies. With a meagre income insufficient for basic health care, such as regular prenatal visits to the doctor, she had to borrow from multiple family members to cover the extra costs of carrying one child to term.

Um Ahmed's mother had five children and worked only in her home. Um Ahmed has one child and has decided not to have another because she simply cannot earn enough, despite yearning for Ahmed to have a sibling. The cost of living always goes beyond her means. "If I want to keep a child, I will need to go through checkups and surgery again, but it is too much of a financial burden. I work so hard but things never seem to improve," she laments.

Her husband wants more children and disputes her choice to use an intrauterine device, although his employment as a labourer is sporadic and marginal. Sometimes, when the arguments escalate, he beats her and shouts that God will provide the income they need. She knows about the hotline she can call to seek protection from him, yet she is afraid that a permanent separation might rupture the relationship with her son.

When Um Ahmed was 10, she was a dedicated student, walking an hour to school and an hour back each day because her family could not afford transport. She dreamed of going to university and getting a decent job with a comfortable house. Now that dream is only for her son. "I am determined, until my last breath, that he will stay in school and have a dignified life."

Guinea-Bissau: seeking a stable partnership

On the western tip of Africa in Guinea-Bissau, Marta Paula Sanca finished secondary school and has a better job than either Um Ahmed or Fanie, even though she started her education under a tree in a poor neighbourhood of Bissau, the capital. She and her brother were only two of five siblings to survive childhood.

When she was 13 and going to the market to fetch items for her mother, a man started talking to her and buying her sweets. She did not understand what was happening when he raped her—or when she became pregnant. She remembers staying at the hospital for some time before the birth because she was so young that doctors were concerned she might die. They also discouraged her parents from authorizing an abortion, stating that it too posed a risk to her life. They insisted that even if Marta Paula died later in the pregnancy, at least the baby might survive. In the end, the delivery happened without incident.

Not long after, in the late 1990s, civil conflict took the life of her father, and her mother became ill. As a teenage mother, Marta Paula was expected to go to work to help her younger brother and her mother. Somehow, she managed child-rearing, working in a cleaning job, selling items on the street and finishing secondary school. She started a relationship that promised to be a stable one, and she and her partner decided to have another child when she was 19. But the father, travelling frequently as a driver, later left her for another woman.

"I would tell all mothers in Guinea-Bissau that when girls reach 12, look for family planning services and choose a contraceptive method."

Marta Paula

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Today she works as a security guard and wishes she could have more children. But like Fanie, she will not do so unless she finds a stable relationship, which so far remains elusive. Long hours on the job mean that her children are often still asleep in the morning when she leaves, and have gone to bed when she returns at night.

She worries about changing norms in her country, now awash in information from the rest of the world. Her pregnancy at 13 was considered extremely unusual for the time. "But today, it is very common," she says, attributing the shift to more permissive parenting and sexual activity at younger ages. Poverty too plays a role, driving some girls to trade their bodies for school fees and money needed by their families.

Family planning information is well disseminated, and reproductive health services are for the most part available, yet teenage girls are somehow not being reached. Both of Marta Paula's children are boys, but she stresses, "I would tell all mothers in Guinea-Bissau that when girls reach 12, look for family planning services and choose a contraceptive method."

Bosnia and Herzegovina: constrained choices for contraception

Married at 15, Mediha Besic first became a mother at 16. At 35, she has five children, ranging in age from 4 to 19. Part of a marginalized Roma community in a rural area of Bosnia and Herzegovina, she and her husband

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find themselves too poor to purchase modern contraception, relying instead on traditional, less effective options like withdrawal. "It would have been easier to raise two kids," Mediha says. "I wanted to use contraception, but when you have no money, it is not affordable."

Like her mother before her, Mediha works only at home. Her husband used to collect and sell leftover construction materials, but that business has diminished over the years, with supplies drying up and gas becoming more expensive. Now he finds work only occasionally as a day labourer. For the most part, the family survives on a publicly provided child allowance of about $50 per month, hardly above the global definition of extreme poverty.

Still, Mediha feels that her life has improved in some ways since she was a child—and certainly since the war that consumed her country in the 1990s, when she remembers never having enough to eat. Today she lives in a larger home than the one she grew up in. It is constructed of brick and not scrap materials, although still has no running water.

Having finished primary school, she can read and write. By contrast, her mother never

"I wanted to use contraception, but when you have no money, it is not affordable."

Mediha

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saw the inside of a classroom. Yet Mediha is very far from a childhood ambition to be a teacher or doctor. "My parents had six children and could not pay for schooling for all of us, so I had to drop out." A sister who did finish school went on to become a nurse.

The first time Mediha ever saw a gynaecologist was when she was five months pregnant with her first child. The doctors talked to her mostly about the baby and her delivery, but shared little information on planning future pregnancies. "In our culture, you don't talk to anyone about family planning," she says, remembering how she felt ashamed and shy.

Today, though, she has made sure to talk to her oldest two children about how they can protect themselves. "I want them to finish school, find a job and then to get married and have their own families," she says. "I feel optimistic that they will have better chances in life."

Brazil: a father encourages a different life

It was only about 70 years ago that Tsitsina Xavante's indigenous community, the A'uwe Uptabi, first made contact with the outside world in Brazil. Before that, they kept to themselves, deep in the rainforest. Her father wore no clothes as a young man and spoke no Portuguese. When he became Brazil's first indigenous member of Congress, he took Tsitsina, his youngest child, to live with him in Brasilia, the capital. Her early

experiences led her to become a leader of the Namunkurá Xavante Association, which represents 305 different indigenous groups. She is careful to say that she does not speak for all indigenous people, only herself.

Among 10 siblings, she is the only one who finished college and even a master's degree. So far, she has chosen not to marry, and not

"They believe that I have a responsibility to have children, to give continuity to our people, but they also realize that I have lived in a different way."

Tsitsina

to have a child, at least not yet. Before her father died in 2002, when she asked him for permission to start dating at the age of 15, he refused. “He wanted me to study longer so I could go anywhere I want,” she recalls. “He said even if I marry I should be financially independent.”

Recently, however, her married sisters have been urging her to have a son or daughter before it is too late. In the tradition of her polygamous community, it would be acceptable to have a relationship with a brother-in-law to get pregnant. “They believe that I have a responsibility to have children, to give continuity to our people,” Tsitsina says. “But they also realize that I have lived in a different way.”

Her concerns about her community include the observation that many people used to wait to have a second child until the first was a toddler, but now women typically have children once a year for many years. Disease risks have risen given the practice of having multiple sexual partners within families. Indigenous health care is available, yet not regularly used. Extreme taboos around speaking openly about sex and sexuality mean many people have little to no information about their own bodies or know how to explore sex with responsibility.

“Many girls will get married at 14 or 15 and have kids really young,” Tsitsina says. “Some are happy with this. But they never learn other perspectives. I would like them to, because otherwise you will always just stick with the life you already know and see as natural, with no new stimuli.”

It is not easy. Her community has no Internet access, although it is now connected to electricity. Getting a boat to the closest city, the only means of transport, is expensive. And in a patriarchal society, where women’s well-defined roles and work are dismissed as less valuable, it can be extraordinarily hard for girls to muster motivation to follow their dreams. They can, however, look to Tsitsina as a model, someone committed to her community even as she lives in a new way.

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"I am lucky that today I have more opportunities because of my parents' support."

Rasamee

Thailand: a changing culture

"I love my work," Rasamee exclaims, quickly sketching her role as chief advocate for sustainable development within Thailand's leading telecommunications company. It's a high-pressure job with long hours. She must strategize with managers and corporate board members on what could be fundamental changes in the way the company does business over the longer term. But she's up to the challenge just five months after giving birth to her first child.

It's a far cry from the era of her grandparents, who emigrated to Thailand from China, and believed that school was for boys and home was for girls. Rasamee has a degree in economics and international business, urged on by her mother, who only finished school through fifth grade. Growing up, Rasamee watched her parents struggle financially. Her mother worked at home and her father sought jobs in construction, but was often derailed by illness.

"I am lucky that today I have more opportunities because of my parents' support," she says. "I used to think about how I wanted a prosperous life. But we were always aware of how many other people were suffering, so that meant not just that I have enough to feed myself, but that I can live a life of purpose." Her current job includes thinking through how the company

can help Thailand advance on the Sustainable Development Goals.

Rasamee thrived as a professional for many years before even thinking about getting married, not long before having her first child. “The culture has changed,” she says. “Women can work and take care of themselves and don’t need to rely on their husbands.”

Support for that freedom comes from the information about family planning that is widely available and routinely taught in schools. Contraception is available in practically every corner shop. “Our Government has promoted this so much,” Rasamee says. She believes that “no one is embarrassed to talk about it.”

After giving birth, she was so eager to return to her job that she took only two months for maternity leave, despite a corporate provision allowing three. She plans to have another child, but not the three or four that used to be common in her community.

“My husband also works—we would never have enough time for that many babies!” she laughs. The two are already working together on an education fund for their newborn, and her husband has a plan to expand his business to sustain the costs of a growing family.

Sri Lanka: an unexpected gift—children after cancer

Growing up in Sri Lanka, Shara Ranasinghe's early life was tumultuous. Her parents had divorced and the court stipulated that she, a single child, live with her father because he had financial stability and her mother did not. "My mother was a brilliant child, but she never went beyond secondary school, and she married and had a child by 20," Shara says.

After her father remarried, Shara suffered at the hands of a stepmother, who beat her at times. When her own mother asked what had happened, she would make up excuses like she had fallen on the stairs, not wanting to stir up more concern and anger.

Despite her unhappy childhood, Shara emerged with an independent and resilient spirit. After moving to Malaysia to pursue a university degree, she began to thrive until in her final year of studies she was diagnosed with cancer. She told her boyfriend that he really ought to leave her, but he refused, standing by her side through gruelling rounds of chemotherapy and radiation.

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"My mother was a brillant child, but she never went beyond secondary school, and she married and had a child by 20."

Shara

When it was over, the doctors said there was a low to zero probability that she would ever bear children. At one point, she had been asked if she wanted to preserve her eggs, but the subject came up in front of her father and felt too uncomfortable for discussion. She and her boyfriend decided to marry anyway, and soon after she found she was pregnant. "The stick turning positive was the best thing that ever happened in my life," she confides.

Two more children have followed since then, and Shara has moved to Australia to pursue advanced degrees, aiming for a doctorate in communications with cancer patients. While she always wanted many offspring, each pregnancy poses some risk to her fragile health. Financially, too, three feels like the right number. While Australia has subsidized childcare, she and her husband have worried about being away from their small children and juggled their work so that one

parent could always be home with them.

At one point, Shara moved ahead in her teaching career and became the main family breadwinner, while her husband took time off from being an engineer to work flexible hours preparing food in cafes. More recently, his parents have come to live with the couple, and her husband has gone back to engineering.

In the world around her, she sees a growing openness, with women finally moving into leadership positions at her university, and a boy at her daughter's school who has, for the first time, asked to be treated as a girl. Her first "miracle" daughter is now approaching 10, a talented, sensitive child. "I want her to be very strong," Shara says. "I hope she does not encounter discrimination, but there are still so many inequalities."

She counts Australia as further ahead in understanding a changing world, compared to Sri Lanka, where she says the majority of people retain deeply conservative expectations of women. She enjoys the staunch support of her parents in making choices to pursue her dreams. But, she says, "my country has a few more years to go. I am hopeful that future generations will be born into a Sri Lanka that fosters equal opportunities for all."

Indicators

Indicators for monitoring ICPD goals

	SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS														
	Contraceptive prevalence rate, women aged 15-49, any method[f]	Contraceptive prevalence rate, women aged 15-49, modern method[f]			Unmet need for family planning, women aged 15-49[f]	Proportion of demand satisfied, women aged 15-49[f]	Proportion of demand satisfied with modern methods, women aged 15-49[f]			Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]		Range of MMR uncertainty (UI 80%), Lower estimate	Upper estimate	Births attended by skilled health personnel, per cent	Decision making on sexual and reproductive health and reproductive rights, per cent
WORLD AND REGIONAL AREAS	2019	1969*	1994	2019	2019	2019	1969*	1994	2019	1994*	2015	2015	2015	2017	2014
WORLD	63	24	52	58	12	84	42	72	78	369	216	207	249	79	57
More developed regions	68	35	57	61	10	88	46	72	79	22	12	11	14	–	–
Less developed regions	62	20	51	57	12	84	40	72	77	409	238	228	274	–	–
Least developed countries	42	1	15	37	21	67	4	31	59	832	436	418	514	56[d]	49
REGIONAL DATA															
Arab States	54	11	33	48	15	78	26	54	69	285	162	138	212	76	–
Asia and the Pacific	67	22	58	62	10	87	45	78	81	316	127	114	151	84[b]	–
Eastern Europe and Central Asia	66	16	36	50	10	87	24	49	66	68	25	22	31	98	–
Latin America and the Caribbean	74	25	57	70	10	89	39	71	83	117	68	64	77	95[c]	–
East and Southern Africa	42	2	14	38	22	66	6	29	60	858	455	419	556	62	51
West and Central Africa	22	0	6	18	24	47	1	17	39	1040	676	586	862	52	38
COUNTRIES, TERRITORIES AND OTHER AREAS	2019	1969*	1994	2019	2019	2019	1969*	1994	2019	1994	2015	2015	2015	2006-2017	2007-2018
Afghanistan	27	1	6	24	24	52	5	17	48	1300	396	253	620	51	–
Albania	64	7	14	26	14	82	9	18	33	49	29	16	46	99	69
Algeria	64	13	46	57	10	87	30	67	77	196	140	82	244	97	–
Angola	17	0	3	16	36	33	1	8	30	1180	477	221	988	50	62
Antigua and Barbuda	64	29	53	61	13	83	47	72	80	–	–	–	–	–	–
Argentina	69	19	48	66	11	86	34	66	82	64	52	44	63	100	–
Armenia	59	15	26	31	13	82	26	35	44	50	25	21	31	100	66
Aruba	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Australia	66	62	66	64	11	86	80	85	83	8	6	5	7	100	–
Austria	67	28	50	64	10	88	39	71	84	7	4	3	5	98	–
Azerbaijan	58	11	18	29	13	82	23	27	40	92	25	17	35	100	–
Bahamas	67	40	61	65	12	85	60	79	83	47	80	53	124	–	–
Bahrain	67	17	33	48	10	87	30	46	63	22	15	12	19	100	–
Bangladesh	64	3	37	57	11	85	9	55	76	495	176	125	280	50	–
Barbados	62	35	54	59	15	80	54	72	76	56	27	19	37	99	–
Belarus	73	18	39	60	7	91	25	54	75	33	4	3	6	100	–
Belgium	72	22	69	71	7	91	27	88	90	9	7	5	10	–	–
Belize	55	20	42	52	19	74	35	60	70	55	28	20	36	97	–
Benin	21	0	3	15	30	41	1	7	30	541	405	279	633	77	38
Bhutan	63	3	22	62	12	84	10	44	83	690	148	101	241	89	–
Bolivia (Plurinational State of)	66	5	18	49	15	81	9	25	59	401	206	140	351	90	–
Bosnia and Herzegovina	50	3	12	21	15	77	5	19	33	24	11	7	17	100	–
Botswana	60	3	38	58	14	82	6	60	79	230	129	102	172	100	–
Brazil	80	35	68	77	7	92	49	79	88	88	44	36	54	99	–

COUNTRIES, TERRITORIES AND OTHER AREAS	SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS														
	Contraceptive prevalence rate, women aged 15-49, any method[f]	Contraceptive prevalence rate, women aged 15-49, modern method[f]			Unmet need for family planning, women aged 15-49[f]	Proportion of demand satisfied, women aged 15-49[f]	Proportion of demand satisfied with modern methods, women aged 15-49[f]			Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]		Range of MMR uncertainty (UI 80%), Lower estimate	Upper estimate	Births attended by skilled health personnel, per cent	Decision making on sexual and reproductive health and reproductive rights, per cent
	2019	1969*	1994	2019	2019	2019	1969*	1994	2019	1994	2015	2015	2015	2006-2017	2007-2018
Brunei Darussalam	–	–	–	–	–	–	–	–	–	34	23	15	30	100	–
Bulgaria	72	6	46	54	10	88	7	52	66	25	11	8	14	100	–
Burkina Faso	26	0	4	26	27	50	0	10	48	655	371	257	509	80	20
Burundi	33	0	4	28	27	55	0	11	47	1250	712	471	1050	85	44
Cambodia	61	0	8	46	12	84	1	18	63	789	161	117	213	89	76
Cameroon, Republic of	37	0	5	25	20	65	1	14	44	749	596	440	881	65	38
Canada	72	63	73	70	8	90	81	89	88	8	7	5	9	98	–
Cape Verde	66	2	32	63	12	84	5	50	81	170	42	20	95	91	–
Central African Republic	26	1	3	21	23	53	2	10	42	1320	882	508	1500	40	–
Chad	8	0	1	7	24	24	0	5	22	1440	856	560	1350	20	27
Chile	75	22	53	72	8	90	38	71	86	43	22	18	26	100	–
China	83	44	83	82	4	96	68	95	95	77	27	22	32	100	–
China, Hong Kong SAR	76	40	80	72	7	92	60	90	88	–	–	–	–	–	–
China, Macao SAR	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Colombia	80	12	59	75	7	92	20	71	86	109	64	56	81	99	–
Comoros	27	1	10	22	30	48	3	19	39	576	335	207	536	82	21
Congo, Democratic Republic of the	25	2	4	12	27	49	4	8	23	904	693	509	1010	80	31
Congo, Republic of the	42	2	8	26	20	68	4	16	43	627	442	300	638	91	27
Costa Rica	79	44	68	77	7	92	60	81	89	43	25	20	29	99	–
Côte d'Ivoire	20	0	4	18	25	44	1	11	40	741	645	458	909	74	25
Croatia	65	7	27	48	11	86	10	35	63	12	8	6	11	100	–
Cuba	74	49	68	72	9	90	68	85	88	57	39	33	47	100	–
Curaçao	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Cyprus	–	–	–	–	–	–	–	–	–	17	7	4	12	97	–
Czechia	80	18	47	71	6	93	23	58	83	11	4	3	6	100	–
Denmark	70	55	66	67	10	88	70	82	84	11	6	5	9	94	–
Djibouti	29	0	3	27	28	50	0	8	48	459	229	111	482	87	–
Dominica	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Dominican Republic	71	22	57	69	11	87	37	73	84	181	92	77	111	100	77
Ecuador	79	14	47	71	7	92	27	62	83	147	64	57	71	97	–
Egypt	61	17	46	60	12	84	36	67	82	88	33	26	39	92	–
El Salvador	72	15	50	68	10	88	31	69	82	135	54	40	69	100	–
Equatorial Guinea	19	1	4	15	32	37	2	11	30	1170	342	207	542	68	–
Eritrea	15	0	4	14	30	34	1	10	31	1210	501	332	750	34	–
Estonia	66	35	49	61	11	85	46	64	79	57	9	6	14	100	–
Eswatini	66	2	25	65	14	83	6	40	81	538	389	251	627	88	49
Ethiopia	41	0	3	40	21	66	0	8	64	1130	353	247	567	28	45
Fiji	49	31	39	45	19	72	50	59	66	54	30	23	41	100	–
Finland	83	59	73	78	5	95	72	87	90	5	3	2	3	100	–

Indicators for monitoring ICPD goals

COUNTRIES, TERRITORIES AND OTHER AREAS	SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS														
	Contraceptive prevalence rate, women aged 15-49, any method[f]	Contraceptive prevalence rate, women aged 15-49, modern method[f]			Unmet need for family planning, women aged 15-49[f]	Proportion of demand satisfied, women aged 15-49[f]	Proportion of demand satisfied with modern methods, women aged 15-49[f]			Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]		Range of MMR uncertainty (UI 80%),		Births attended by skilled health personnel, per cent	Decision making on sexual and reproductive health and reproductive rights, per cent
												Lower estimate	Upper estimate		
	2019	1969*	1994	2019	2019	2019	1969*	1994	2019	1994	2015	2015	2015	2006-2017	2007-2018
France	76	17	70	74	5	94	22	86	91	14	8	7	10	97	–
French Guiana	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
French Polynesia	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Gabon	37	2	10	26	25	60	4	18	42	408	291	197	442	89	48
Gambia	14	1	9	12	26	35	3	23	32	994	706	484	1030	57	41
Georgia	55	9	20	41	15	79	20	35	58	34	36	28	47	100	–
Germany	63	40	65	62	11	85	50	83	83	9	6	5	8	99	–
Ghana	33	2	10	29	27	55	6	18	48	535	319	216	458	71	52
Greece	70	19	32	50	9	89	23	40	64	4	3	2	4	–	–
Grenada	66	18	52	62	12	84	34	71	80	38	27	19	42	–	–
Guadeloupe	59	19	41	55	16	79	33	60	73	–	–	–	–	–	–
Guam	53	23	37	46	16	76	41	57	67	–	–	–	–	–	–
Guatemala	62	10	26	52	14	82	22	44	69	178	88	77	100	63	65
Guinea	10	0	2	9	25	29	0	6	25	967	679	504	927	63	23
Guinea-Bissau	20	0	3	18	21	49	1	12	45	799	549	273	1090	45	–
Guyana	42	19	36	41	27	61	31	53	59	190	229	184	301	86	71
Haiti	37	4	13	34	35	51	7	22	47	551	359	236	601	49	59
Honduras	73	13	39	65	10	88	25	55	78	186	129	99	166	83	70
Hungary	68	30	65	60	10	87	37	77	76	21	17	12	22	–	–
Iceland	–	–	–	–	–	–	–	–	–	6	3	2	6	98	–
India	57	9	39	51	12	82	22	62	74	488	174	139	217	86	–
Indonesia	61	5	52	59	13	83	15	74	80	347	126	93	179	93	–
Iran (Islamic Republic of)	78	16	52	65	5	94	32	66	78	87	25	21	31	99	–
Iraq	58	10	22	44	12	83	25	42	63	92	50	35	69	70	–
Ireland	68	44	61	63	11	87	56	76	81	9	8	6	11	100	–
Israel	72	27	51	57	8	90	43	65	71	9	5	4	6	–	–
Italy	69	15	38	54	9	88	20	50	69	7	4	3	5	100	–
Jamaica	72	33	57	69	10	88	51	74	84	80	89	70	115	99	–
Japan	44	53	54	40	21	68	75	74	62	11	5	4	7	100	–
Jordan	63	16	33	47	12	85	29	48	63	96	58	44	75	100	73
Kazakhstan	57	27	47	55	15	80	44	63	77	86	12	10	15	99	–
Kenya	65	2	27	62	14	82	4	41	79	684	510	344	754	62	56
Kiribati	29	16	24	24	26	52	33	44	45	215	90	51	152	80	–
Korea, Democratic People's Republic of	75	29	56	71	8	90	47	72	86	65	82	37	190	100	–
Korea, Republic of	78	19	67	70	6	93	36	80	84	19	11	9	13	100	–
Kuwait	57	16	37	47	15	80	32	58	65	8	4	3	6	100	–
Kyrgyzstan	44	28	47	41	17	72	48	69	68	89	76	59	96	98	77
Lao People's Democratic Republic	57	1	17	51	17	77	4	32	69	734	197	136	307	40	–
Latvia	69	39	56	62	11	87	50	69	78	61	18	13	26	100	–

COUNTRIES, TERRITORIES AND OTHER AREAS	SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS														
	Contraceptive prevalence rate, women aged 15-49, any method[f]	Contraceptive prevalence rate, women aged 15-49, modern method[f]			Unmet need for family planning, women aged 15-49[f]	Proportion of demand satisfied, women aged 15-49[f]	Proportion of demand satisfied with modern methods, women aged 15-49[f]			Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]		Range of MMR uncertainty (UI 80%), Lower estimate	Upper estimate	Births attended by skilled health personnel, per cent	Decision making on sexual and reproductive health and reproductive rights, per cent
	2019	1969*	1994	2019	2019	2019	1969*	1994	2019	1994	2015	2015	2015	2006-2017	2007-2018
Lebanon	61	24	38	48	13	83	36	51	65	57	15	10	22	–	–
Lesotho	62	1	22	61	16	79	2	37	79	522	487	310	871	78	61
Liberia	31	1	8	31	28	53	4	18	52	1890	725	527	1030	61	67
Libya	51	10	25	34	18	74	21	38	49	27	9	6	15	100	–
Lithuania	66	28	37	56	11	85	39	51	73	31	10	7	14	–	–
Luxembourg	–	–	–	–	–	–	–	–	–	13	10	7	16	100	–
Madagascar	47	0	7	41	18	72	1	15	63	676	353	256	484	44	74
Malawi	62	0	11	61	16	79	1	21	77	956	634	422	1080	90	47
Malaysia	53	13	34	39	17	76	27	48	56	67	40	32	53	99	–
Maldives	45	7	25	38	23	67	16	41	56	370	68	45	108	96	–
Mali	16	0	4	16	26	39	0	11	38	940	587	448	823	44	7
Malta	84	26	54	67	4	96	29	60	76	13	9	6	15	100	–
Martinique	61	24	46	57	15	80	39	64	75	–	–	–	–	–	–
Mauritania	21	0	2	19	30	41	0	6	37	827	602	399	984	69	–
Mauritius	67	17	46	44	10	87	27	57	57	68	53	38	77	100	–
Mexico	71	17	57	68	11	87	29	71	82	86	38	34	42	98	–
Micronesia (Federated States of)	–	–	–	–	–	–	–	–	–	169	100	46	211	85	–
Moldova, Republic of	64	18	39	49	12	84	23	50	65	63	23	19	28	99	–
Mongolia	58	22	44	52	14	81	41	62	73	208	44	35	55	99	–
Montenegro	39	8	22	24	21	65	11	33	41	12	7	4	12	99	–
Morocco	70	8	41	62	9	89	21	61	79	264	121	93	142	74	–
Mozambique	30	0	5	29	24	56	1	16	53	1210	489	360	686	54	49
Myanmar	54	2	21	53	15	78	6	43	76	389	178	121	284	60	68
Namibia	60	3	31	59	16	79	8	55	78	323	265	172	423	88	71
Nepal	54	1	23	48	22	71	4	40	63	693	258	176	425	58	48
Netherlands	72	49	73	69	8	91	64	89	86	13	7	5	9	–	–
New Caledonia	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
New Zealand	71	52	69	68	9	89	70	85	85	14	11	9	14	96	–
Nicaragua	80	11	50	77	6	93	21	66	90	199	150	115	196	88	–
Niger	21	0	3	19	19	52	1	13	48	836	553	411	752	40	7
Nigeria	19	0	8	15	23	45	1	23	36	1270	814	596	1180	43	51
North Macedonia	48	3	11	23	18	73	5	16	35	12	8	5	10	100	–
Norway	75	55	64	70	7	91	70	80	84	7	5	4	6	99	–
Oman	38	3	16	26	25	60	8	30	41	21	17	13	24	99	–
Pakistan	42	3	14	33	19	68	9	30	54	375	178	111	283	52	–
Palestine[1]	60	12	30	47	12	83	26	48	65	101	45	21	99	100	–
Panama	60	37	53	57	16	79	53	71	75	85	94	77	121	95	–
Papua New Guinea	37	15	20	31	25	60	29	36	50	388	215	98	457	53	–
Paraguay	72	14	41	68	9	89	28	57	85	147	132	107	163	96	–
Peru	76	10	39	56	7	92	16	48	68	215	68	54	80	92	–

Indicators for monitoring ICPD goals

COUNTRIES, TERRITORIES AND OTHER AREAS	SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS														
	Contraceptive prevalence rate, women aged 15-49, any method[f]	Contraceptive prevalence rate, women aged 15-49, modern method[f]			Unmet need for family planning, women aged 15-49[f]	Proportion of demand satisfied, women aged 15-49[f]	Proportion of demand satisfied with modern methods, women aged 15-49[f]			Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]		Range of MMR uncertainty (UI 80%),		Births attended by skilled health personnel, per cent	Decision making on sexual and reproductive health and reproductive rights, per cent
												Lower estimate	Upper estimate		
	2019	1969*	1994	2019	2019	2019	1969*	1994	2019	1994	2015	2015	2015	2006-2017	2007-2018
Philippines	56	11	27	42	17	77	20	37	57	121	114	87	175	73	81
Poland	61	12	33	52	14	82	16	42	69	14	3	2	4	100	–
Portugal	70	21	55	63	9	89	26	67	80	15	10	9	13	99	–
Puerto Rico	78	52	67	70	6	93	69	81	84	25	14	10	18	–	–
Qatar	47	15	32	41	17	74	32	54	65	29	13	9	19	100	–
Reunion	73	18	67	71	8	90	29	83	87	–	–	–	–	–	–
Romania	70	3	17	58	8	89	4	23	74	81	31	22	44	95	–
Russian Federation	69	20	46	58	9	88	26	60	74	88	25	18	33	99	–
Rwanda	57	0	10	52	17	77	0	17	70	1270	290	208	389	91	70
Saint Kitts and Nevis	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Saint Lucia	59	31	48	56	16	79	51	68	75	40	48	32	72	99	–
Saint Vincent and the Grenadines	66	34	57	63	12	84	52	76	81	74	45	34	63	–	–
Samoa	30	17	23	28	41	42	28	34	39	125	51	24	115	83	–
San Marino	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
São Tomé and Príncipe	44	4	20	41	29	60	8	33	56	271	156	83	268	93	46
Saudi Arabia	31	11	26	25	26	54	24	46	43	36	12	7	20	–	–
Senegal	26	0	6	24	25	51	1	15	48	511	315	214	468	59	7
Serbia	58	4	22	28	13	82	6	30	40	16	17	12	24	98	–
Seychelles	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Sierra Leone	20	0	3	19	26	44	1	9	42	2900	1360	999	1980	60	40
Singapore	66	46	53	59	11	86	64	70	77	12	10	6	17	100	–
Sint Maarten	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Slovakia	72	15	42	61	9	89	19	53	76	10	6	4	7	–	–
Slovenia	77	13	57	66	6	93	17	66	79	13	9	6	14	100	–
Solomon Islands	32	16	24	27	25	56	33	44	48	288	114	75	175	86	–
Somalia	31	0	6	30	27	53	1	15	52	1200	732	361	1390	9	–
South Africa	57	16	52	57	14	80	29	74	79	69	138	124	154	97	–
South Sudan	10	0	1	7	30	24	0	3	18	1580	789	523	1150	19	–
Spain	69	9	55	67	11	87	12	67	85	6	5	4	6	–	–
Sri Lanka	65	17	49	54	8	90	32	64	74	69	30	26	38	99	–
Sudan	17	3	7	16	28	38	8	18	36	667	311	214	433	78	–
Suriname	53	22	43	52	19	74	38	64	73	174	155	110	220	90	–
Sweden	69	53	60	63	10	87	66	76	80	7	4	3	5	–	–
Switzerland	73	48	73	69	7	91	61	87	86	8	5	4	7	–	–
Syrian Arab Republic	60	12	30	45	14	81	25	46	61	94	68	48	97	96	–
Tajikistan	36	15	28	33	21	63	33	50	58	140	32	19	51	87	33
Tanzania, United Republic of	43	1	12	37	21	67	2	26	58	979	398	281	570	64	47
Thailand	78	18	72	76	6	93	38	89	90	25	20	14	32	99	–
Timor-Leste, Democratic Republic of	29	7	20	26	25	54	22	54	49	958	215	150	300	57	40
Togo	23	0	6	21	33	42	1	9	38	566	368	255	518	45	30

COUNTRIES, TERRITORIES AND OTHER AREAS	SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS														
	Contraceptive prevalence rate, women aged 15-49, any method[ʃ]	Contraceptive prevalence rate, women aged 15-49, modern method[ʃ]			Unmet need for family planning, women aged 15-49[ʃ]	Proportion of demand satisfied, women aged 15-49[ʃ]	Proportion of demand satisfied with modern methods, women aged 15-49[ʃ]			Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]		Range of MMR uncertainty (UI 80%),		Births attended by skilled health personnel, per cent	Decision making on sexual and reproductive health and reproductive rights, per cent
												Lower estimate	Upper estimate		
	2019	1969*	1994	2019	2019	2019	1969*	1994	2019	1994	2015	2015	2015	2006-2017	2007-2018
Tonga	36	18	25	33	27	57	33	42	51	93	124	57	270	96	–
Trinidad and Tobago	48	36	41	44	21	70	55	61	64	80	63	49	80	97	–
Tunisia	67	16	49	57	9	88	33	69	76	114	62	42	92	74	–
Turkey	75	11	36	51	6	92	19	46	63	87	16	12	21	97	–
Turkmenistan	55	28	50	52	15	79	48	69	74	88	42	20	73	100	–
Turks and Caicos Islands	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Tuvalu	–	–	–	–	–	–	–	–	–	–	–	–	–	93	–
Uganda	40	0	7	36	28	59	1	16	53	692	343	247	493	74	62
Ukraine	67	17	38	54	10	87	22	49	70	49	24	19	32	99	81
United Arab Emirates	51	8	23	42	18	74	19	42	62	13	6	3	11	100	–
United Kingdom	79	61	78	79	6	93	75	92	93	11	9	8	11	–	–
United States of America	74	53	70	67	7	91	71	86	83	12	14	12	16	99	–
United States Virgin Islands	68	34	55	64	11	86	52	73	80	–	–	–	–	–	–
Uruguay	79	52	76	76	7	92	65	87	89	36	15	11	19	98	–
Uzbekistan	68	27	51	64	9	88	48	74	84	37	36	20	65	100	–
Vanuatu	46	17	31	40	23	67	33	50	59	192	78	36	169	89	–
Venezuela (Bolivarian Republic of)	73	29	56	68	11	87	42	70	82	93	95	77	124	96	–
Viet Nam	79	9	46	65	6	94	20	59	77	113	54	41	74	94	–
Western Sahara	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Yemen	44	1	8	37	24	64	2	15	55	507	385	274	582	45	–
Zambia	55	1	12	51	18	75	2	24	70	597	224	162	306	63	47
Zimbabwe	67	5	43	66	10	87	11	64	86	427	443	363	563	78	60

NOTES

– Data not available.

* Figures in this column are listed as 1969 and 1994 to conform with key dates covered in this report: 1969 through 2019. The 1969 figures are actually estimates from 1970 and 1994 figures are estimates from 1995.

ʃ Women currently married or in union.

a The MMR has been rounded according to the following scheme: <100, rounded to nearest 1; 100-999, rounded to nearest 1; and ≥1000, rounded to nearest 10.

b Excludes Cook Islands, Marshall Islands, Nauru, Niue, Palau, Tokelau, and Tuvalu due to data availability.

c Excludes Anguilla, Aruba, Bermuda, British Virgin Islands, Cayman Islands, Curaçao, Montserrat, Sint Maarten, and Turks and Caicos Islands due to data availability.

d Excludes Tuvalu due to data availability.

1 On 29 November 2012, the United Nations General Assembly passed Resolution 67/19, which accorded Palestine "non-member observer State status in the United Nations..."

Indicators for monitoring ICPD goals

WORLD AND REGIONAL AREAS	ADOLESCENTS AND YOUTH								
	Adolescent birth rate per 1,000 girls aged 15-19	Child marriage by age 18, per cent	FGM prevalence among girls aged 15-19, per cent	Adjusted net enrolment rate, primary education, per cent, 2017		Gender parity index, primary education	Net enrolment rate, secondary education, per cent, 2017		Gender parity index, secondary education
	2018	2017	2017	male	female	2017	male	female	2017
WORLD	44	21	–	92	90	0.98	66	66	1.00
More developed regions	14	–	–	97	97	1.00	93	93	1.01
Less developed regions	48	–	–	91	89	0.98	62	62	0.99
Least developed countries	91	40	–	83	80	0.96	38	36	0.95
REGIONAL DATA									
Arab States	50	21	55	85	83	0.97	63	59	0.93
Asia and the Pacific	28[a]	26	–	95	94	0.99	67	68	1.02
Eastern Europe and Central Asia	26	11	–	96	95	1.00	88	87	0.99
Latin America and the Caribbean	62[b]	26	–	95	96	1.01	75	79	1.05
East and Southern Africa	93[c]	35	–	86	83	0.97	35	33	0.93
West and Central Africa	114	42	22	79	71	0.90	39	34	0.86
COUNTRIES, TERRITORIES AND OTHER AREAS				2009-2018			2009-2018		
	2006-2017	2006-2017	2004-2017	male	female	2009-2018	male	female	2009-2018
Afghanistan	87	35	–	–	–	–	62	36	0.58
Albania	20	10	–	98	96	0.99	88	87	0.99
Algeria	12	3	–	100	98	0.98	–	–	–
Angola	163	30	–	89	66	0.75	13	10	0.79
Antigua and Barbuda	–	–	–	82	81	0.99	73	76	1.04
Argentina	65	–	–	100	99	0.99	87	92	1.05
Armenia	24	5	–	92	92	1.00	87	88	1.01
Aruba	35	–	–	99	99	1.00	73	81	1.10
Australia	12	–	–	96	97	1.01	93	94	1.01
Austria	8	–	–	–	–	–	87	88	1.00
Azerbaijan	53	11	–	93	95	1.02	87	88	1.01
Bahamas	32	–	–	85	92	1.08	79	86	1.09
Bahrain	14	–	–	99	99	1.00	92	94	1.02
Bangladesh	78	59	–	92	98	1.07	57	67	1.17
Barbados	50	11	–	90	91	1.00	93	99	1.07
Belarus	16	3	–	96	96	1.00	95	96	1.01
Belgium	7	–	–	99	99	1.00	94	94	1.00
Belize	69	26	–	100	99	0.99	68	73	1.07
Benin	94	26	2	100	90	0.90	53	40	0.75
Bhutan	28	26	–	81	83	1.02	61	71	1.17
Bolivia (Plurinational State of)	71	19	–	93	92	0.99	78	78	1.00
Bosnia and Herzegovina	11	4	–	–	–	–	–	–	–
Botswana	39	–	–	89	90	1.01	–	–	–
Brazil	62	26	–	96	98	1.02	80	84	1.05
Brunei Darussalam	11	–	–	97	96	1.00	82	85	1.03
Bulgaria	39	–	–	93	93	1.00	91	89	0.97
Burkina Faso	129	52	58	78	76	0.98	29	29	1.01

COUNTRIES, TERRITORIES AND OTHER AREAS	ADOLESCENTS AND YOUTH								
	Adolescent birth rate per 1,000 girls aged 15-19	Child marriage by age 18, per cent	FGM prevalence among girls aged 15-19, per cent	Adjusted net enrolment rate, primary education, per cent, 2009-2018		Gender parity index, primary education	Net enrolment rate, secondary education, per cent, 2009-2018		Gender parity index, secondary education
	2006-2017	2006-2017	2004-2017	male	female	2009-2018	male	female	2009-2018
Burundi	58	20	–	96	98	1.02	26	32	1.21
Cambodia	57	19	–	91	90	1.00	–	–	–
Cameroon, Republic of	119	31	0	99	91	0.92	50	44	0.88
Canada	11	–	–	–	–	–	99	100	1.01
Cape Verde	80	–	–	87	86	0.98	61	68	1.11
Central African Republic	229	68	18	77	60	0.79	16	10	0.61
Chad	179	67	32	71	55	0.77	–	–	–
Chile	41	–	–	93	93	1.00	86	89	1.04
China	9	–	–	–	–	–	–	–	–
China, Hong Kong SAR	3	–	–	–	–	–	93	93	1.00
China, Macao SAR	3	–	–	99	99	1.00	84	87	1.05
Colombia	75	23	–	93	94	1.01	76	82	1.07
Comoros	70	32	–	85	84	0.99	41	45	1.09
Congo, Democratic Republic of the	138	37	–	–	–	–	–	–	–
Congo, Republic of the	147	27	–	84	91	1.09	–	–	–
Costa Rica	53	21	–	97	97	1.00	81	84	1.04
Côte d'Ivoire	129	27	27	93	85	0.91	45	33	0.75
Croatia	10	–	–	96	99	1.04	89	92	1.04
Cuba	50	26	–	97	97	1.00	84	89	1.06
Curaçao	35	–	–	–	–	–	–	–	–
Cyprus	5	–	–	98	98	1.01	94	95	1.01
Czechia	12	–	–	–	–	–	90	92	1.02
Denmark	3	–	–	99	99	1.01	88	92	1.04
Djibouti	21	5	90	62	56	0.89	38	32	0.83
Dominica	–	–	–	97	99	1.02	90	97	1.08
Dominican Republic	90	36	–	88	88	1.00	62	71	1.13
Ecuador	111	–	–	97	99	1.02	87	89	1.02
Egypt	56	17	70	98	99	1.01	81	82	1.00
El Salvador	69	26	–	81	82	1.01	60	61	1.02
Equatorial Guinea	176	30	–	44	45	1.02	–	–	–
Eritrea	76	41	69	39	36	0.91	27	25	0.92
Estonia	13	–	–	93	94	1.01	93	95	1.02
Eswatini	87	5	–	76	75	0.98	32	41	1.29
Ethiopia	80	40	47	89	83	0.93	31	30	0.97
Fiji	40	–	–	98	98	1.01	79	88	1.11
Finland	6	–	–	99	99	1.00	96	96	1.01
France	5	–	–	99	99	1.01	93	94	1.01
French Guiana	87	–	–	–	–	–	–	–	–
French Polynesia	40	–	–	–	–	–	–	–	–
Gabon	91	22	–	–	–	–	–	–	–
Gambia	88	30	76	75	83	1.10	–	–	–
Georgia	44	14	–	98	98	0.99	97	99	1.02

Indicators for monitoring ICPD goals

COUNTRIES, TERRITORIES AND OTHER AREAS	ADOLESCENTS AND YOUTH								
	Adolescent birth rate per 1,000 girls aged 15-19	Child marriage by age 18, per cent	FGM prevalence among girls aged 15-19, per cent	Adjusted net enrolment rate, primary education, per cent, 2009-2018		Gender parity index, primary education	Net enrolment rate, secondary education, per cent, 2009-2018		Gender parity index, secondary education
	2006-2017	2006-2017	2004-2017	male	female	2009-2018	male	female	2009-2018
Germany	8	–	–	–	–	–	–	–	–
Ghana	76	21	2	84	86	1.02	56	57	1.01
Greece	8	–	–	93	93	1.00	91	89	0.99
Grenada	–	–	–	96	97	1.01	80	72	0.91
Guadeloupe	–	–	–	–	–	–	–	–	–
Guam	38	–	–	–	–	–	–	–	–
Guatemala	92	30	–	87	87	1.00	48	46	0.96
Guinea	146	51	95	86	71	0.83	40	26	0.66
Guinea-Bissau	106	24	42	74	70	0.95	–	–	–
Guyana	74	30	–	95	97	1.02	81	86	1.06
Haiti	55	18	–	–	–	–	–	–	–
Honduras	103	34	–	83	84	1.02	43	48	1.14
Hungary	23	–	–	97	97	1.00	89	89	1.00
Iceland	8	–	–	100	99	1.00	89	91	1.03
India	28	27	–	97	98	1.01	61	62	1.01
Indonesia	48	14	–	95	90	0.95	76	78	1.02
Iran (Islamic Republic of)	38	17	–	–	–	–	72	73	1.00
Iraq	82	24	5	–	–	–	–	–	–
Ireland	9	–	–	100	100	1.00	97	99	1.01
Israel	10	–	–	97	98	1.01	98	100	1.02
Italy	5	–	–	99	98	1.00	96	96	1.00
Jamaica	46	8	–	–	–	–	71	77	1.09
Japan	4	–	–	98	98	1.00	99	100	1.01
Jordan	26	8	–	–	–	–	63	65	1.03
Kazakhstan	31	7	–	98	100	1.02	100	100	1.00
Kenya	96	23	11	81	85	1.04	50	47	0.94
Kiribati	49	20	–	–	–	–	–	–	–
Korea, Democratic People's Republic of	1	–	–	97	97	1.00	90	91	1.01
Korea, Republic of	1	–	–	96	97	1.00	97	98	1.00
Kuwait	6	–	–	93	93	1.00	84	89	1.07
Kyrgyzstan	38	12	–	99	98	0.99	87	87	1.00
Lao People's Democratic Republic	76	35	–	94	93	0.99	61	60	0.98
Latvia	18	–	–	96	97	1.01	93	95	1.02
Lebanon	–	6	–	91	86	0.94	65	65	1.00
Lesotho	94	17	–	81	83	1.03	29	45	1.53
Liberia	149	36	26[d]	39	36	0.93	16	14	0.88
Libya	11	–	–	–	–	–	–	–	–
Lithuania	14	–	–	100	100	1.00	98	97	1.00
Luxembourg	6	–	–	99	99	1.00	83	86	1.04
Madagascar	152	41	–	–	–	–	28	30	1.08
Malawi	136	42	–	95	99	1.04	32	31	0.96
Malaysia	12	–	–	98	99	1.00	72	78	1.08

COUNTRIES, TERRITORIES AND OTHER AREAS	ADOLESCENTS AND YOUTH								
	Adolescent birth rate per 1,000 girls aged 15-19	Child marriage by age 18, per cent	FGM prevalence among girls aged 15-19, per cent	Adjusted net enrolment rate, primary education, per cent, 2009-2018		Gender parity index, primary education	Net enrolment rate, secondary education, per cent, 2009-2018		Gender parity index, secondary education
	2006-2017	2006-2017	2004-2017	male	female	2009-2018	male	female	2009-2018
Maldives	13	4	–	100	100	1.00	–	–	–
Mali	174	52	83	71	63	0.89	32	26	0.80
Malta	11	–	–	97	100	1.03	87	92	1.05
Martinique	20	–	–	–	–	–	–	–	–
Mauritania	71	37	63	75	78	1.05	26	25	0.97
Mauritius	24	–	–	95	97	1.02	82	88	1.08
Mexico	63	26	–	98	100	1.02	76	79	1.04
Micronesia (Federated States of)	44	–	–	83	85	1.03	–	–	–
Moldova, Republic of	27	12	–	90	90	1.00	78	78	1.00
Mongolia	27	5	–	99	98	0.99	–	–	–
Montenegro	11	5	–	97	96	0.99	89	89	1.00
Morocco	32	–	–	97	97	1.00	64	63	0.99
Mozambique	167	48	–	89	86	0.97	19	19	1.02
Myanmar	36	16	–	90	89	0.99	57	62	1.09
Namibia	82	7	–	96	100	1.04	–	–	–
Nepal	88	40	–	96	93	0.97	53	57	1.07
Netherlands	3	–	–	–	–	–	93	94	1.01
New Caledonia	22	–	–	–	–	–	–	–	–
New Zealand	16	–	–	98	99	1.01	95	97	1.02
Nicaragua	92	35	–	97	100	1.03	45	53	1.17
Niger	210	76	1	71	62	0.87	24	17	0.73
Nigeria	145	44	12	72	60	0.84	–	–	–
North Macedonia	16	7	–	92	92	1.00	–	–	–
Norway	5	–	–	100	100	1.00	95	96	1.01
Oman	14	–	–	99	99	1.00	91	91	0.99
Pakistan	44	21	–	82	71	0.86	49	40	0.81
Palestine[1]	48	15	–	94	94	1.00	79	87	1.10
Panama	79	26	–	88	87	0.99	67	72	1.07
Papua New Guinea	–	21	–	80	75	0.93	36	30	0.82
Paraguay	62	22	–	79	79	1.00	63	67	1.07
Peru	65	22	–	99	100	1.01	80	81	1.02
Philippines	47	15	–	95	96	1.01	60	72	1.19
Poland	12	–	–	96	96	1.00	92	93	1.01
Portugal	8	–	–	97	96	1.00	93	94	1.01
Puerto Rico	30	–	–	79	84	1.07	72	77	1.07
Qatar	10	4	–	99	98	0.99	68	85	1.25
Reunion	44	–	–	–	–	–	–	–	–
Romania	35	–	–	90	90	1.00	81	81	1.00
Russian Federation	24	–	–	97	98	1.01	94	95	1.01
Rwanda	45	7	–	94	94	1.01	25	30	1.18
Saint Kitts and Nevis	46	–	–	–	–	–	–	–	–
Saint Lucia	–	8	–	–	–	–	79	81	1.03

Indicators for monitoring ICPD goals

COUNTRIES, TERRITORIES AND OTHER AREAS	ADOLESCENTS AND YOUTH								
	Adolescent birth rate per 1,000 girls aged 15-19	Child marriage by age 18, per cent	FGM prevalence among girls aged 15-19, per cent	Adjusted net enrolment rate, primary education, per cent, 2009-2018		Gender parity index, primary education	Net enrolment rate, secondary education, per cent, 2009-2018		Gender parity index, secondary education
	2006-2017	2006-2017	2004-2017	male	female	2009-2018	male	female	2009-2018
Saint Vincent and the Grenadines	64	–	–	99	98	0.99	91	91	0.99
Samoa	39	11	–	96	97	1.01	74	81	1.10
San Marino	0	–	–	93	93	1.00	–	–	–
São Tomé and Príncipe	92	35	–	97	97	0.99	61	68	1.11
Saudi Arabia	7	–	–	99	100	1.00	86	84	0.97
Senegal	80	31	21	71	79	1.12	35	39	1.10
Serbia	16	3	–	98	99	1.00	92	93	1.01
Seychelles	66	–	–	–	–	–	87	90	1.03
Sierra Leone	125	39	74	99	99	1.01	38	37	0.97
Singapore	3	–	–	–	–	–	100	100	1.00
Sint Maarten	–	–	–	–	–	–	–	–	–
Slovakia	24	–	–	–	–	–	84	86	1.01
Slovenia	5	–	–	97	98	1.01	95	95	1.01
Solomon Islands	78	21	–	69	70	1.01	–	–	–
Somalia	64	45	97	–	–	–	–	–	–
South Africa	71	–	–	91	92	1.01	86	84	0.98
South Sudan	155	52	–	36	28	0.76	6	4	0.70
Spain	8	–	–	98	99	1.00	95	97	1.02
Sri Lanka	20	12	–	98	96	0.98	87	90	1.03
Sudan	87	34	82	57	63	1.10	–	–	–
Suriname	58	19	–	96	100	1.04	53	65	1.22
Sweden	4	–	–	100	99	1.00	100	99	1.00
Switzerland	6	–	–	100	100	1.00	87	84	0.97
Syrian Arab Republic	54	13	–	68	67	0.98	46	45	0.99
Tajikistan	54	12	–	99	98	0.99	87	78	0.90
Tanzania, United Republic of	132	31	5	78	81	1.04	23	23	1.02
Thailand	43	23	–	98	98	1.00	77	77	1.01
Timor-Leste, Democratic Republic of	50	19	–	79	82	1.04	55	64	1.16
Togo	85	22	2	95	89	0.94	48	33	0.69
Tonga	30	6	–	95	97	1.03	74	79	1.07
Trinidad and Tobago	38	11	–	99	98	0.99	–	–	–
Tunisia	7	2	–	99	98	0.99	–	–	–
Turkey	27	15	–	95	94	0.99	86	85	0.99
Turkmenistan	28	6	–	–	–	–	–	–	–
Turks and Caicos Islands	–	–	–	–	–	–	–	–	–
Tuvalu	28	10	–	–	–	–	63	79	1.26
Uganda	140	40	1	90	92	1.03	–	–	–
Ukraine	26	9	–	92	94	1.02	86	87	1.01
United Arab Emirates	34	–	–	98	96	0.98	89	86	0.96
United Kingdom	14	–	–	100	100	1.00	98	98	1.00
United States of America	20	–	–	96	96	1.00	92	92	1.00
United States Virgin Islands	25	–	–	–	–	–	–	–	–

COUNTRIES, TERRITORIES AND OTHER AREAS	ADOLESCENTS AND YOUTH								
	Adolescent birth rate per 1,000 girls aged 15-19	Child marriage by age 18, per cent	FGM prevalence among girls aged 15-19, per cent	Adjusted net enrolment rate, primary education, per cent, 2009-2018		Gender parity index, primary education	Net enrolment rate, secondary education, per cent, 2009-2018		Gender parity index, secondary education
	2006-2017	2006-2017	2004-2017	male	female	2009-2018	male	female	2009-2018
Uruguay	51	25	–	98	98	1.00	80	86	1.08
Uzbekistan	30	7	–	99	98	0.98	91	90	0.99
Vanuatu	78	21	–	86	88	1.03	48	51	1.07
Venezuela (Bolivarian Republic of)	95	–	–	86	86	1.00	67	73	1.10
Viet Nam	30	11	–	–	–	–	–	–	–
Western Sahara	–	–	–	–	–	–	–	–	–
Yemen	67	32	16	88	78	0.88	54	40	0.74
Zambia	141	31	–	87	89	1.02	–	–	–
Zimbabwe	110	32	–	84	86	1.02	44	44	1.01

NOTES

– Data not available.

a Excludes Cook Islands, Marshall Islands, Nauru, Niue, Palau, Tokelau, and Tuvalu due to data availability.

b Excludes Anguilla, Antigua and Barbuda, Bermuda, British Virgin Islands, Cayman Islands, Ecuador, Grenada, Montserrat, Sint Maarten, and Saint Kitts and Nevis due to data availability.

c Includes Seychelles.

d Percentage of girls aged 15-19 years who are members of the Sande society. Membership in Sande society is a proxy for FGM.

1 On 29 November 2012, the United Nations General Assembly passed Resolution 67/19, which accorded Palestine "non-member observer State status in the United Nations..."

Demographic indicators

WORLD AND REGIONAL AREAS	POPULATION			FERTILITY			LIFE EXPECTANCY			POPULATION CHANGE	POPULATION COMPOSITION (BY AGE)			
	Total population in millions			Total fertility rate, per woman			Life expectancy at birth, years			Average annual rate per cent	0-14 per cent	10-24 per cent	15-64 per cent	65 and over per cent
	1969	1994	2019	1969	1994	2019	1969	1994	2019	2010-2019	2019	2019	2019	2019
WORLD	3626	5670	7715	4.8	2.9	2.5	56	65	72	1.1	26	24	65	9
More developed regions	1001	1167	1266	2.3	1.6	1.7	71	74	80	0.3	16	17	65	19
Less developed regions	2625	4503	6448	5.9	3.2	2.6	53	63	71	1.3	27	25	65	7
Least developed countries	301	570	1050	6.8	5.6	3.9	44	52	65	2.4	39	32	57	4
REGIONAL DATA														
Arab States	112	223	373	6.9	4.5	3.3	52	64	70	2.0	34	28	61	5
Asia and the Pacific	1818	3027	4030	5.9	2.8	2.1[a]	53	64	72[a]	1.0	24[a]	23[a]	68[a]	8[a]
Eastern Europe and Central Asia	154	211	247	3.6	2.4	2.0	61	67	73	0.9	23	21	67	10
Latin America and the Caribbean	278	474	653	5.4	3.0	2.0[b]	59	69	76[b]	1.1	24[b]	25[b]	67[b]	9[b]
East and Southern Africa	154	312	613	6.8	5.9	4.3	46	49	64	2.7	41	32	55	3
West and Central Africa	118	229	447	6.6	6.3	5.1	41	49	58	2.7	43	32	54	3
COUNTRIES, TERRITORIES AND OTHER AREAS														
Afghanistan	10.9	16.2	37.2	7.5	7.6	4.2	36	53	65	2.8	42	35	55	3
Albania	2.1	3.1	2.9	5.1	2.7	1.7	67	72	79	0.0	17	21	69	14
Algeria	14.1	28.4	42.7	7.7	3.7	2.6	50	68	77	1.9	30	22	64	7
Angola	6.6	13.8	31.8	7.6	7.0	5.5	37	43	62	3.4	46	33	51	3
Antigua and Barbuda	0.1	0.1	0.1	3.8	2.2	2.0	66	72	77	1.1	23	24	69	7
Argentina	23.6	34.6	45.1	3.1	2.8	2.2	66	72	77	1.0	24	24	64	11
Armenia	2.5	3.3	2.9	3.3	2.2	1.6	70	69	75	0.2	20	19	68	12
Aruba	0.1	0.1	0.1	3.1	2.1	1.8	69	74	76	0.5	17	21	68	14
Australia[1]	12.6	17.9	25.1	2.8	1.8	1.8	71	78	83	1.4	19	19	65	16
Austria	7.5	7.9	8.8	2.4	1.5	1.5	70	77	82	0.5	14	15	66	20
Azerbaijan[2]	5.1	7.7	10.0	5.2	2.7	2.0	63	65	72	1.1	23	21	70	6
Bahamas	0.2	0.3	0.4	3.6	2.6	1.7	66	71	76	1.2	20	21	70	10
Bahrain	0.2	0.5	1.6	6.7	3.2	2.0	63	73	77	3.1	19	18	79	3
Bangladesh	63.4	116.2	168.1	6.9	3.8	2.0	48	61	73	1.1	27	28	68	5
Barbados	0.2	0.3	0.3	3.3	1.7	1.8	65	72	76	0.3	19	19	65	16
Belarus	8.9	10.2	9.4	2.3	1.5	1.7	71	69	73	0.0	17	15	67	15
Belgium	9.6	10.2	11.6	2.3	1.6	1.8	71	77	82	0.6	17	17	64	19
Belize	0.1	0.2	0.4	6.3	4.2	2.4	65	70	71	2.1	30	30	66	4
Benin	2.9	5.7	11.8	6.7	6.4	4.8	42	55	62	2.8	42	32	55	3
Bhutan	0.3	0.5	0.8	6.7	4.8	2.0	39	56	71	1.4	26	27	69	5
Bolivia (Plurinational State of)	4.4	7.4	11.4	6.3	4.6	2.8	45	57	70	1.5	31	29	62	7
Bosnia and Herzegovina	3.7	3.9	3.5	3.0	1.7	1.4	66	71	77	–0.7	14	17	68	17
Botswana	0.7	1.5	2.4	6.7	4.1	2.6	54	57	69	1.8	31	28	65	4
Brazil	92.9	159.7	212.4	5.2	2.6	1.7	59	67	76	0.8	21	23	70	9
Brunei Darussalam	0.1	0.3	0.4	5.8	2.9	1.8	67	74	78	1.4	22	23	72	5
Bulgaria	8.5	8.5	7.0	2.1	1.4	1.6	71	71	75	–0.6	15	14	64	21
Burkina Faso	5.5	9.8	20.3	6.6	6.9	5.1	39	49	62	2.9	45	33	53	2

COUNTRIES, TERRITORIES AND OTHER AREAS	POPULATION			FERTILITY			LIFE EXPECTANCY			POPULATION CHANGE	POPULATION COMPOSITION (BY AGE)			
	Total population in millions			Total fertility rate, per woman			Life expectancy at birth, years			Average annual rate per cent	0-14 per cent	10-24 per cent	15-64 per cent	65 and over per cent
	1969	1994	2019	1969	1994	2019	1969	1994	2019	2010-2019	2019	2019	2019	2019
Burundi	3.4	5.9	11.6	7.3	7.3	5.5	44	48	59	3.1	45	31	52	3
Cambodia	6.9	10.3	16.5	6.6	4.9	2.5	42	55	70	1.6	31	28	64	5
Cameroon, Republic of	6.4	13.1	25.3	6.2	6.1	4.5	46	50	60	2.6	42	32	55	3
Canada	21.1	29.0	37.3	2.4	1.7	1.6	72	78	83	1.0	16	17	66	18
Cape Verde	0.3	0.4	0.6	7.0	4.7	2.2	53	66	73	1.2	29	30	66	5
Central African Republic	1.8	3.3	4.8	6.0	5.7	4.6	41	47	54	0.9	42	34	54	4
Chad	3.6	6.8	15.8	6.5	7.4	5.6	41	47	54	3.2	47	34	51	3
Chile	9.4	14.1	18.3	4.2	2.4	1.8	62	75	80	0.8	20	21	68	12
China[3]	803.6	1229.0	1420.1	5.9	1.7	1.6	58	70	77	0.5	18	17	71	12
China, Hong Kong SAR[4]	3.8	6.1	7.5	3.4	1.2	1.4	71	79	84	0.7	12	13	70	17
China, Macao SAR[5]	0.2	0.4	0.6	2.4	1.3	1.4	69	79	84	2.0	14	13	75	11
Colombia	21.5	36.8	49.8	5.8	2.7	1.8	61	69	75	0.9	23	24	69	8
Comoros	0.2	0.5	0.9	7.1	5.9	4.1	45	58	64	2.3	39	31	58	3
Congo, Democratic Republic of the	19.5	40.3	86.7	6.2	6.8	5.8	44	49	61	3.3	46	32	51	3
Congo, Republic of the	1.3	2.7	5.5	6.3	5.2	4.5	53	54	66	2.6	42	31	55	3
Costa Rica	1.8	3.4	5.0	4.9	2.9	1.7	66	76	80	1.1	21	23	69	10
Côte d'Ivoire	5.0	14.1	25.5	7.9	6.3	4.7	43	50	55	2.5	42	32	55	3
Croatia	4.4	4.7	4.1	2.0	1.6	1.4	68	73	78	–0.5	15	16	65	21
Cuba	8.6	10.9	11.5	4.2	1.6	1.7	69	75	80	0.2	16	17	69	16
Curaçao	0.1	0.1	0.2	3.5	2.2	2.0	69	75	79	1.1	18	18	64	17
Cyprus[6]	0.6	0.8	1.2	2.7	2.2	1.3	72	77	81	0.8	17	20	69	14
Czechia	9.8	10.4	10.6	2.0	1.5	1.6	70	73	79	0.1	16	14	64	20
Denmark	4.9	5.2	5.8	2.2	1.8	1.8	73	75	81	0.4	16	18	64	20
Djibouti	0.1	0.6	1.0	6.8	5.5	2.7	48	57	63	1.6	30	30	66	4
Dominica	0.1	0.1	0.1	–	–	–	–	–	–	0.5	–	–	–	–
Dominican Republic	4.4	7.8	11.0	6.4	3.2	2.3	58	69	74	1.2	29	27	64	7
Ecuador	5.9	11.2	17.1	6.3	3.4	2.4	57	71	77	1.5	28	26	65	8
Egypt	34.2	62.5	101.2	6.3	3.9	3.1	52	66	72	2.1	33	26	62	5
El Salvador	3.6	5.5	6.4	6.3	3.7	2.0	55	67	74	0.5	27	28	65	9
Equatorial Guinea	0.3	0.5	1.4	5.8	6.0	4.4	39	50	59	4.0	37	29	60	3
Eritrea	1.8	3.1	5.3	6.7	6.0	3.9	43	52	66	2.1	41	32	55	4
Estonia	1.3	1.5	1.3	2.1	1.5	1.7	70	69	78	–0.2	17	15	63	20
Eswatini	0.4	0.9	1.4	6.9	5.0	2.9	47	58	59	1.8	37	32	60	3
Ethiopia	27.7	55.4	110.1	6.9	7.0	3.9	43	49	67	2.5	39	34	57	4
Fiji	0.5	0.8	0.9	4.7	3.3	2.4	59	66	71	0.7	28	26	65	7
Finland[7]	4.6	5.1	5.6	2.0	1.8	1.8	70	76	82	0.4	17	17	62	22
France	50.5	58.0	65.5	2.6	1.7	2.0	72	78	83	0.4	18	18	62	20
French Guiana	0.0	0.1	0.3	4.8	4.0	3.2	65	73	81	2.6	32	28	62	6
French Polynesia	0.1	0.2	0.3	5.1	2.9	2.0	60	70	77	0.8	23	24	69	8
Gabon	0.6	1.1	2.1	5.0	5.1	3.6	46	61	67	2.8	36	28	60	4
Gambia	0.4	1.0	2.2	6.0	6.1	5.2	37	53	62	3.1	45	33	53	2
Georgia[8]	4.7	5.1	3.9	2.7	1.9	2.0	67	70	74	–0.9	20	18	65	15

Demographic indicators

COUNTRIES, TERRITORIES AND OTHER AREAS	POPULATION			FERTILITY			LIFE EXPECTANCY			POPULATION CHANGE	POPULATION COMPOSITION (BY AGE)			
	Total population in millions			Total fertility rate, per woman			Life expectancy at birth, years			Average annual rate per cent	0-14 per cent	10-24 per cent	15-64 per cent	65 and over per cent
	1969	1994	2019	1969	1994	2019	1969	1994	2019	2010-2019	2019	2019	2019	2019
Germany	78.3	80.9	82.4	2.2	1.3	1.5	71	76	82	0.2	13	14	65	22
Ghana	8.4	16.3	30.1	7.0	5.2	3.8	49	58	64	2.3	38	31	58	3
Greece	8.6	10.7	11.1	2.6	1.4	1.3	71	78	82	–0.3	14	15	65	21
Grenada	0.1	0.1	0.1	4.7	3.3	2.0	64	69	74	0.4	26	25	66	8
Guadeloupe[9]	0.3	0.4	0.4	5.0	2.1	1.9	64	75	82	0.0	18	21	64	19
Guam	0.1	0.1	0.2	4.5	2.9	2.3	65	73	80	0.5	24	25	66	10
Guatemala	5.5	10.2	17.6	6.7	5.2	2.8	52	65	74	2.0	34	32	61	5
Guinea	4.2	7.5	13.4	6.2	6.4	4.6	36	52	62	2.4	42	32	55	3
Guinea-Bissau	0.7	1.1	2.0	6.0	6.4	4.4	41	51	59	2.5	41	31	56	3
Guyana	0.7	0.8	0.8	5.5	3.1	2.4	62	64	67	0.6	28	29	66	6
Haiti	4.6	7.7	11.2	5.8	5.0	2.8	47	56	64	1.3	32	30	63	5
Honduras	2.6	5.6	9.6	7.3	4.7	2.4	52	68	74	1.7	30	31	65	5
Hungary	10.3	10.4	9.7	2.0	1.6	1.4	69	70	76	–0.3	14	16	66	20
Iceland	0.2	0.3	0.3	3.1	2.2	1.9	74	79	83	0.7	20	20	65	15
India	541.5	942.2	1368.7	5.6	3.7	2.3	47	60	69	1.2	27	27	67	6
Indonesia	111.8	193.9	269.5	5.5	2.8	2.3	54	65	70	1.2	27	26	68	6
Iran (Islamic Republic of)	27.8	59.7	82.8	6.5	3.5	1.6	50	68	77	1.2	24	21	70	6
Iraq	9.6	19.6	40.4	7.4	5.5	4.2	58	68	70	3.0	40	31	57	3
Ireland	2.9	3.6	4.8	3.8	1.9	2.0	71	75	82	0.5	21	19	64	15
Israel	2.8	5.2	8.6	3.8	2.9	2.9	72	78	83	1.6	28	23	60	12
Italy	53.2	57.3	59.2	2.5	1.2	1.5	71	78	84	–0.1	13	14	63	24
Jamaica	1.8	2.5	2.9	5.6	2.8	2.0	68	72	76	0.3	23	25	67	10
Japan	103.5	126.1	126.9	2.1	1.4	1.5	72	80	84	–0.1	13	14	59	28
Jordan	1.6	4.4	10.1	8.0	4.8	3.2	59	71	75	3.8	35	30	61	4
Kazakhstan	12.9	16.2	18.6	3.6	2.4	2.5	62	64	70	1.4	29	20	64	7
Kenya	10.9	26.5	52.2	8.1	5.5	3.7	52	55	68	2.6	40	33	58	3
Kiribati	0.1	0.1	0.1	5.7	4.4	3.5	54	62	67	1.8	36	29	60	4
Korea, Democratic People's Republic of	14.0	21.6	25.7	4.4	2.2	1.9	59	68	72	0.5	20	22	71	9
Korea, Republic of	31.6	44.8	51.3	4.5	1.6	1.3	60	73	83	0.4	13	16	72	15
Kuwait	0.7	1.7	4.2	7.3	2.7	1.9	66	73	75	3.9	21	19	76	3
Kyrgyzstan	2.9	4.5	6.2	5.2	3.4	2.9	60	66	71	1.5	32	25	63	5
Lao People's Democratic Republic	2.6	4.7	7.1	6.0	5.6	2.5	46	56	68	1.4	32	30	64	4
Latvia	2.4	2.5	1.9	1.9	1.5	1.6	70	68	75	–1.1	16	14	64	20
Lebanon	2.3	3.0	6.1	5.1	2.7	1.7	66	72	80	3.7	22	25	69	9
Lesotho	1.0	1.7	2.3	5.8	4.6	2.9	49	58	55	1.3	35	32	60	5
Liberia	1.4	2.0	5.0	6.7	6.2	4.4	39	49	64	2.6	41	32	56	3
Libya	2.0	4.9	6.6	8.1	3.9	2.2	55	70	72	0.7	28	25	68	5
Lithuania	3.1	3.6	2.9	2.3	1.7	1.7	71	70	75	–1.0	15	16	65	19
Luxembourg	0.3	0.4	0.6	2.1	1.7	1.6	70	76	82	1.8	16	18	69	15
Madagascar	6.4	13.1	27.0	7.3	6.0	4.0	44	54	67	2.7	40	33	57	3
Malawi	4.5	9.8	19.7	7.3	6.5	4.4	40	47	64	2.9	43	34	54	3
Malaysia[10]	10.5	20.0	32.5	5.2	3.4	2.0	64	72	76	1.6	24	25	69	7
Maldives	0.1	0.2	0.5	7.2	4.6	2.0	43	65	78	2.4	23	21	72	4

COUNTRIES, TERRITORIES AND OTHER AREAS	POPULATION			FERTILITY			LIFE EXPECTANCY			POPULATION CHANGE	POPULATION COMPOSITION (BY AGE)			
	Total population in millions			Total fertility rate, per woman			Life expectancy at birth, years			Average annual rate per cent	0-14 per cent	10-24 per cent	15-64 per cent	65 and over per cent
	1969	1994	2019	1969	1994	2019	1969	1994	2019	2010-2019	2019	2019	2019	2019
Mali	5.9	9.4	19.7	7.1	7.1	5.8	32	47	59	3.0	47	33	50	2
Malta	0.3	0.4	0.4	2.0	2.0	1.5	71	77	81	0.4	15	15	65	20
Martinique	0.3	0.4	0.4	4.8	1.9	1.9	65	76	83	–0.3	17	19	63	20
Mauritania	1.1	2.3	4.7	6.8	5.8	4.5	49	59	64	2.8	39	31	57	3
Mauritius[11]	0.8	1.1	1.3	4.2	2.2	1.4	63	70	75	0.2	17	22	71	12
Mexico	50.4	92.3	132.3	6.8	3.1	2.1	61	72	78	1.3	26	26	67	7
Micronesia (Federated States of)	0.1	0.1	0.1	6.9	4.7	3.0	61	67	70	0.4	32	33	62	5
Moldova, Republic of[12]	3.5	4.4	4.0	2.6	2.0	1.2	65	67	72	–0.1	16	17	72	12
Mongolia	1.2	2.3	3.2	7.6	2.9	2.6	55	61	70	1.7	30	22	66	4
Montenegro	0.5	0.6	0.6	2.8	2.0	1.6	69	74	78	0.1	18	19	66	16
Morocco	15.7	26.7	36.6	6.7	3.4	2.4	52	67	77	1.4	27	24	66	7
Mozambique	9.0	15.2	31.4	6.8	6.0	5.1	39	45	60	2.9	44	33	53	3
Myanmar	25.7	42.7	54.3	6.0	3.1	2.1	50	60	67	0.9	26	27	68	6
Namibia	0.8	1.6	2.6	6.4	4.7	3.2	52	61	66	2.2	36	31	60	4
Nepal	11.8	20.9	29.9	5.9	4.8	2.0	40	58	71	1.1	29	32	64	6
Netherlands	12.9	15.4	17.1	2.6	1.6	1.8	74	77	82	0.3	16	18	64	20
New Caledonia	0.1	0.2	0.3	5.3	2.8	2.1	62	72	78	1.3	22	22	68	10
New Zealand	2.8	3.6	4.8	3.2	2.0	2.0	71	77	82	1.0	20	20	64	16
Nicaragua	2.3	4.5	6.4	6.9	3.9	2.1	53	67	76	1.1	28	28	66	6
Niger	4.4	9.2	23.2	7.6	7.7	7.1	36	46	61	3.8	50	33	47	3
Nigeria	54.7	105.4	201.0	6.4	6.3	5.3	41	46	55	2.6	44	32	54	3
North Macedonia	1.7	2.0	2.1	3.3	2.0	1.6	66	72	76	0.1	16	18	69	14
Norway[13]	3.8	4.3	5.4	2.7	1.9	1.8	74	78	83	1.1	18	18	65	17
Oman	0.7	2.1	5.0	7.3	5.7	2.5	50	69	78	5.5	21	19	76	2
Pakistan	56.5	119.8	204.6	6.6	5.5	3.3	52	61	67	2.0	35	29	61	5
Palestine[14]	1.1	2.5	5.2	7.9	6.4	3.8	55	69	74	2.7	39	32	58	3
Panama	1.5	2.7	4.2	5.3	2.9	2.4	65	74	79	1.6	27	25	65	8
Papua New Guinea	2.5	4.8	8.6	6.2	4.7	3.5	48	60	66	2.1	35	31	61	4
Paraguay	2.4	4.7	7.0	5.9	4.2	2.4	65	69	73	1.3	29	28	64	7
Peru	13.0	23.6	32.9	6.5	3.4	2.3	53	68	76	1.3	27	26	66	8
Philippines	34.8	68.2	108.1	6.4	4.1	2.8	61	66	70	1.6	31	29	64	5
Poland	32.4	38.4	38.0	2.3	1.8	1.3	70	72	78	–0.1	15	15	67	18
Portugal	8.7	10.1	10.3	3.0	1.5	1.2	67	75	82	–0.4	13	15	65	22
Puerto Rico	2.7	3.7	3.7	3.2	2.1	1.5	71	74	81	–0.2	17	21	67	16
Qatar	0.1	0.5	2.7	6.9	3.6	1.8	68	76	79	4.8	14	18	84	2
Reunion	0.5	0.7	0.9	5.1	2.4	2.2	62	74	81	0.8	23	23	65	12
Romania	20.3	23.1	19.5	2.8	1.4	1.6	68	70	76	–0.5	15	16	66	19
Russian Federation	129.5	148.4	143.9	2.0	1.4	1.8	69	66	71	0.1	18	15	67	15
Rwanda	3.6	6.0	12.8	8.2	6.3	3.7	44	29	68	2.5	39	32	57	3
Saint Kitts and Nevis	0.0	0.0	0.1	–	–	–	–	–	–	1.0	–	–	–	–
Saint Lucia	0.1	0.1	0.2	6.2	3.0	1.4	62	71	76	0.5	18	23	72	10
Saint Vincent and the Grenadines	0.1	0.1	0.1	6.2	2.8	1.9	65	71	74	0.1	23	25	69	8

Demographic indicators

COUNTRIES, TERRITORIES AND OTHER AREAS	POPULATION			FERTILITY			LIFE EXPECTANCY			POPULATION CHANGE	POPULATION COMPOSITION (BY AGE)			
	Total population in millions			Total fertility rate, per woman			Life expectancy at birth, years			Average annual rate per cent	0-14 per cent	10-24 per cent	15-64 per cent	65 and over per cent
	1969	1994	2019	1969	1994	2019	1969	1994	2019	2010-2019	2019	2019	2019	2019
Samoa	0.1	0.2	0.2	7.3	4.8	3.8	54	67	76	0.7	36	32	58	6
San Marino	0.0	0.0	0.0	–	–	–	–	–	–	0.9	–	–	–	–
São Tomé and Príncipe	0.1	0.1	0.2	6.4	5.6	4.3	55	62	67	2.2	42	33	55	3
Saudi Arabia	5.6	18.3	34.1	7.3	5.2	2.4	52	71	75	2.4	25	21	72	4
Senegal	4.1	8.5	16.7	7.3	6.1	4.6	39	57	68	2.9	43	32	54	3
Serbia[15]	8.1	9.9	8.7	2.4	1.9	1.6	67	72	76	–0.4	16	18	65	18
Seychelles	0.1	0.1	0.1	5.9	2.4	2.2	65	71	74	0.5	22	19	68	9
Sierra Leone	2.6	4.3	7.9	6.5	6.6	4.2	34	36	53	2.2	41	33	56	3
Singapore	2.0	3.4	5.9	3.4	1.7	1.3	68	77	84	1.6	15	17	71	14
Sint Maarten	0.0	0.0	0.0	–	–	–	–	–	–	2.4	–	–	–	–
Slovakia	4.5	5.4	5.5	2.5	1.7	1.5	70	72	77	0.1	16	16	68	16
Slovenia	1.7	2.0	2.1	2.2	1.3	1.7	69	74	81	0.2	15	14	65	20
Solomon Islands	0.2	0.3	0.6	6.8	5.3	3.7	54	59	72	2.1	38	32	58	4
Somalia	3.4	7.6	15.6	7.2	7.6	6.0	41	46	58	2.9	46	33	51	3
South Africa	22.2	41.2	58.1	5.7	3.2	2.4	55	62	64	1.3	29	27	66	6
South Sudan	3.6	5.4	13.3	6.9	6.6	4.6	35	46	58	3.1	41	32	55	3
Spain[16]	33.6	39.8	46.4	2.9	1.2	1.4	72	78	84	–0.1	14	15	66	20
Sri Lanka	12.2	18.1	21.0	4.5	2.3	2.0	64	69	76	0.4	23	23	66	11
Sudan	10.0	23.3	42.5	6.9	5.9	4.3	52	56	65	2.4	40	33	56	4
Suriname	0.4	0.4	0.6	5.8	3.1	2.3	63	68	72	1.0	26	26	67	7
Sweden	8.0	8.8	10.1	2.1	1.9	1.9	74	79	83	0.8	18	17	62	20
Switzerland	6.1	7.0	8.6	2.2	1.5	1.6	73	78	84	1.1	15	15	66	19
Syrian Arab Republic	6.1	13.9	18.5	7.6	4.6	2.8	58	72	73	–1.4	35	35	60	5
Tajikistan	2.8	5.7	9.3	7.0	4.7	3.2	60	63	72	2.2	35	28	61	4
Tanzania, United Republic of[17]	13.2	29.1	60.9	6.8	5.9	4.8	46	49	67	3.1	44	32	52	3
Thailand	35.8	58.9	69.3	5.8	1.9	1.4	59	70	76	0.3	17	19	71	12
Timor-Leste, Democratic Republic of	0.6	0.9	1.4	6.0	6.1	5.2	39	52	70	2.2	43	35	53	4
Togo	2.0	4.2	8.2	7.0	5.9	4.3	46	55	61	2.6	41	32	56	3
Tonga	0.1	0.1	0.1	6.2	4.5	3.5	65	70	73	0.6	35	33	59	6
Trinidad and Tobago	0.9	1.3	1.4	3.7	2.0	1.7	65	68	71	0.4	20	19	69	11
Tunisia	5.0	9.0	11.8	6.8	2.7	2.1	50	71	76	1.1	24	21	67	9
Turkey	34.1	57.6	83.0	5.7	2.8	2.0	52	66	77	1.5	24	24	67	9
Turkmenistan	2.1	4.1	5.9	6.5	3.7	2.7	58	63	68	1.7	31	25	65	5
Turks and Caicos Islands	0.0	0.0	0.0	–	–	–	–	–	–	1.8	–	–	–	–
Tuvalu	0.0	0.0	0.0	–	–	–	–	–	–	0.9	–	–	–	–
Uganda	9.2	19.9	45.7	7.1	7.0	5.3	49	44	61	3.3	47	34	51	2
Ukraine[18]	46.7	51.1	43.8	2.0	1.5	1.6	71	68	72	–0.5	16	15	67	17
United Arab Emirates	0.2	2.3	9.7	6.7	3.6	1.7	61	73	78	1.8	14	16	85	1
United Kingdom	55.4	57.8	67.0	2.4	1.8	1.9	72	77	82	0.6	18	17	63	19
United States of America	207.7	262.7	329.1	2.4	2.0	1.9	71	76	80	0.7	19	20	65	16
United States Virgin Islands	0.1	0.1	0.1	5.3	2.6	2.2	69	75	80	–0.1	20	20	60	20
Uruguay	2.8	3.2	3.5	2.9	2.4	2.0	69	73	78	0.3	21	22	64	15

COUNTRIES, TERRITORIES AND OTHER AREAS	POPULATION			FERTILITY			LIFE EXPECTANCY			POPULATION CHANGE	POPULATION COMPOSITION (BY AGE)			
	Total population in millions			Total fertility rate, per woman			Life expectancy at birth, years			Average annual rate per cent	0-14 per cent	10-24 per cent	15-64 per cent	65 and over per cent
	1969	1994	2019	1969	1994	2019	1969	1994	2019	2010-2019	2019	2019	2019	2019
Uzbekistan	11.7	22.4	32.8	6.4	3.7	2.2	62	66	72	1.5	28	25	67	5
Vanuatu	0.1	0.2	0.3	6.3	4.8	3.2	52	65	73	2.2	36	29	60	5
Venezuela (Bolivarian Republic of)	11.2	21.7	32.8	5.6	3.1	2.2	64	71	75	1.4	27	26	66	7
Viet Nam	42.3	73.9	97.4	6.5	2.9	1.9	60	72	77	1.1	23	21	69	8
Western Sahara	0.1	0.2	0.6	6.6	3.8	2.4	42	60	70	2.1	27	25	69	3
Yemen	6.1	14.7	29.6	7.8	7.8	3.7	40	59	66	2.5	39	33	58	3
Zambia	4.0	8.9	18.1	7.3	6.2	4.8	49	43	63	3.0	44	34	53	2
Zimbabwe	5.0	11.1	17.3	7.4	4.6	3.5	55	52	62	2.3	41	32	56	3

NOTES

– Data not available.

a Excludes Cook Islands, Marshall Islands, Nauru, Niue, Palau, Tokelau, and Tuvalu due to data availability.

b Excludes Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Dominica, Montserrat, Saint Kitts and Nevis, Sint Maarten, and Turks and Caicos Islands due to data availability.

1 Includes Christmas Island, Cocos (Keeling) Islands and Norfolk Island.

2 Includes Nagorno-Karabakh.

3 For statistical purposes, the data for China do not include Hong Kong and Macao, Special Administrative Regions (SAR) of China, and Taiwan Province of China.

4 As of 1 July 1997, Hong Kong became a Special Administrative Region (SAR) of China.

5 As of 20 December 1999, Macao became a Special Administrative Region (SAR) of China.

6 Refers to the whole country.

7 Includes Åland Islands.

8 Includes Abkhazia and South Ossetia.

9 Includes Saint-Barthélemy and Saint-Martin (French part).

10 Includes Sabah and Sarawak.

11 Includes Agalega, Rodrigues and Saint Brandon.

12 Includes Transnistria.

13 Includes Svalbard and Jan Mayen Islands.

14 Includes East Jerusalem. On 29 November 2012, the United Nations General Assembly passed Resolution 67/19, which accorded Palestine "non-member observer State status in the United Nations..."

15 Includes Kosovo.

16 Includes Canary Islands, Ceuta and Melilla.

17 Includes Zanzibar.

18 Includes Crimea.

Technical notes for indicators

The statistical tables in *State of World Population 2019* include indicators that track progress toward the goals of the Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development (ICPD), and the Sustainable Development Goals (SDGs) in the areas of maternal health, access to education, reproductive and sexual health. In addition, these tables include a variety of demographic indicators. The statistical tables support UNFPA's focus on progress and results towards delivering a world where every pregnancy is wanted, every birth is safe, and every young person's potential is fulfilled.

Different national authorities and international organizations may employ different methodologies in gathering, extrapolating or analyzing data. To facilitate the international comparability of data, UNFPA relies on the standard methodologies employed by the main sources of data. In some instances, therefore, the data in these tables differ from those generated by national authorities. Data presented in the tables are not comparable to the data in previous *State of the World Population* reports due to regional classifications updates, methodological updates, and revisions of time series data.

The statistical tables draw on nationally representative household surveys such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), United Nations organizations estimates, and inter-agency estimates. They also include the latest population estimates and projections from World Population Prospects: The 2017 revision, and Model-based Estimates and Projections of Family Planning Indicators 2018 (United Nations Department of Economic and Social Affairs, Population Division). Data are accompanied by definitions, sources, and notes. The statistical tables in *State of World Population 2019* generally reflect information available as of January 2019.

Indicators for monitoring ICPD goals

Sexual and Reproductive Health and Rights

Contraceptive prevalence rate, women aged 15-49, any method (2019). Source: United Nations Population Division. Model-based estimates are based on data that are derived from sample survey reports. Survey data estimate the proportion of married women (including women in consensual unions) currently using, respectively, any method or modern methods of contraception. Modern or clinic and supply methods include male and female sterilization, IUD, the pill, injectables, hormonal implants, condoms and female barrier methods.

Contraceptive prevalence rate, women aged 15-49, modern method (1969, 1994, 2019). Source: United Nations Population Division. Model-based estimates are based on data that are derived from sample survey reports. Survey data estimate the proportion of married women (including women in consensual unions) currently using, respectively, any method or modern methods of contraception. Modern or clinic and supply methods include male and female sterilization, IUD, the pill, injectables, hormonal implants, condoms and female barrier methods.

Unmet need for family planning, women aged 15-49 (2019). Source: United Nations Population Division. Percentage of married or in-union women aged 15 to 49 who want to stop or delay childbearing but are not using a method of contraception.

Proportion of demand satisfied, women aged 15-49 (2019). Source: United Nations Population Division. Percentage of total demand for family planning among married or in-union women aged 15 to 49 that is satisfied. Contraceptive prevalence or modern contraceptive prevalence divided by total demand for family planning. Total demand for family planning is the sum of contraceptive prevalence and unmet need for family planning.

Proportion of demand satisfied with modern methods, women aged 15-49 (1969, 1994, 2019). Source: United Nations Population Division. Percentage of total demand for family planning among married or in-union women aged 15 to 49 that is satisfied by the use of modern contraception. Contraceptive prevalence or modern contraceptive prevalence divided by total demand for family planning. Total demand for family planning is the sum of contraceptive prevalence and unmet need for family planning.

Maternal mortality ratio (MMR), deaths per 100,000 live births (1994 and 2015) and Range of MMR uncertainty (UI 80%), Lower and upper estimates (2015). Source: United Nations Maternal Mortality Estimation Inter-agency Group (WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division). This indicator presents the number of deaths of women from pregnancy-related causes per 100,000 live births. The estimates are produced by the Maternal Mortality Estimation Inter-agency Group (MMEIG) using data from vital registration systems, household surveys and population censuses. UNFPA, WHO, the World Bank, UNICEF, and the United Nations Population Division are members of the MMEIG. Estimates and methodologies are reviewed regularly by MMEIG and other agencies and academic institutions and are revised where necessary, as part of the ongoing process of improving maternal mortality data. Estimates should not be compared with previous inter-agency estimates.

Births attended by skilled health personnel, per cent (2017). Source: Joint global database on skilled attendance at birth, 2017, United Nations Children's Fund (UNICEF) and World Health Organisation (WHO). Regional aggregates calculated by UNFPA based on data from the joint global database. Percentage of births attended by skilled health personnel (doctors, nurses or midwives) is the percentage of deliveries attended by health personnel trained in providing life-saving obstetric care, including giving the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period; conducting deliveries on their own; and caring for newborns. Traditional birth attendants, even if they receive "a short training course, are not included.

The United Nations Population Division produces a systematic and comprehensive set of annual, model-based estimates, and projections are provided for a range of family planning indicators for a 60-year time period. Indicators include

contraceptive prevalence, unmet need for family planning, total demand for family planning and the percentage of demand for family planning that is satisfied among married or in-union women for the period from 1970 to 2030. A Bayesian hierarchical model combined with country-specific time trends was used to generate the estimates, projections and uncertainty assessments. The model advances prior work and accounts for differences by data source, sample population, and contraceptive methods included in measures of prevalence. More information on family planning model-based estimates, methodology and updates can be found at http://www.un.org/en/development/desa/population/theme/family-planning/cp_model.shtml. The estimates are based on the country-specific data compiled in World Contraceptive Use 2018.

Decision making on sexual and reproductive health and reproductive rights, per cent (2014). Source: UNFPA. Percentage of women aged 15-49 years who are married (or in union), who make their own decisions on all three areas — sexual intercourse with their partner, use of contraception, and their healthcare.

Indicators for monitoring ICPD Goals:

Adolescents and Youth

Adolescent birth rate per 1,000 girls aged 15-19 (2018) Source: SDG global database.The adolescent birth rate represents the risk of childbearing among adolescent women 15 to 19 years of age. For civil registration, rates are subject to limitations which depend on the completeness of birth registration, the treatment of infants born alive but dead before registration or within the first 24 hours of life, the quality of the reported information relating to age of the mother, and the inclusion of births from previous periods. The population estimates may suffer from limitations connected to age misreporting and coverage. For survey and census data, both the numerator and denominator come from the same population. The main limitations concern age misreporting, birth omissions, misreporting the date of birth of the child, and sampling variability in the case of surveys.

Child marriage by age 18, per cent (2017). Source: SDG global database. Regional aggregates calculated by UNFPA based on data from SDG global database. Proportion of women aged 20-24 years who were married or in a union before age 18.

FGM prevalence among girls aged 15-19, per cent (2017). Source: UNFPA. Proportion of girls aged 15-19 years who have undergone female genital mutilation.

Adjusted net enrolment rate, primary education, per cent (2017). Source: UNESCO Institute for Statistics (UIS). Percentage of children of the official primary age group who are enrolled in primary or secondary education.

Gender parity index, primary education (2017). Source: UNESCO Institute for Statistics (UIS). Ratio of female to male values of adjusted primary school net enrolment ratio.

Net enrolment rate, secondary education, per cent, (2017). Source: UNESCO Institute for Statistics (UIS). Percentage of children of the official secondary age group who are enrolled in secondary education.

Gender parity index, secondary education (2017). Source: UNESCO Institute for Statistics (UIS). Ratio of female to male values of secondary school net enrolment ratio.

Demographic Indicators

Population

Total population in millions (1969, 1994, 2019). Source: United Nations Population Division. Regional aggregates calculated by UNFPA based on data from United Nations Population Division. Estimated size of national populations at mid-year.

Fertility

Total fertility rate, per woman (1969, 1994, 2019). Source: United Nations Population Division. Regional aggregates calculated by UNFPA based on data from United Nations Population Division. Number of children who would be born per woman if she lived to the end of her childbearing years and bore children at each age in accordance with prevailing age-specific fertility rates.

Life Expectancy

Life expectancy at birth, years (1969, 1994, 2019). Source: United Nations Population Division. Regional aggregates calculated by UNFPA based on data from United Nations Population Division. Number of years newborn children would live if subject to the mortality risks prevailing for the cross section of population at the time of their birth.

Population Change

Average annual rate of population change, per cent (2010-2019). Source: UNFPA calculation based on data from United Nations Population Division. Average exponential rate of growth of the population over a given period, based on a medium variant projection.

Population Composition

Population aged 0-14, per cent (2019). Source: UNFPA calculation based on data from United Nations Population Division. Proportion of the population between age 0 and age 14.

Population aged 10-24, per cent (2019). Source: UNFPA calculation based on data from United Nations Population Division. Proportion of the population between age 10 and age 24.

Population aged 15-64, per cent (2019). Source: UNFPA calculation based on data from United Nations Population Division. Proportion of the population between age 15 and age 64.

Population aged 65 and older, per cent (2019). Source: UNFPA calculation based on data from United Nations Population Division. Proportion of the population aged 65 and older.

Regional classifications

UNFPA averages presented at the end of the statistical tables are calculated using data from countries and areas as classified below.

Arab States Region
Algeria; Djibouti; Egypt; Iraq; Jordan; Lebanon; Libya; Morocco; Oman; Palestine; Somalia; Sudan; Syrian Arab Republic; Tunisia; Yemen

Asia and Pacific Region
Afghanistan; Bangladesh; Bhutan; Cambodia; China; Cook Islands; Fiji; India; Indonesia; Iran (Islamic Republic of); Kiribati; Korea, Democratic People's Republic of; Lao People's Democratic Republic; Malaysia; Maldives; Marshall Islands; Micronesia (Federated States of); Mongolia; Myanmar; Nauru; Nepal; Niue; Pakistan; Palau; Papua New Guinea; Philippines; Samoa; Solomon Islands; Sri Lanka; Thailand; Timor-Leste, Democratic Republic of; Tokelau; Tonga; Tuvalu; Vanuatu; Viet Nam

Eastern Europe and Central Asia Region
Albania; Armenia; Azerbaijan; Belarus; Bosnia and Herzegovina; Georgia; Kazakhstan; Kyrgyzstan; Moldova, North Macedonia, Republic of; Serbia; Tajikistan; Turkey; Turkmenistan; Ukraine, Uzbekistan.

East and Southern Africa Region
Angola; Botswana; Burundi; Comoros; Congo, Democratic Republic of the; Eritrea; Eswatini; Ethiopia; Kenya; Lesotho; Madagascar; Malawi; Mauritius; Mozambique; Namibia; Rwanda; South Africa; South Sudan; Tanzania, United Republic of; Uganda; Zambia; Zimbabwe

Latin American and the Caribbean Region
Anguilla; Antigua and Barbuda; Argentina; Aruba; Bahamas; Barbados; Belize; Bermuda; Bolivia (Plurinational State of); Brazil; British Virgin Islands; Cayman Islands; Chile; Colombia; Costa Rica; Cuba; Curaçao; Dominica; Dominican Republic; Ecuador; El Salvador; Grenada; Guatemala; Guyana; Haiti; Honduras; Jamaica; Mexico; Montserrat; Nicaragua; Panama; Paraguay; Peru; Saint Kitts and Nevis; Saint Lucia; Saint Vincent and the Grenadines; Sint Maarten; Suriname; Trinidad and Tobago; Turks and Caicos Islands; Uruguay; Venezuela (Bolivarian Republic of)

West and Central Africa Region
Benin; Burkina Faso; Cameroon, Republic of; Cape Verde; Central African Republic; Chad; Congo, Republic of the; Côte d'Ivoire; Equatorial Guinea; Gabon; Gambia; Ghana; Guinea; Guinea-Bissau; Liberia; Mali; Mauritania; Niger; Nigeria; São Tomé and Príncipe; Senegal; Sierra Leone; Togo

More developed regions comprise United Nations Population Division regions Europe, Northern America, Australia/New Zealand and Japan.

Less developed regions comprise all United Nations Population Division regions of Africa, Asia (except Japan), Latin America and the Caribbean plus Melanesia, Micronesia and Polynesia.

The least developed countries, as defined by the United Nations General Assembly in its resolutions (59/209, 59/210, 60/33, 62/97, 64/L.55, 67/L.43, 64/295 and 68/18) included 47 countries (as of March 2018): 33 in Africa, 9 in Asia, 4 in Oceania and one in Latin America and the Caribbean — Afghanistan, Angola, Bangladesh, Benin, Bhutan, Burkina Faso, Burundi, Cambodia, Central African Republic, Chad, Comoros, Democratic Republic of the Congo, Djibouti, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Haiti, Kiribati, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Myanmar, Nepal, Niger, Rwanda, São Tomé and Príncipe, Senegal, Sierra Leone, Solomon Islands, Somalia, South Sudan, Sudan, Timor-Leste, Togo, Tuvalu, Uganda, United Republic of Tanzania, Vanuatu, Yemen and Zambia. These countries are also included in the less developed regions.

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United Nations Population Fund
605 Third Avenue
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+1 (212) 297-5000
www.unfpa.org
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