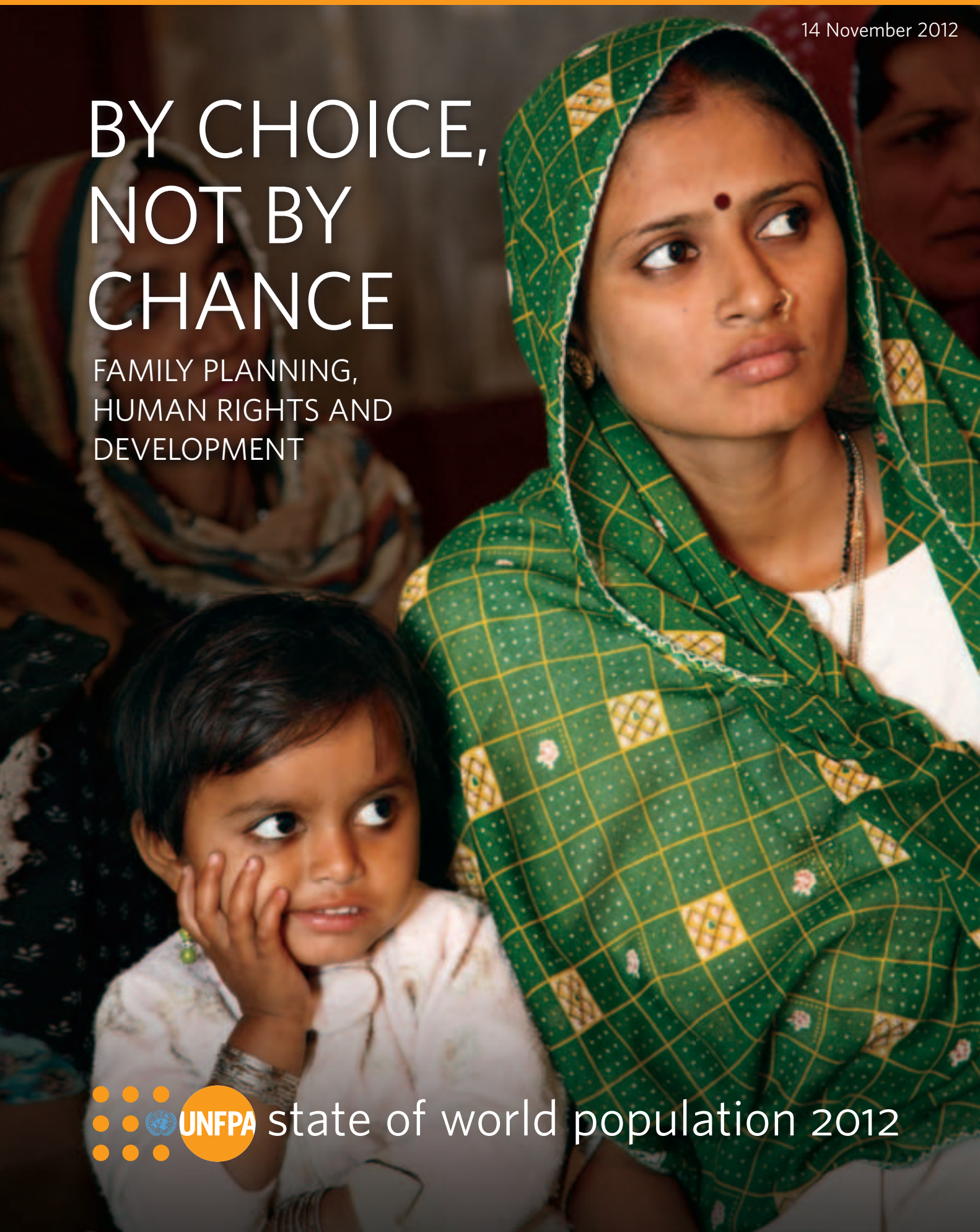
14 November 2012

BY CHOICE, NOT BY CHANCE

FAMILY PLANNING, HUMAN RIGHTS AND DEVELOPMENT



UNFPA state of world population 2012

All countries should take steps to meet the family-planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family-planning methods and to related reproductive health services which are not against the law. The aim should be to assist couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice.

—Programme of Action of the International Conference on Population and Development, paragraph 7.16

The State of World Population 2012

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Cover photo: Mother and child, Pakistan.

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Teenage girl attends informational meeting about family planning in Dominica.

Foreword

The right of the individual to freely and responsibly decide how many children to have and when to have them has been the guiding principle in sexual and reproductive health, including family planning for decades, but especially since 1994, when 179 governments came together and adopted the groundbreaking Programme of Action of the International Conference on Population and Development, the ICPD.

The ICPD marked a great paradigm shift in the field of population and development, replacing a demographically driven approach to family planning with one that is based on human rights and the needs, aspirations, and circumstances of each woman.

The impact of this milestone has been nothing short of revolutionary for the hundreds of millions of women and young people who have over the past 18 years gained the power and the means to avoid or delay pregnancy.

The results of the rights-based approach to sexual and reproductive health and family planning have been extraordinary. Millions more women have become empowered to have fewer children and to start their families later in life, giving them an opportunity to complete their schooling, earn a better living and escape the trap of poverty.

Countless studies have shown that women who use family planning are generally healthier, better educated, more empowered in their households and communities and are more economically productive. And in homes where parents have the power and the means to decide on the number and spacing of pregnancies, their children tend to be healthier, do better in school and grow up to earn higher incomes.

And now there is indisputable evidence that when family planning is integrated into broader economic and social development initiatives, it can have a positive multiplier effect on human development and the well-being of entire nations.

The visionaries who forged the ICPD Programme of Action in 1994 have much to be proud of; the progress made since then has been remarkable.

Still, wherever I travel, I continue to meet women and girls who tell me they are unable to exercise their right to family planning and end up having more children than they intend, burdening them economically, harming their health, and undermining opportunities for a better life for themselves and their families.

Recent statistics show that 867 million women of childbearing age in developing countries have a need for modern contraceptives. Of that total, 645 million have access to them. But a staggering 222 million still do not. This is inexcusable. Family planning is a *human right*. It must therefore be available to all who want it. But clearly this right has not yet been extended to all, especially in the poorest countries.

Obstacles remain. Some have to do with the quality and availability of supplies and services,

▲ *UNFPA Executive Director Babatunde Osotimehin pledging continued assistance for reproductive health and voluntary family planning in the Philippines.*
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but many others have to do with economic circumstances and social constraints. Regardless of the type of obstacle, it must be removed.

Recognizing the urgent need to address this lingering and massive unmet need for family planning, UNFPA, the United Kingdom Department for International Development, the Bill and Melinda Gates Foundation and other partners organized a summit in July 2012 that garnered $2 billion in funding commitments from developing countries and $2.6 billion from donor nations. This new funding aims to make voluntary family planning available to an additional 120 million women and adolescent girls in developing countries by 2020. But additional resources and political commitments are needed to meet the *entire* unmet need.

Family planning is central to many of the international community's goals—to improve the health of mothers and children, to promote gender equality, to increase access to education, to enable young people to fully participate in their economies and communities, and to reduce poverty. It must therefore be fully integrated into all current and future development initiatives, including the global sustainable development framework that will build on the Millennium Development Goals after 2015.

The international community made a commitment in 1994 to all women, men and young people to protect their rights as individuals to make one of life's most fundamental decisions. It is high time we lived up to that commitment and made voluntary family planning available to all.

Dr. Babatunde Osotimehin
United Nations Under-Secretary-General
and Executive Director
UNFPA, the United Nations Population Fund

Overview

One hundred seventy-nine governments affirmed individuals' right to family planning at the International Conference on Population and Development, ICPD, in 1994, when signatories of the ICPD Programme of Action stated that, "the aim of family planning programmes must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so." This affirmation marked a paradigm shift in the way governments and international organizations looked at development and population issues.

Family planning is critical to individuals' abilities to exercise their reproductive rights, and other basic human rights. The international consensus around the right to decide the timing and spacing of pregnancies is the result of decades of research, advocacy and debate. Reflecting this consensus, there is now a renewed focus in the development community about the need for more policy and programmatic action to ensure that all people can equally exercise their right to access high-quality services, supplies and information when they need them.

A broad range of services must be provided to ensure sexual and reproductive health. Family planning is just one such service, which should be integrated with:

- primary health care as well as antenatal care, safe delivery and post-natal care;
- prevention and appropriate treatment of infertility;
- management of the consequences of unsafe abortion;
- treatment of reproductive tract infections;
- prevention, care and treatment of sexually transmitted infections and HIV/AIDS;
- information, education and counselling on human sexuality and reproductive health;
- prevention and surveillance of violence against women and care for survivors of violence; and
- other actions to eliminate traditional harmful practices, such as female genital mutilation/cutting.

This report focuses on family planning and rights because:

- The basic right of all couples and individuals to decide freely and responsibly on the timing and number of their children is understood as a key dimension of reproductive rights, alongside the right to attain the highest standard of sexual and reproductive health, and the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.
- A person's ability to plan the timing and size of his or her family closely determines the realization of other rights.
- And the right to family planning is one that many have had to fight for and still today requires advocacy, despite the strong global rights and development frameworks that support it.

Women who are able to plan their families are more likely to be able to send their children to school. And the longer children stay in school the higher their lifetime earnings will be, helping them to lift themselves out of poverty.

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The shift towards a rights-based approach to family planning

The value of a rights-based approach to family planning is that it treats individuals as full human beings in their own right, as active agents, not as passive beneficiaries. This approach is built upon the explicit identification of rights-holders (individuals) and the duty-bearers (governments and others) that are responsible for delivering on rights. Today, family planning is widely accepted as a foundation for a range of rights.

For this reason, a rights-based approach may be the premise for the global sustainable development framework that will succeed the Millennium Development Goals, MDGs, which will conclude in 2015. In a recent essay about the post-2015 agenda, the Office of the United Nations High Commissioner for Human Rights stressed that the "increasing global embrace of human-rights-based approaches to development, based on the principles of participation, accountability, non-discrimination, empowerment and the rule of law, offers hope that a more enlightened model of development is now emerging."

Rights-based approaches—to family planning or other aspects of sustainable development—can lead to greater equity, equality and non-discrimination.

Children by choice, not by chance

This *State of World Population* report explains why family planning is a human right and what that means for individuals in developing and developed countries alike. The report synthesizes several frameworks for health, reproductive health, and family planning, while also building upon them by: elevating the discussion about the importance of engaging men in family planning as partners in relationships and in life, and as beneficiaries of services; underscoring the need to collect more data and devise programming that also reaches unmarried young and older people alike; drawing attention to the high rates of unintended and unwanted pregnancies in both developing and developed countries; and showing how changing sexual behaviour in different social contexts and across age groups is increasingly at variance with old patterns about sexuality, which represent a barrier to making family planning available and accessible to all.

The report is structured to answer the following key questions:

What is a rights-based approach to family planning?

Chapter 1 provides an overview of the international commitments to sexual and reproductive health, including family planning, with a particular emphasis on the ICPD Programme of Action and the renewed international commitment to invest in family planning in a post-MDG sustainable development agenda. The chapter outlines the freedoms and entitlements associated with reproductive rights, drawing from civil, political, economic, social and cultural rights. The chapter outlines States' obligations to fulfil citizens' right to family planning and an accountability framework to monitor implementation.

Where have gains been made and who cannot yet fully exercise their right to family planning?

Chapters 2 and 3 draw on research and programmatic evidence to describe global trends and show disparities in enjoyment of the benefits of family planning. Chapter 2 calls attention to inequalities in several key family planning indicators. Inequalities in access to and use of family planning services are examined across levels of wealth, education and place of residence. The chapter discusses why people use specific methods, the predominant use of female methods, and the impact of family planning use on abortion. Chapter 3 discusses the relatively high unmet needs of specific large—and largely neglected—sub-populations: young people, unmarried people of all ages, men and boys, the poor, and other socially marginalized groups with restricted access to information and services. This chapter discusses how the dynamics of sexual activity and marriage patterns are changing and how those changes affect the need for family planning.

Maternal health in Tajikistan.
©UNFPA/Natasha Warcholak

What are the social and economic benefits of a rights-based approach to family planning?

Chapter 4 summarizes the social and economic benefits of expanding access to family planning, with an emphasis on underserved populations in greatest need. Reductions in maternal mortality and morbidities, gains in women's education and improved life prospects for children are among the benefits to individuals, with broad implications for families, communities and countries. When governments prioritize family planning as part of an integrated development strategy, they make a strategic investment that both fulfils their obligation to protect citizens' rights and helps alleviate poverty and stimulate economic growth.

What are the cost implications of a rights-based approach to family planning?

Government and development agencies have to invest more resources to realize the individual and broader social and economic gains that can be achieved through a rights-based approach to family planning. Chapter 5 consolidates the latest research on costing, which finds that unmet need will continue to rise as more young people enter their reproductive years. Research confirms that family planning is a cost-effective public health investment. Taking into consideration its contributions to the realization of human rights and its cost-effectiveness, family planning is a strategic investment.

What should the international community do to implement a rights-based approach?

Chapter 6 outlines recommendations to guide future investments, policies, and programmes. Key stakeholders must recognize systematic inequalities in family planning as an infringement of human rights and a hindrance to direct information and services for underserved populations. Families, communities, institutions, and governments will have to modify their strategies to ensure that all people are able to realize their human right to family planning. This work will expand conventional approaches to family planning programmes. The adoption of post-MDG indicators that allow for nuanced assessments of sexual and reproductive health disparities is critical.

CHAPTER ONE

The right to family planning

A fundamental human right

Planning the number and timing of one's children is today largely taken for granted by the millions of people who have the means and power to do so. Yet a large proportion of the world's people do not enjoy the right to choose when and how many children to have because they have no access to family planning information and services, or because the quality of services available to them is so poor that they go without and are vulnerable to unintended pregnancy.

The international community agreed in 1994 at the International Conference for Population and Development, ICPD, that family planning should be made available to everyone who wants it, and that governments should create the conditions that support people's right to plan their families. But recent research shows that 222 million women in developing countries today do not have the means to delay pregnancies and childbearing. Millions of women in developed countries are also unable to plan their families because they lack access to information, education, and counselling on family planning, cannot access contraceptives and face social, economic or cultural barriers, including discrimination, coercion and violence in the context of their sexual and reproductive lives.

The number and spacing of children can have an impact on the schooling prospects, income and well-being of women and girls, and also of men and boys. The right to family planning therefore permits the enjoyment of other rights, including the rights to health, education, and the achievement of a life with dignity. An informed rights-based approach to family planning is the most cost-effective intervention for addressing maternal mortality and morbidity. Ensuring the right to family planning can ultimately accelerate a country's progress towards reducing poverty and achieving development goals. Universal access to reproductive health services, including family planning, is sufficiently important that it is part of the United Nations Millennium Development Goals. And it will be fundamental to achieving many of the priority goals emerging from the post-2015 sustainable development framework.

Although family planning is a fundamental right, it is met at times with ambivalence from communities, health systems and governments. The commitment to family planning can be undermined by its association with sexual activity and its meaning in the context of social and cultural values. In practical terms, concerns with extending access to specific population

Mothers at a women's advocacy centre attend a talk on contraception in Pakistan.

"All human beings are born free and equal in dignity and rights... Everyone is entitled to all the rights and freedoms set forth in this declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status... Everyone has the right to life, liberty and security of person."

— Universal Declaration of Human Rights

groups can also weaken a broader commitment to family planning.

Many groups, including young people and unmarried people, have been excluded or have not benefited from family planning programmes. Other groups, including persons with disabilities or older people, have been denied access to family planning programmes based on prevailing misconceptions that they do not have sexual needs.

This report makes the case that the inability to determine when to have children and how large a family to have results from and further reinforces social injustice and a lack of freedom. This report promotes the right to family planning as an essential and sometimes neglected focus of the range of services required to support sexual and reproductive health more broadly. It also underscores that family planning is one of the most cost-effective public health and sustainable development interventions ever developed (Levine, What Works Group and Kinder, 2004).

Family planning reinforces other human rights

The world has evolved a globally shared understanding about sexual and reproductive health and the institutional, social, political and economic factors needed to support it. This shared understanding was documented most fully at the ICPD, which marked a profound change in the international community's approach to sexual and reproductive health and shaped many policies in place today. The ICPD Programme of Action formally recognized the rights of individuals to have children by choice, not by chance.

Individuals have the right to determine their family size, and the right to choose when to have their children. Several features of the ICPD Programme of Action have contributed to making it possible for more people to exercise their reproductive rights. First, the ICPD Programme of Action contributed to advancing reproductive rights by defining the broad concept of "sexual and reproductive health," and by giving attention to the social conditions that shape it. It explicitly acknowledged the importance of sexual and reproductive health in the lives of women as well as the specific needs of adolescents and the roles of men and boys. It laid out a mandate for development programmes to take into account—and respond

The ICPD defines sexual and reproductive health as "a state of complete physical, mental and social well-being...in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so."

— ICPD Programme of Action, paragraph 7.2

to—the social, political and economic factors that affect people differently because of who they are, where they live and what they do.

One additional contribution of the ICPD: Whereas earlier programmes had treated family planning as a standalone activity, the Programme of Action situated family planning in the context of broader sexual and reproductive health programmes. Reproductive rights rest not only on the recognition of the right of couples and individuals to plan their family, but on "the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents" (UNFPA, 1994).

By reducing worry about unintended pregnancy, family planning can contribute to building relationships between partners and ensuring a satisfying and safe sex life. Respecting, protecting and fulfilling people's human rights make it easier for people to achieve the full benefit of investments in family planning (Cottingham, Germain and Hunt 2012).

International commitments

Sexual and reproductive health and reproductive rights do not represent a new set of rights but are rights already recognized implicitly or explicitly in national laws, international human rights documents and other relevant United Nations consensus documents. Some of these international norms rest on broader human rights that also underpin the right to sexual and reproductive health, including family planning.

Reproductive rights encompass both freedoms and entitlements involving civil, political, economic, social and cultural rights. The right to decide the number and spacing of children is integral to the reproductive rights framework and is therefore directly related to other basic human rights, including:

- **The right to life;**
- **The right to liberty and security of person;**
- **The right to health, including sexual and reproductive health;**
- **The right to consent to marriage and to equality in marriage;**
- **The right to privacy;**
- **The right to equality and non-discrimination;**
- **The right not to be subjected to torture or other cruel, inhuman, or degrading treatment or punishment;**
- **The right to education, including access to sexuality education;**
- **The right to participate in the conduct of public affairs and the right to free, active and meaningful participation;**
- **The right to seek, impart and receive information and to have freedom of expression;**
- **The right to benefit from scientific progress.**

(Center for Reproductive Rights, 2009; International Planned Parenthood Federation, 1996).

These rights are derived from numerous international and regional treaties and conventions. As such they reflect a common understanding of fundamental human rights. These and other human rights related to reproductive rights and their sources are laid out in *Reproductive Rights are Human Rights,* by the Center for Reproductive Rights (2009).

Responding to the realities of gender inequalities and the nature of reproductive physiology, a number of human rights documents reference the special challenges and discrimination women and girls face. The human rights of most direct relevance to gender inequality include the right to be free from discriminatory practices that especially harm women and girls, and the right to be free from sexual coercion and gender-based violence.

Treaties, conventions and agreements relevant to reproductive health and rights

1948	***Universal Declaration of Human Rights:*** A key document that has inspired the whole human rights discourse and many constitutions and national laws, and a source of international customary law.
1968	***Tehran Conference on Human Rights*** proclaims and declares the right of individuals and couples to information, access and choice to determine the number and spacing of their children.
1969	***Convention on the Elimination of all Forms of Racial Discrimination***
1969	***United Nations General Assembly Declaration on Social Progress and Development***, resolution 2542 (XXIV), Article 4: "Parents have the exclusive right to determine freely and responsibly the number and spacing of their children." The Assembly also resolved that the implementation of this right requires, "the provision to families of the knowledge and means necessary to enable them to exercise their right..."
1974/1984	***The World Population Plan of Action*** adopted at the 1974 World Population Conference in Bucharest, and the 88 recommendations for its further implementation approved at the International Conference on Population in Mexico City in 1984.
1976	***International Covenant on Civil and Political Rights,*** which is used by civil rights groups in their fight against government abuses of political power.
1976	***International Covenant on Economic, Social and Cultural Rights*** adopted in 1966 and entered into force in 1976. Article 12 of the Covenant recognized the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
1979	***The Convention on the Elimination of All Forms of Discrimination Against Women*** (CEDAW) is the only international human rights document that specifically references family planning as key for ensuring the health and well-being of families. CEDAW provides the basis for realizing equality between women and men by ensuring women's equal access to, and equal opportunities in, political and public life—including the right to vote and to stand for election—as well as education, health and employment.
1986	***Declaration on the Right to Development*** calls for development that aims at the well-being of the entire population, free and meaningful participation and the fair distribution of the resulting benefits.
1989	***Convention on the Rights of the Child*** sets standards for the defense of a child against neglect and abuse in countries throughout the globe. In order to protect the best interests of the child, it aims to: • Protect children from harmful acts and practices, including commercial and sexual exploitation and physical and mental abuse, and maintains that parents will be helped in their responsibilities of the positive upbringing of a child where assistance is needed. • Ensure the right of children to have access to certain services, such as health care and information on sexuality and reproduction. • Guarantee the participation of the child in matters concerning his or her life as s/he gets older. This includes exercising the right of freedom of speech and opinion.
1993	***United Nations World Conference on Human Rights*** in Vienna affirmed women's rights are human rights.

1994 At the ***International Conference on Population and Development*** (ICPD) in Cairo, 179 governments agreed that population and development are inextricably linked, and that empowering women and meeting people's needs for education and health, including reproductive health, are necessary for both individual advancement and balanced development. The conference adopted a 20-year Programme of Action, which focused on individuals' needs and rights, rather than on achieving demographic targets. Advancing gender equality, eliminating violence against women and ensuring women's ability to control their own fertility were acknowledged as cornerstones of population and development policies. Concrete goals of the ICPD centred on providing universal access to education, particularly for girls; reducing infant, child and maternal deaths; and ensuring universal access by 2015 to reproductive health care, including family planning, assisted childbirth and prevention of sexually transmitted infections including HIV.

1995 ***Beijing Declaration and Platform for Action***, United Nations Fourth World Conference on Women Reiterates broad definition of right to family planning laid out in ICPD Programme of Action.

1999 ***Key Actions for the Further Implementation of the ICPD Programme of Action***
A gender perspective should be adopted in all processes of policy formulation and implementation and in the delivery of services, especially in sexual and reproductive health, including family planning. Emphasized giving priority to sexual and reproductive health in the context of broader health reform, with special attention to rights and excluded groups.

2000 ***The Millennium Declaration*** was drafted by 189 nations which promised to free people from extreme poverty by 2015. The connections with reproductive health were initially understated.

2001 ***The Millennium Development Goals*** (MDGs). The goals are a road map with measurable targets and clear deadlines; the targets relevant to reproductive health include:

- Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio (MDG-5).
- Achieve, by 2015, universal access to reproductive health (MDG 5-B).

2004 The ***57th World Health Assembly*** adopted the World Health Organization's first strategy on reproductive health, recognized the Programme of Action and urged countries to implement the new strategy as part of national efforts to achieve the MDGs.

- Make reproductive and sexual health and integral part of planning, budgeting as well as monitoring and reporting on progress towards the MDGs.
- Strengthen health systems to provide universal access to reproductive and sexual health care, with special attention to the poor and other marginalized groups, including adolescents and men.

2005 ***World Summit 2005***, follow-up to the 2000 Millennium World Summit. World leaders committed to universal access to reproductive health by 2015, to promote gender equality and end discrimination against women.

2006 ***Convention on the Rights of Persons with Disabilities***

2010 ***MDG/10 Review Summit.*** World leaders renewed their commitment to universal access to reproductive health by 2015 and promote gender equality and end discrimination against women.

2011 ***The Committee on the Elimination of Discrimination against Women*** issued a decision establishing that all States have a human rights obligation to guarantee women of all racial and economic backgrounds timely and non-discriminatory access to appropriate maternal health services.

Health: a social and economic right

The International Covenant on Civil and Political Rights, ICCPR and the International Covenant on Economic, Social and Cultural Rights, ICESCR, were developed during the 1960s to ensure the principles referenced in the Universal Declaration of Human Rights would be implemented. Human rights activists have ensured that the ICCPR has played a key part in protecting people against government abuses of political power while today the ICESCR is instrumental in activist efforts to persuade governments to place the right to a house or a meal on an equal footing with the right to vote (*The Economist*, 2001). Activists in and committed to some of the world's poorest countries have demanded that economic and social goods be treated as entitlements in places where access to food and shelter is so lacking as to make even civil and political rights seem like luxuries.

Since 1998, the World Health Organization has been asking the international community to formally respect and uphold health as a human right. The challenge has been to define what these social and economic rights—including the right to health—mean in specific and concrete terms that facilitate advocacy and implementation. In 2000, the United Nations Committee on Economic, Social and Cultural Rights defined governments' "core obligations" to include providing equal access to health services, sufficient food, potable water, sanitation and essential drugs.

Accountability for rights

No right exists without obligation, and no obligation is meaningful without accountability. United Nations treaty-monitoring bodies are charged with tracking government compliance with major human rights treaties and now routinely recommend that governments take action to protect sexual and reproductive health and reproductive rights (Center for Reproductive Rights, 2009). Under the auspices of the Human Rights Council of the United Nations, the Universal Periodic Review involves a State-driven review of the human rights records of all United Nations Member States once every four years. Each State is given the opportunity to declare the actions they have taken to improve the human rights situations in their countries and to fulfil their human rights obligations.

The Committee on the Elimination of Discrimination Against Women reviews evidence on the protection of human rights around the world and issues recommendations. In 2011, for example, the Committee issued strong recommendations to the Governments of Nepal, Zambia and Costa Rica to ensure the sexual and reproductive rights of their citizens (Center for Reproductive Rights, 2011a). The independent Expert Review Group was created in 2011 by the United Nations Secretary-General to track the Global Strategy for Women's and Children's Health and the Commission on Information and Accountability (World Health Organization, 2010a). With a special focus on ensuring the commitment of resources to fulfil Millennium Development Goals 4 (to reduce child death rates) and 5 (to reduce maternal death rates), the independent Expert Review Group will last four years, delivering its first report to the United Nations General Assembly in September 2012.

National human rights institutions and courts of justice are directly responsible for ensuring the realization of reproductive rights. The Kenya National Commission on Human Rights, for example, recently conducted an inquiry into a range of reproductive rights abuses in that country (Kenya National Commission on Human

Rights, 2012). The charges had been brought in late 2009 by the Federation of Women Lawyers–Kenya and the Center for Reproductive Rights, alleging violations of reproductive rights in Kenyan health facilities. The Commission's assessment found that people's rights had been abused, largely as a consequence of the poor service quality and called on the Government to make the needed improvements.

The Colombian Constitutional Court has passed important judgments ensuring access to sexual and reproductive health services (Corte Constitucional de Colombia, 2012; Reprohealthlaw, 2012). In 2010, for example, it affirmed the legality of and ensured access to emergency contraception.

In 2003 UNFPA conducted a global survey of national experiences 10 years after the ICPD (UNFPA, 2005a). Of the 151 countries surveyed, 145 provided responses on the enforcement of reproductive rights. Of those that responded, 131 reported adopting new policies, national plans, programmes, strategies or legislation on reproductive rights.

Family planning and human rights: a framework

At the ICPD in 1994, the international community translated its recognition of peoples' right to family planning into a commitment to a human rights-based approach to health, which focuses on building the capacity of States and individuals to realize rights. Thus people not only have rights, but States have the *obligation* to respect, protect and fulfil these rights (Center for Reproductive Rights and United Nations Population Fund, 2010).

In their work to support human rights, United Nations agencies are guided by the United Nations Common Understanding on the Human Rights Based Approach to Development Cooperation (2003): in the pursuit of the realization of human rights as laid down in the Universal Declaration of Human Rights and other international human rights agreements, "human rights standards and principles must guide all development cooperation and programming in all sectors and phases of the programming process" (World Health Organization and Office of the High Commissioner for Human Rights, 2010). A human rights-based approach is operationally directed towards developing the capacities of rights holders to claim their rights and the capacities of duty-bearers to meet their

▲ *Grace Matthews, a mother-of-two, walked and cycled for three hours to get contraceptives. She decided to have an injection to delay her next pregnancy.*
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"Everyone has the right to education, which shall be directed to the full development of human resources, and human dignity and potential, with particular attention to women and the girl child. Education should be designed to strengthen respect for human rights and fundamental freedoms, including those relating to population and development."

— ICPD Programme of Action, Principle 10.

obligations (United Nations Practitioner's Portal on Human Rights Based Approaches to Programming).

The practical expressions of the right to family planning can be divided into freedoms and entitlements to be enjoyed by individuals, and the obligations of the State (Center for Reproductive Rights and UNFPA, 2010). The freedoms and entitlements of individuals are strongly dependent on States' obligations to ensure an equal opportunity and the progressive realization of human rights, including the right to health, for all without discrimination. They achieve this through strategies that contribute to removing obstacles and the adoption of positive measures that compensate for the factors that systematically prevent specific groups from accessing quality services.

▼ *Mother and child, Kiribati.* ©UNFPA/Ariela Zibiah

Freedoms and entitlements of individuals

The right to family planning entitles individuals and couples to access a range of quality family planning *goods and services*, including the full range of methods for men and women.

The right to family planning *information and sexuality education* is central to people's entitlements. Individuals must have access to sexual and reproductive health-related information, whether through comprehensive sexuality education programmes in schools, campaigns, or counselling and training. This information "should be scientifically accurate, objective, and free of prejudice and discrimination" (Center for Reproductive Rights, 2008).

The third element of the right to family planning is *informed consent and freedom from discrimination, coercion, or violence.* Women and men, girls and boys, must be able to make informed choices that are free from coercion, discrimination, or violence (Center for Reproductive Rights and UNFPA 2010; International Federation of Gynecology and Obstetrics Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health, 2009).

Obligations of the State

The Programme of Action of the ICPD affirms that "States should take all appropriate measures to ensure, on the basis of equality of men and women, universal access to health-care services, including those related to reproductive

health care, which includes family planning and sexual health. Reproductive health-care programmes should provide the widest range of services without any form of coercion." (UNFPA, 1994)

The State's obligations to *respect, protect and fulfil the right to contraceptive information and services* include both limitations on its actions and proactive obligations it must undertake (Center for Reproductive Rights and UNFPA, 2010; Hunt and de Mesquita, 2007).

- **Respect:** States must refrain from interfering in the enjoyment of the right to family planning by, for example, restricting access through spousal or parental consent laws or and by prohibiting a particular family planning method.
- **Protect:** States must also prevent third parties from infringing people's access to family planning information and services, for example, in instances of refusal by a pharmacist to provide legally available contraceptive methods.
- **Fulfil:** States are required to adopt legislative, budgetary, judicial, and/or administrative measures to achieve people's full right to family planning, which may, for example, require subsidizing goods and services.

Governments may be prevented by their limited resources from immediately fulfilling certain economic, social, and cultural rights underpinning individuals' right to family planning information and services. This is where the principle of "progressive realization" comes in: In recognition of these realities, human rights law permits States to demonstrate they are taking steps "with a view to achieving progressively the full realization" of these rights, to the extent of their maximum available resources (International Covenant on Economic, Social and Cultural Rights, 1966).

In addition to allocating resources, States must take steps towards incorporating family planning into national public health policies and programmes, and establish measures of reproductive health that assist in monitoring national progress towards family planning goals.

UNFPA FAMILY PLANNING STRATEGY 2012-2020

Goal: *to deliver access to family planning for 120 million additional women in 69 countries by 2020.*

The UNFPA family planning strategy is founded on key principles: a rights-based approach including a commitment to gender equality; geographical, social and economic equity in services; a focus on innovation and efficiency; sustainable results, and integration with national priorities.

UNFPA's commitment to the integration of human rights in family planning policies and programmes emphasizes two essential actions. All policies, services, information and communications must meet human rights standards for voluntary use of contraception and quality of care in service delivery. And actions must be taken to reduce the poverty, marginalization and gender inequalities that are often the root causes of violations of the right to family planning and of people's inability to enjoy their right to family planning (Cottingham, Germain and Hunt, 2012; Center for Reproductive Rights and UNFPA, 2010). In focusing on rights, UNFPA commits in particular to:

- Ensuring that the contraceptives procured respond to gender-specific needs;
- Informing men, women and young people about the availability of contraceptives and where they can access them—and supporting them as they exercise their rights to family planning;
- Supporting both men and women to transform gender attitudes and cultural barriers that impede access to and use of family planning.

UNFPA focuses on:

- strengthening political and financial commitment to family planning;
- Increasing demand for family planning;
- Improving national supply chain management;
- Improving availability and quality of family planning services;
- Improving knowledge management on family planning.

▼ *Women lining up for free family planning services. An estimated 222 million women in developing countries lack access to modern contraceptives.*

A set of "minimum core obligations" are independent of national resources and are therefore not subject to progressive realization. These include providing access to family planning information and services on a non-discriminatory basis, and providing essential drugs as defined under the World Health Organization Action Programme on Essential Drugs, which includes the full range of contraceptive methods. (Center for Reproductive Rights and UNFPA, 2010)

A human rights-based approach to family planning

Human rights standards, as laid out in international treaties and further developed in national laws and regulations provide the legal basis for

designing and delivering accessible, acceptable and high-quality family planning information and services and for establishing the basis for advocacy by individuals and communities who want these services (Cottingham, Germain and Hunt, 2010). Advocacy includes lobbying for the translation of international commitments into national laws, policies and regulations, and for accountability in implementing these laws, policies and regulations.

Human rights standards and the authoritative interpretation of the standards by the corresponding treaty monitoring bodies (General Comments) provide an objective set of parameters and criteria that help translate the right to family planning at the abstract normative level into policies and programmes. As part of ensuring this translation, development cooperation must contribute to developing the capacities of "duty-bearers" (especially States) to meet their obligations, and to "rights-holders" (individuals and communities) to claim their rights (World Health Organization and Office of the High Commissioner for Human Rights, 2010). The committee on Economic Social and Cultural Rights in its General Comment Number 14 on the right to the highest attainable standard of physical and mental health has defined the following normative elements that apply to all the underlying determinants of health:

Availability

The State's obligation to ensure the availability of the full range of family planning methods extends to offering services, to regulating conscientious objection and private service delivery, and to ensuring that providers are offering the full range of legally permissible services. The State's role to protect and fulfil rights includes ensuring that the exercise of conscientious objection among healthcare providers does not result in unavailability of services. "Conscientious objection" occurs when healthcare practitioners for reasons of their own religious or other beliefs do not want to provide full information on some alternatives. "[T]hey have, as a matter of respect for their patient's human rights, an ethical obligation to disclose their objection, and to make an appropriate referral so [the patient] may obtain the full information necessary to make a valid choice" (International Federation of Gynecology and Obstetrics Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health, 2009). The United States is responding to conscientious objection in the context of the Affordable Care Act. In January 2012, the U.S. Department of Health and Human Services specified preventive health services that new insurance plans would be required to cover (Galston and Rogers, 2010). The list included contraceptives and sterilizations including emergency contraception. Churches were narrowly exempted from this rule, but religiously affiliated hospitals and social service agencies were not. If they were not already providing these services,

UNFPA ENSURING A RELIABLE SUPPLY OF QUALITY CONTRACEPTIVES

Through its Global Programme to Enhance Reproductive Health Commodity Security, UNFPA ensures access to a reliable supply of contraceptives in 46 developing countries.

Since the Programme's inception in 2007, UNFPA has mobilized $450 million for reproductive health commodities, including contraceptives. In 2011 alone, the Programme provided $32 million for these commodities and $44 million for initiatives to strengthen national health care systems and build their capacities to deliver reproductive health services.

In 2011, the Programme funded about 15 million vials of injectable contraceptives, 1.1 million intrauterine devices, 14 million cycles of oral contraception, 316,000 doses of emergency oral contraception, 308,000 contraceptive implants, 253 million male condoms and 3.5 million female condoms.

this latter group would have one year to comply with the new mandate. During this year, they would be required to disclose the limitations to their coverage and direct employees to affordable contraceptive services elsewhere.

"In order to effectively claim their rights, rights-holders must be able to access information, organize and participate, advocate for policy change and obtain redress."

— Office of the High Commissioner for Human Rights and the World Health Organization

Accessibility

Even when services exist, social norms and practices can limit individual access to them. The subordination of the rights of young people to those of their parents, for example, can limit access to information and services and the capacity to act. The ICPD Programme of Action recognized the need for parents to prioritize the best interest of their childern (based on the Convention on the Rights of the Child). Since then, other negotiations, notably the 2009 and 2012 Commission on Population and Development meetings, have emphasized the rights of the child and the "duties and responsibilities" of parents, including their sole responsibility for deciding on the number and spacing of their children.

Acceptability

Information and services may exist, and they may be readily available to individuals in a community. But if they are not acceptable for cultural, religious or other reasons, they will not be used. Research in one community in Mexico, for example, found that married Catholic women in their main childbearing years relied primarily on withdrawal and periodic abstinence, as the women interviewed for this study said that modern contraceptives, such as the pill or intrauterine devices, were against their religious beliefs and were therefore unacceptable to them (Hirsch, 2008; Hirsch and Nathanson, 2001).

Quality

To be in line with fundamental rights, family planning services must meet certain quality standards. Considerable agreement has evolved over the definition of "quality of care" since it was first defined in 1990 (Bruce, 1990). Its focus on service quality from the perspective of individuals has highlighted a number of specific elements: choice among contraceptive methods; accurate information on method effectiveness, risks and benefits; technical competence of providers; provider–user relationships based on respect for informed choice, privacy and confidentiality; follow-up; and the appropriate constellation of services. Providing good quality services meets human rights standards and also attracts more clients, increases family planning

UNFPA, RIGHTS AND FAMILY PLANNING

UNFPA works for the realization of reproductive rights, including the right to the highest attainable standard of sexual and reproductive health, through the application of the principles of a human rights-based approach, gender equality and cultural sensitivity to the sexual and reproductive health framework. In light of these principles, individuals are treated as active participants in the policy process with the ability to hold governments accountable in their obligations to respect, protect and fulfil human rights.

As the lead United Nations agency working to improve sexual and reproductive health, UNFPA promotes legal, institutional and policy changes, and raises human rights awareness, empowering people to exercise control over their sexual and reproductive lives and to become active participants in development. UNFPA promotes the development of national policy frameworks and accountability systems to ensure universal access to quality sexual and reproductive health information, goods and services without discrimination or coercion on any grounds. At the same time, UNFPA emphasizes the need to build cultural legitimacy for human rights principles so that communities can make them their own.

use, and reduces unintended pregnancy (Creel, Sass and Yinger, 2002).

In recent years, consensus has emerged on what ensuring quality means in the context of family planning and human rights. It includes:

- Providing family planning as part of other reproductive health services, such as prevention and treatment of sexually transmitted infections, and post-abortion care (Mora et al., 1993);
- Disallowing family planning targets, incentives and disincentives, such as providing money to women who undergo sterilization or to health-care providers on the basis of number of women "recruited" for family planning;
- Including assessments of gender relations in plans and budgeting for family planning services (AbouZahr et al., 1996);
- Accounting for factors such as the distance clients must travel, affordability and attitudes of providers.

In settings as diverse as Senegal and Bangladesh, women are more likely to use family planning where they are receiving good care (Sanogo et al., 2003; Koenig, Hossain and Whittaker, 1997). Among women not using contraception, their perceptions of the quality of care significantly predicted the likelihood that they would start using a method; similarly, those currently using contraception were far more likely to continue using their method. By improving the quality of services, programmes have also created a greater sense of entitlement, leading clients to demand better quality in other parts of the health system (Creel, Sass and Yinger, 2002).

A human rights-based approach to sustainable development gives equal importance to both the outcomes and processes through which it is achieved. Human rights standards guide the formulation of development outcomes and the content of interventions, including meeting the unmet need for family planning. Human rights principles lend quality and legitimacy to development processes. Processes have to be inclusive, participatory and transparent. Of critical importance is the priority that must be given to the rights and needs of those groups of population left behind and excluded as a result of persistent patterns of discrimination and disempowerment.

▲ *Woman and child, Tanzania*
©UNFPA/Sawiche Wamunz

"Ill health constitutes a human rights violation when it arises, in whole or in part, from the failure of a duty-bearer—typically a State—to respect, protect or fulfil a human rights obligation. Obstacles stand between individuals and their enjoyment of sexual and reproductive health. From the human rights perspective, a key question is: are human rights duty-bearers doing all in their power to dismantle these barriers?"

(Hunt and de Mesquita, 2007).

Three cross-cutting principles contribute to building strong, rights-based family planning programmes:

- **Participation**—a commitment to engaging key stakeholders, especially the most vulnerable beneficiaries, at all stages of decision making, from policies to programme implementation to monitoring (UNFPA, 2005).
- **Equality and non-discrimination**—a commitment to ensuring that all individuals enjoy their human rights independent of sex, race, age, or any other status.
- **Accountability**—mechanisms must be in place for ensuring that governments are fulfilling their responsibilities with regard to family planning information and services. Accountability includes monitoring and evaluation systems, with clear benchmarks and targets in order to assess government policy efforts in meeting people's rights. Monitoring and evaluation are essential for giving governments the means to identify the major barriers to family planning and the groups that have the greatest difficulty with these barriers. Monitoring and evaluation also provide individuals—rights holders—and communities with information to hold governments to account when rights are not being upheld.

Conclusion

Hundreds of millions of the world's men and women wish to have children by choice and not by chance. Many of their fellow citizens—those who are wealthier and more educated—seem to be able to achieve this right (Foreit, Karra

Viet Nam has expanded reproductive health services, which include family planning, pre- and post-natal care and HIV prevention.
©UNFPA/Doan Bau Chau

For UNFPA, the key benefits to implementing a human rights-based approach to sexual and reproductive health programming, including family planning, are that doing so:

- Promotes realization of human rights and helps government partners to achieve their human rights commitments;
- Increases and strengthens the participation of the local community;
- Improves transparency;
- Promotes results (and aligns with results based management);
- Increases accountability;
- Reduces vulnerabilities by focusing on the most marginalized and excluded in society; and
- Leads to sustained change as human rights-based programmes have greater impact on norms and values, structures, policy and practice.

and Pandit-Rajani, 2010; Loaiza and Blake, 2010; World Heath Organization, 2011). The Programme of Action of the ICPD framed this right to family planning in the context of the right to sexual and reproductive health and reproductive rights, paying special attention to the needs of specific excluded populations and to gender equality.

This year's *State of World Population* Report builds on an earlier human rights and health framework developed by UNFPA and the Center for Reproductive Rights to include boys and men, many of whom also want to use family planning but who have typically been left out of the discussion. It also emphasizes the context of the sexual relationships within which individuals and couples elect to use family planning. And it advocates for a focus on extending access to family planning more equitably across population groups, particularly with reference to the socioeconomic differentials that exist in virtually *every country of the world.*

"A human rights-based approach to sustainable development gives equal importance to both the outcomes and processes through which it is achieved."

The right to family planning has been strongly upheld and reinforced by a series of international treaties and conventions, endorsed by the international community and is firmly grounded in human rights. The right to family planning is also a gateway to the achievement of other rights.

CHAPTER TWO

Analysing data and trends to understand the needs

Global trends in fertility

Last year, the world's population surpassed 7 billion and it is projected to reach 9 billion by 2050. Population growth is generally highest in the poorest countries, where fertility preferences are the highest, where governments lack the resources to meet the increasing demand for services and infrastructure, where jobs growth is not keeping pace with the number of new entrants into the labour force, and where many population groups face great difficulty in accessing family planning information and services (Population Reference Bureau, 2011; UNFPA, 2011b).

Worldwide, birth rates have continued to decline slowly. However, large disparities exist between more developed and less developed regions. This is particularly true for sub-Saharan Africa, where women give birth to three times as many children on average as women in more developed regions of the world (5.1 versus 1.7 births per woman).

A large part of this difference reflects a desire for larger families in sub-Saharan Africa, but as most women in this region now want to have fewer children (Westoff and Bankole, 2002), fertility differences increasingly reveal limited and unequal access in the developing world to the means to prevent unintended pregnancy.

Poverty, gender inequality and social pressures are all reasons for persistent high fertility. But in nearly all of the least-developed countries, lack of access to voluntary family planning is a major contributing factor.

Fertility rates

	Total fertility rate (births per woman)
World	2.5
More Developed	1.7
Less Developed	2.8
Least Developed	4.5
Sub-Saharan Africa	5.1

Source: United Nations, 2011a.

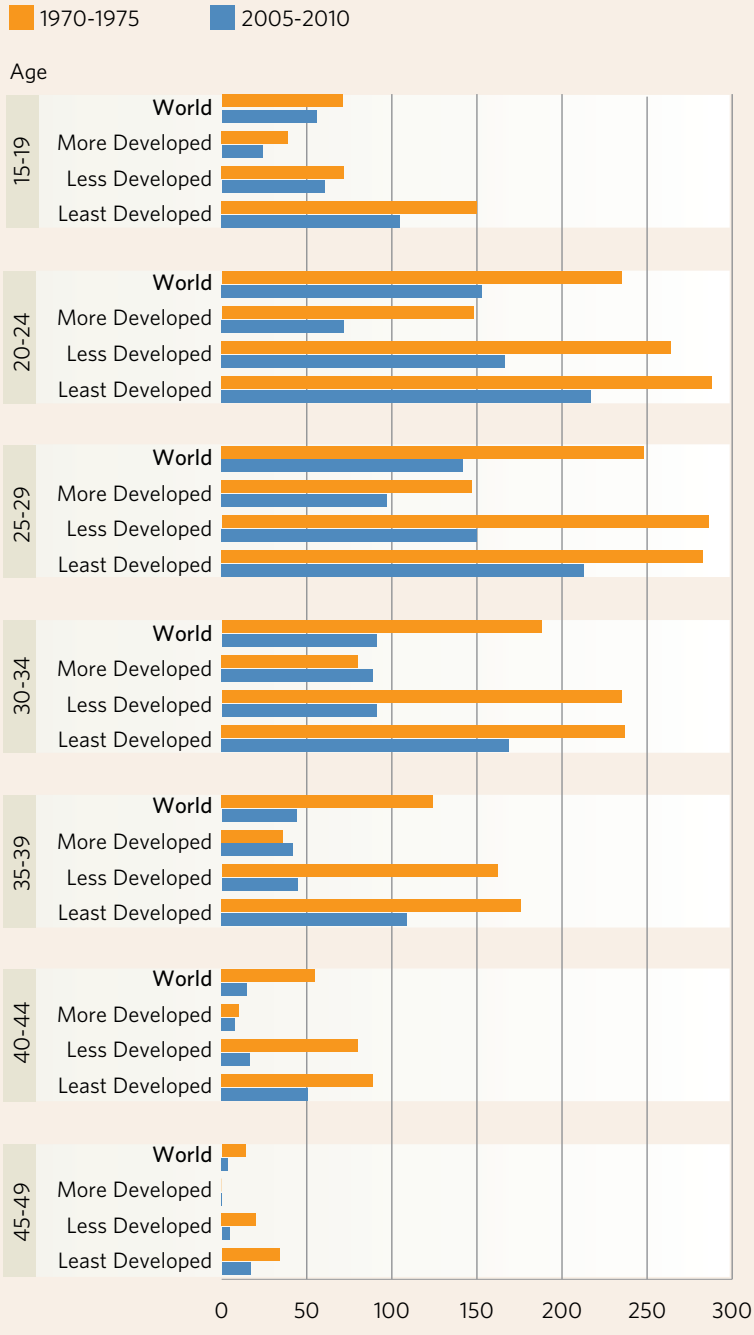
Who is using family planning?

The use of modern family planning methods as measured by the contraceptive prevalence rate has increased globally at a very modest pace of 0.1 per cent per year in recent years, more slowly than in the previous decade (United Nations, Department of Economic and Social Affairs, 2011). The modest increase is partially a function of the large increase in the numbers of married women of reproductive age—a 25 per cent increase

◀ *In Mali, a couple with their sons.*
©Panos/Giacomo Pirozzi

CHANGE IN AGE-SPECIFIC FERTILITY RATES OVER TIME

(BIRTHS PER 1,000 WOMEN)



Source: United Nations, 2011a.

between 2000 and 2010 in 88 countries that receive donor support for contraception (Ross, Weissman and Stover, 2009). Due to earlier high fertility, many more people in developing countries have now reached their reproductive ages, and meeting the contraceptive needs of many more women has contributed to only a marginal gain in the percentage covered.

Globally, about three of every four sexually active women of reproductive ages 15 to 49, who are able to become pregnant, but are not pregnant nor wanting to become pregnant, are currently using contraception (Singh and Darroch, 2012). In every country of the world, most women who are educated and well-off use family planning. In East Asia, 83 per cent of married women use contraception (United Nations, Department of Economic and Social Affairs, 2011). Conversely, in the poorest regions of the world, contraceptive prevalence rates are lowest and have increased most slowly. Contraceptive use among women in sub-Saharan Africa in 2010 was lower than use among women in other regions in 1990.

Family size and contraceptive use changed dramatically worldwide in the 1970s, when couples had an average of five children per family. Today they have an average of 2.5 (United Nations Department of Economic and Social Affairs, 2010). Increased contraceptive use is largely responsible for fertility declines in developing countries (Singh and Darroch, 2012). Though levels of contraceptive prevalence have stabilized since 2000, the desire to have smaller families remains strong worldwide and is increasing in developing countries.

Use varies according to income levels

Most surveys calculate national wealth scores and disaggregate indicators by wealth quintile, from the poorest 20 per cent of the population

through the wealthiest 20 per cent. Quintile analyses of population-based surveys can help identify inequalities and family planning needs within countries, especially in combination with data on urban-rural and other important dimensions of access (Health Policy Initiative, Task Order 1, 2010).

Because poverty takes on specific characteristics within a given setting, some researchers now advocate for separate quintile rankings for urban and rural populations to paint a more complete picture of inequalities between poverty and wealth in both urban and rural areas. This approach makes it possible to compare the different experiences of poor women in urban settings and relatively wealthy women in rural communities. Research from a 16-country study across Africa, Asia, and Latin America and the Caribbean finds strong relationships between family planning use, socioeconomic status, and place of residence (Foreit, Karra and Pandit-Rajani, 2010).

In countries such as Bangladesh, the prevalence of modern contraceptive use is the same across wealth quintiles in urban and rural settings: there is a nominal difference between contraceptive use among rich and poor in urban communities, and between the wealthiest and poorest within rural settings (Demographic and Health Surveys, 2007). In Bangladesh, the prevalence of contraceptive use is greater (by 6 per cent) in urban areas. Similar findings, which support pro-rural strategies, have been found in Peru, which would warrant pro-rural programming, as would Bolivia, Ethiopia, Madagascar, Tanzania and Zambia (Health Policy Initiative, Task Order 1, 2010). In some countries, such as Nigeria (DHS, 2008), modern contraceptive use increases with increasing wealth for people who live in urban *and* rural areas. The key difference is the rate of change: wealthier people in rural settings report *higher* use of contraceptives than the urban poor. These results would support policies that focus on reaching the urban poor, especially if similar patterns of disparities exist among indicators that measure adverse sexual and reproductive health outcomes.

Educational achievement influences desired family size, family planning use and fertility

Level of schooling is associated with desired family size, contraceptive use and fertility. An analysis of 24 sub-Saharan African countries showed that the adolescents most likely to become mothers are poor, uneducated and live in rural areas (Lloyd, 2009). Birth rates are more than four times as high among uneducated adolescent girls ages 15 to 19 as among girls who have at least secondary schooling. A similar gap exists based on wealth and residence. And in these countries, the gaps are widening: births among adolescent girls between the ages of 15 and 19 with no education have increased

▼ *High school students in Bucharest, Romania, read a leaflet about condoms.*
©Panos/Peter Barker

SEXUALITY, SEXUAL AND GENDER STEREOTYPES AND LIMITED USE OF VASECTOMY

A lack of information and access to vasectomy services can compromise the rights and health of men and women who, if they were appropriately informed, might prefer this relatively safe, simple, permanent and non-invasive procedure over female sterilization. Men who choose vasectomies decide upon the long-term method after considering numerous physiological, psychological, social and cultural factors. In many places, male sterilization is not well understood and is viewed as a threat to male sexuality and sexual performance.

When men and women have access to a full range of family planning information and services, more couples may choose vasectomy as their preferred method of contraception. The low uptake of vasectomies reflects limited access to appropriate information about the procedure, institutional biases against the method, and individual concerns about the effects of vasectomies on sexual performance and pleasure.

Sources: Landry and Ward, 1997; Greene and Gold, n.d.; EngenderHealth, 2002.

by about 7 per cent in the past decade, while births among girls with secondary plus schooling have declined by about 14 per cent (Loaiza and Blake, 2010).

The widening disparities in birth rates among educated and uneducated girls over time reflect a similar increasing gap in their use of contraception. In sub-Saharan African, girls with secondary schooling were found to be more than four times more likely to use contraception than girls with no education (Lloyd, 2009).

Whereas contraceptive use among *educated* adolescent girls has risen somewhat between the two surveys to 42 per cent overall, there was no change among *uneducated* girls. No more than one in 10 uneducated adolescents uses contraception, even though one in four girls in these countries, independent of wealth, education or residence, has an unmet need for family planning. These figures suggest that efforts to improve access to reproductive health services among youth by expanding youth-friendly services have not benefited young women who are poor, live in rural areas, and are poorly educated. Those most in need of these services lag the furthest behind (Loaiza and Blake, 2010). The most plausible explanations for the positive family planning outcomes associated with education are that better-educated women marry later and less often, use contraception more effectively, have greater knowledge about and access to contraception, exercise greater autonomy in reproductive decision-making, and are more aware of the socioeconomic costs of unintended child-bearing (Bongaarts, 2010).

CASE STUDY

Youth-friendly services in Malawi

The sexual and reproductive health needs of adolescents and young people were not well served in Malawi, as in many other parts of Africa. The lack of information, long distances to services and unfriendly providers contributed to high rates of unintended pregnancy and HIV.

UNFPA has partnered with the Malawian Ministry of Health and the Family Planning Association of Malawi to provide integrated youth-friendly sexual and reproductive health services through multi-purpose Youth Life Centres as well as via community-based and mobile services; they have strengthened their infrastructure as part of improving quality of care for young people. Services include contraception, including emergency contraception, pregnancy testing, treatment of sexually transmitted infections, HIV counselling and testing, antiretroviral therapy, treatment of opportunistic infections, cervical cancer screening and treatment, general sexual and reproductive health counselling, post-abortion care, and prenatal and postnatal care for teen mothers. The services are promoted through newspa-

pers, advertisements and by word of mouth. Improvements in service infrastructure, the participation of young people in service provision, the integration of sexual and reproductive health and HIV services, and the frequent solicitation of input from young clients—all of these things have improved the quality of the sexual and reproductive health services and have significantly increased their use.

The connections between schooling, family planning use and fertility are most readily evident in adolescence. But the effects of education on desired family size and contraceptive use persist into adulthood. The adjacent figure shows that women with secondary education use family planning at *four times* the rate of women with no schooling in sub-Saharan Africa. This effect reflects both preferences for number of children and access to family planning (UNFPA, 2010).

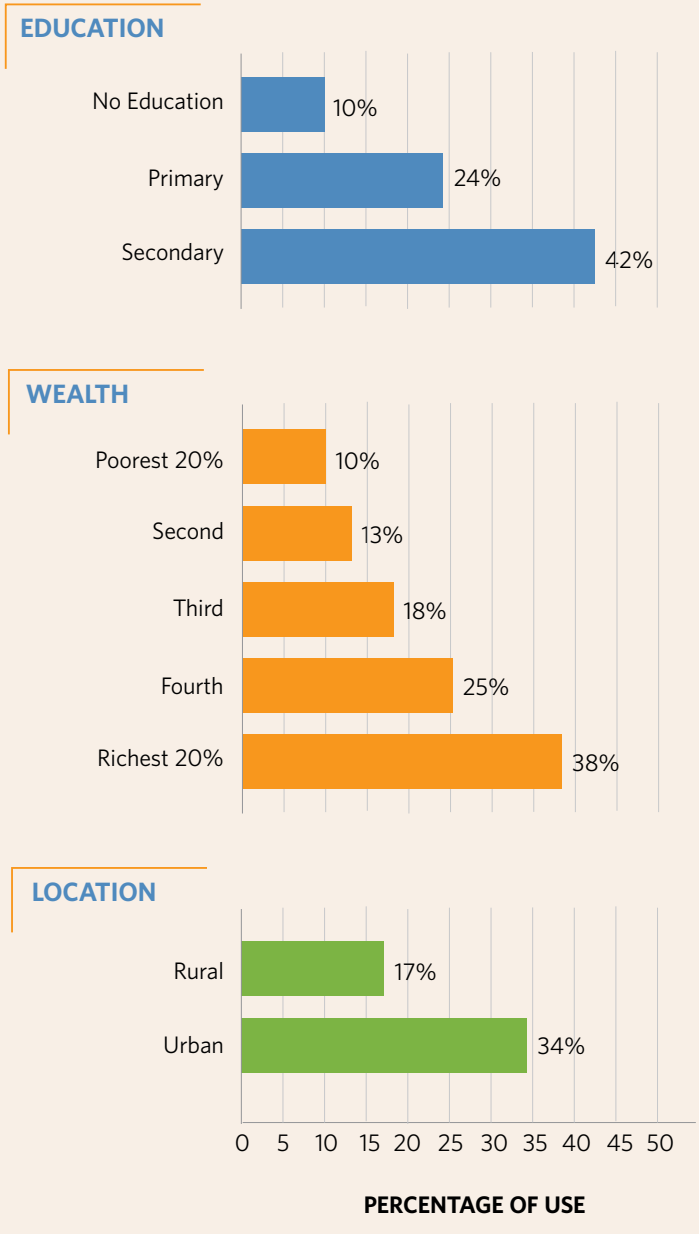
Family planning use and place of residence

Contraceptive use in sub-Saharan Africa is double in urban areas than what it is in rural areas. Many countries, especially the world's poorest, struggle to bring services to rural areas. In addition, people in rural areas tend to have less access to schooling, another important correlate of preferences for smaller families and use of family planning.

Family planning demand and use evolve through life

A review of global data shows that sexual activity evolves over a person's lifetime. Women and men have sex for different reasons and under different circumstances at various times in their lives. Individual decisions to initiate sex with a partner are

THE POOREST, LEAST EDUCATED AND RURAL WOMEN HAVE THE LOWEST RATES OF CONTRACEPTIVE USE IN SUB-SAHARAN AFRICA



Contraceptive prevalence by background characteristics from 24 sub-Saharan African countries at most recent survey, 1998-2008 (Percentage of women aged 1-49, married or in union, using any method of contraceptive).

Source: Demographic and Health Surveys (calculated using data in Annex III).

not necessarily associated with a desire to have children. In many instances—absent coercion, exploitation, or violence—it is the human desire for intimacy and relationships that drives sexual behaviour.

Young people

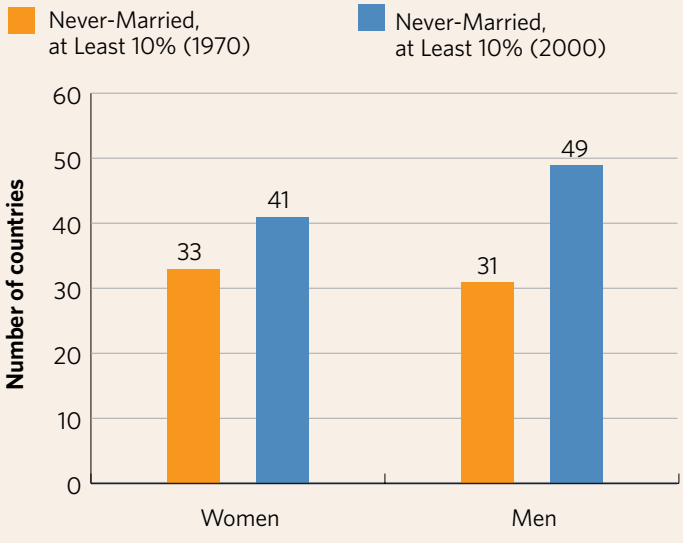
Even though most of young peoples' sexual activity takes place in marriage, many young people are sexually active outside of marriage. Sexual initiation is increasingly taking place outside of marriage for adolescent girls, though often with a future husband (McQueston, Silverman and Glassman, 2012; National Research Council and Institute of Medicine, 2005). Declines in age at menarche are likely to contribute to increased reproductive health risks for young women, increasing the number of years between menarche and marriage. Very early intercourse (at age 14 or younger) continues to occur among approximately a third of girls in Bangladesh, Chad, Mali, and Niger (Dixon-Mueller, 2008). The proportion making this transition varies very widely (between 40 and 80 per cent) among sub-Saharan African countries, for example.

Boys are much less likely than girls to have sex before age 15 where early, arranged marriage for girls is common. Where it is less common, however, boys in many settings are more likely to be sexually active than girls of the same age. As some researchers have noted, "the shift over time from marital to non-marital sexual initiation may be advantageous for girls' sexual and reproductive health," since non-marital sex generally entails less frequent and more often protected sex than occurs in marital relationships (Clark, Bruce and Dude, 2006).

Young women and men face different challenges from early adolescence through young adulthood. Most young people do not have consensual sex to prematurely become mothers and fathers. Globally, young people are increasingly delaying marriage. For women, the singulate mean age at marriage (only those who marry before age 50) has increased in 100 of 114 countries with available data since 1970 (United Nations, Department of Economic and Social Affairs, 2011b).

In many countries, however, earlier introduction to marriage and sex continues to set young women down a path of greater risk for several adverse outcomes. Across several regions, girls remain significantly more likely than their male peers to be married as children and to begin having sex at a young age. While younger women may have sex earlier in their lives, research finds that young men are more likely than their female peers to have sex with someone who is not a

NUMBER OF COUNTRIES WHERE AT LEAST 10 PER CENT OF WOMEN AND MEN NEVER MARRY



Source: United Nations, Department of Economic and Social Affairs, Population Division (2009). World Marriage Data 2008 (POP/DB/Marr/ Rev2008).

▲ *A Cameroonian home just visited by a community-based family planning counsellor.*
© UNFPA/Alain Sibenaler

cohabitating partner (UNICEF, Office of the Deputy Director, Policy and Practice, 2011). These details help contextualize family planning data on young people, and tell a more complete picture of why young men are more likely than young women to use condoms.

Adults

Even though age at first marriage has risen, the majority of women and men eventually marry or live in consensual unions (United Nations, Department of Economic and Social Affairs, 2009). As a result, childbearing remains commonplace within legally recognized unions—a reality in alignment with social acceptability in most countries where childbearing should occur between married couples. Recent data highlight, however, how adults' need for family planning may increasingly arise while they are single, separated, or divorced.

Today, adults are spending more time out of marriage compared to previous generations, and their family planning needs reflect these realities. In developing as well as developed countries, the proportion of never-married adults is increasing. Over the last 40 years, the number of countries where at least 10 per cent of women never married (by age 50) has increased from 33 to 41; the number of countries where at least 10 per cent of men do not marry before their 50th birthday increased from 31 to 49.

Consensual unions account for an increasing proportion of live-in partnerships, and these partnerships are less stable and more fluid than formal marriages. In Latin America and the Caribbean, over a quarter of women between the ages of 20 and 34 live in consensual unions (United Nations, Department of Economic and Social Affairs, 2009). This arrangement is less common in sub-Saharan Africa and Asia where about 10 per cent and 2 per cent of women, respectively, live in consensual unions. Globally, the proportion of adults (between the ages of 35 and 39) who are divorced or separated has risen from 2 per cent to 4 per cent between 1970 and 2000, a trend concentrated in developed countries (Organisation for Economic Co-operation and Development, 2010).

Preferred methods

The use of modern methods of family planning has increased in recent years in Eastern Africa, particularly Ethiopia, Malawi and Rwanda, and in Southeast Asia, but there has been no

increase in use of modern methods in Central and Western Africa (Singh and Darroch, 2012). When women have access to a selection of contraceptive methods, several factors influence their contraceptive preference. Significant among these factors are health-related side effects, ease of use, and partner preference (Bradley, Schwandt and Khan, 2009; Darroch, Sedgh and Ball, 2011). For example, estimates suggest that 34 million of the 104 million women with method-related reasons for unmet need for modern contraceptives would like methods that do not cause, or seem to cause, health problems or side effects (Singh and Darroch, 2012). Long-term methods such as intrauterine devices and injectables require fewer clinical visits and rely less on users' recall to consistently use a method. Individuals and couples who use contraceptives also weigh methods' effectiveness and failure rates with its impact on sexual pleasure.

In some cases, women are covertly using "invisible" methods such as injectables for fear of their husbands' opposition. As women increasingly want to control their own fertility or have wanted to and are now more aware that they *can*, some women choose to thwart this opposition by using contraceptives that cannot be detected by their partners. A few studies and anecdotal evidence suggest that some of the rapid rise in use of injectables (6 per cent to 20 per cent) in sub-Saharan Africa and elsewhere is attributed to covert use by women who feel they must conceal contraception from their husbands, families or communities (Biddlecom and Fapohunda, 1998).

METHOD EFFECTIVENESS

Method, ranked from most to least effective	Pregnancies per 100 women in first year of typical use
Implant	.05
Vasectomy	.15
Female sterilization	.5
Intrauterine device (IUD) (Copper T)	.8
Levonorgestrel-releasing IUD	.2
Injectable – 3 month	6
Vaginal ring	9
Patch	9
Pill, combined oral	9
Diaphragm	12
Male condom	18
Female condom	21
Sponge	12-24
Withdrawal	22
Fertility awareness methods: standard days, two-day, Symptothermal	24
Spermicides	28
No method	85

Source: Guttmacher Institute, 2012. (Based on data from the United States)

Method effectiveness

Long acting methods such as the implant and the intrauterine device are highly effective at preventing pregnancy, in large part because they do not require a daily or periodic action, such as taking a pill or getting another injection on time. The pill, patch, vaginal ring, injectables, and barrier methods are all much more effective in "perfect use" than they are in typical use, because people may forget to use the method or use it incorrectly.

Most modern methods are highly effective if used correctly and consistently. Fertility awareness-related methods are also quite effective if used correctly, and are sometimes preferred by women who have religious objections to other forms of contraception. Even the least effective

methods are several times more effective in preventing pregnancy than no method. About 85 of every 100 sexually active women who chose not to use a method will become pregnant within the first year (Guttmacher Insititute, 2012).

Method effectiveness—measured in pregnancies per 100 women in the first year of typical use—ranges from .05 for the implant, to 28 for spermicides, compared with 85 for no method at all (Guttmacher Institute 2012). Worldwide, almost one in three women using contraception relies on female sterilization. About one in four relies on an intrauterine device. More than one in 10 relies on a traditional method, predominantly withdrawal and rhythm.

Use depends on available options, ease of use and information

Women may have unmet need or discontinue contraceptive use because they are dissatisfied with current options (Frost and Darroch, 2008; Bradley, Schwandt and Khan, 2009). Most of the available options depend on technologies developed in the 1960s and 1970s, and there has since been nominal investment into the discovery and dissemination of new methods (Harper, 2005; Darroch, 2007). In addition to strengthening the quality of information services about modern methods, national efforts to fulfil the rights of women and men may require investment into new contraceptive methods, including methods that do not cause systemic side effects, can be used on demand, and do not require partner participation or knowledge (Darroch, Sedgh and Ball, 2011).

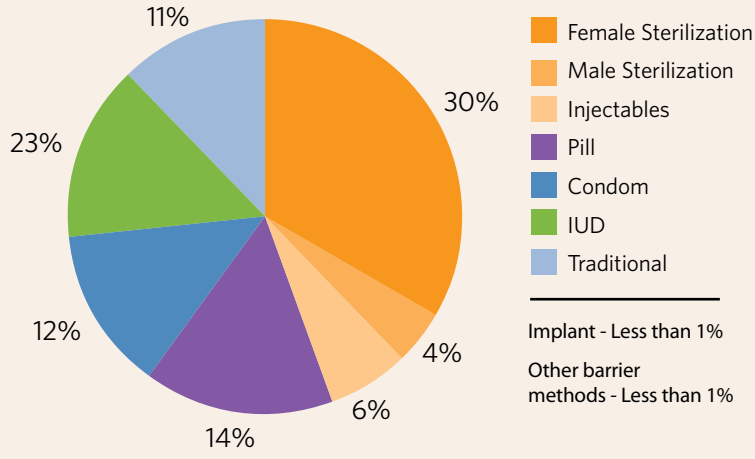
New methods alone would not eliminate unmet need. However, newer methods that governments have recently approved could enable women to exercise their right to more reliably and safely prevent pregnancies. Studies find that the leading causes of discontinuation—side effects and fear of side effects—impede efforts to meet unmet need (Cottingham, Germain and Hunt, 2012).

Effectiveness and a full range of methods are part of demand but also reflect supply. The quality of services may be poor and the full range of methods is not available to most people; as a consequence, family planning may not be attractive to them even if they wish to postpone or end their childbearing.

Family planning use and reliability of supplies

A growing number of contraceptive options are available, especially in developed countries. However, women in most developing countries have far fewer options, although the range of methods available is improving and now often includes injectables and implants in addition to pills and condoms. Obtaining contraceptive

GLOBAL CONTRACEPTIVE USE BY METHOD



Source: United Nations. 2011 World Contraceptive Data Sheet

▲ *Couple visiting a rural family planning clinic. Mindanao, Philippines.* ©Panos/Chris Stowers

methods is one challenge; distributing them is another: The majority of international funding for condoms is spent on the procurement of the commodity with relatively little spent on delivery, distribution and administration.

CASE STUDY

Supplies in Swaziland

Access to supplies and their reliable provision are essential to the realization of individuals' right to family planning. Like many other African countries, Swaziland has experienced stock-outs, making it difficult for people to choose and have confidence in relying on specific contraceptive methods. Reproductive health commodity security programming had focused mainly on the procurement of contraceptives by the government, with poor results.

As part of its effort to address high maternal mortality and adolescent pregnancy, Swaziland has invested in reproductive health commodity security. The Ministry of Health strengthened its relationship with civil society and UNFPA by establishing a partnership with the Family Life Association of Swaziland, Management Sciences for Health and UNFPA in 2011 to strengthen programme delivery. Its overall objective was to increase the health system's effectiveness in ensuring reproductive health commodities through three strategies: National systems were strengthened for reproductive health and commodity security; human resources capacity was strengthened for implementation, monitoring and reporting; and political and financial commitment to reproductive health commodity security were enhanced. By conventional standards, success was achieved through an increase in contraceptive prevalence. Just as important, however, was the increase in the number of facilities offering family planning services and the reliability of those services. ■

Traditional methods of family planning remain popular

Traditional methods remain widely used, especially in developing countries. Survey data do not often shed light on why people use traditional rather than modern methods of family planning.

Traditional methods include periodic abstinence, withdrawal, lactational amenorrhea (extended breast-feeding) and "folk" practices; thus their effectiveness varies very significantly. Comparative studies across diverse settings confirm that women who use modern methods are much less likely to become pregnant than women who rely on a traditional method (Trussell, 2011).

Despite the tendency to consolidate all traditional methods into a singular category, not all traditional methods are the same. Several countries have good histories with non-modern, traditional methods. For example, withdrawal is a commonly used among educated couples in Iran and Turkey and has been widely used to prevent pregnancy in Sicily and Pakistan (Cottingham, Germain and Hunt, 2012; Erfani, 2010). The Demographic and Health Surveys categorize *coitus interruptus* as a "totally ineffective folk method," even though this method is used extensively in a number of countries and is about as effective as condoms (Cottingham, Germain and Hunt, 2012).

Female methods of family planning more widely used than male methods

The ICPD Programme of Action noted as a "high priority… the development of new methods for the regulation of fertility for men," and called for the involvement of private industry. It urged countries to take special efforts to enhance male involvement and responsibility in family planning (Paragraph 12.14.). Nearly 20 years later, no new male methods have been widely introduced to the public. With few contraceptive options for men, men's use of family planning has been less than envisioned by the ICPD. Today, even if all traditional methods requiring men's cooperation (rhythm, withdrawal and others) are counted together with male condoms, male methods account for about 26 per cent of global contraceptive prevalence (United Nations, Department of Economic and Social Affairs, 2011).

Female sterilization rates far outnumber male rates. Although the decision to permanently end childbearing can be difficult, sterilization is the most commonly used family planning method in the world, relied upon by more than one in five married women. Nearly everywhere, women are far more likely to undergo the sterilization procedure than men. In Colombia, for example, where 78 per cent of women are current contraceptive users, nearly a third of all women (31 per cent) have been sterilized, compared with just two per cent of men (United Nations, Department of Economic and Social Affairs, 2011). Since desired fertility declines over time, couples married at young ages will stop having children at earlier ages. After reaching their desired fertility, these younger couples may have to avoid unintended pregnancy for up to 25 years, making permanent methods attractive to them.

"Although the decision to permanently end childbearing can be difficult, sterilization is the most commonly used family planning method in the world, relied upon by more than one in five married women."

While female sterilization rates are highest in Latin and Central America, ranging as high as 47 per cent in the Dominican Republic, only 14 countries in the world have at least 5 per cent of men who have undergone vasectomy. Male and female sterilization rates are most similar in Australia and New Zealand, where about 15 per cent of both men and women have been sterilized (United Nations, Department of Economic and Social Affairs, 2011). Male sterilization exceeds female sterilization in only a handful of countries, most notably in Canada and the United Kingdom, where men are about twice as likely as women to be sterilized.

One might infer from the mostly developed countries that vasectomy rates primarily reflect women's economic power and rights in these countries. Nepal is among the few developing countries where vasectomy rates are above

5 per cent and equal a third or more of female sterilizations, suggesting that increased female empowerment in Nepal may be having an effect on contraceptive choice (EngenderHealth, 2002).

Female sterilization is a significantly more invasive, costly and risky procedure than male sterilization, and is somewhat less effective, yet its prevalence dramatically surpasses vasectomy everywhere except in North America and Western Europe (Greene and Gold, n.d.; Shih, Turok and Parker, 2011). That female sterilization has become the norm, while male sterilization remains rare, is a clarifying moment of gender inequality. The lack of access to and failure to promote vasectomy compromises both men's and women's rights.

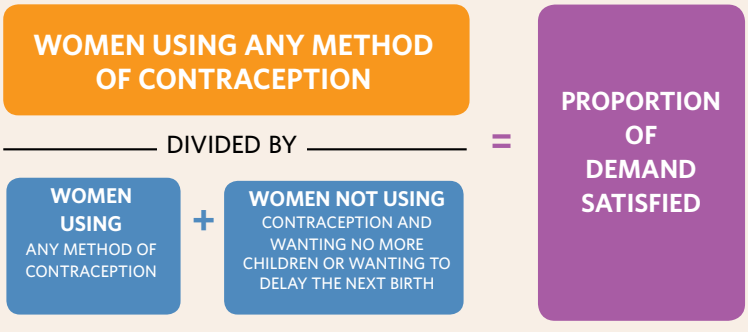
Given these realities, what factors do couples take into consideration, if indeed they discuss which of them will be sterilized? One multi-country study showed that some men who chose vasectomy did so out of concern for their partners' health (Landry and Ward, 1997). Other men were dissatisfied with the choice of methods available, or their wives had discontinued other methods due to side effects. In some poor families, vasectomy was chosen because women could not be spared from child and household care for the time it would take them to recover. Some men decided that they had enough children and did not consult their wives before being sterilized. In the United States, prevalence of vasectomy is highest among men with higher educations and incomes, whereas female sterilization is more prevalent among women with lower incomes and education (Anderson et al., 2012).

Vasectomy is uncommon in sub-Saharan Africa, where rates are well below 1 per cent (Bunce et al., 2007). Few providers are trained to perform vasectomies and many, if not most men and women, have not heard of the method. A study of the acceptability of vasectomy in Tanzania found that both men and women had concerns about sexual side effects (Bunce et al., 2007). While some women feared their husbands would become unfaithful, men had heard rumors that vasectomy caused impotence and feared their wives might leave them if their sexual performance suffered.

DEMAND AND SUPPLY OVER TIME

Measures of contraceptive prevalence and unmet need are limited in their ability to capture the dynamic nature of individuals' decisions regarding their sexual activity, as well as the context in which these decisions take place. For example, contraceptive prevalence and unmet need are influenced by factors that women in need of contraceptives cannot control, including changing availability and supply of contraceptives over a period of time. Furthermore, unmet need for family planning reflects both individuals' demand for specific methods and the supply. As more people learn about the benefits of exercising their right to plan their families, the demand for services can potentially outpace supply. This may occur in hard-to-reach regions and among populations whose sexual activity defies commonly held beliefs about when sex is appropriate.

While contraceptive prevalence and unmet need are important indicators, the limitations of contraceptive prevalence and unmet need call attention to the need for additional indicators that better capture the proportion of demand for contraceptives that health systems satisfy (UNFPA, 2011). One such indicator is the "proportion of demand satisfied." This indicator is derived from current data collection methods and more accurately monitors whether women's stated desires for family planning are being met. Additionally, more consistent use of adjusted urban vs. rural quintile analyses can help policymakers and development practitioners design tailored need-based family planning strategies and programmes.



Source: United Nations Population Fund (2010). *Sexual and Reproductive Health for All: Reducing poverty, advancing development and protecting human rights*. New York: UNFPA

CASE STUDY

No-scalpel vasectomy in the Solomon Islands

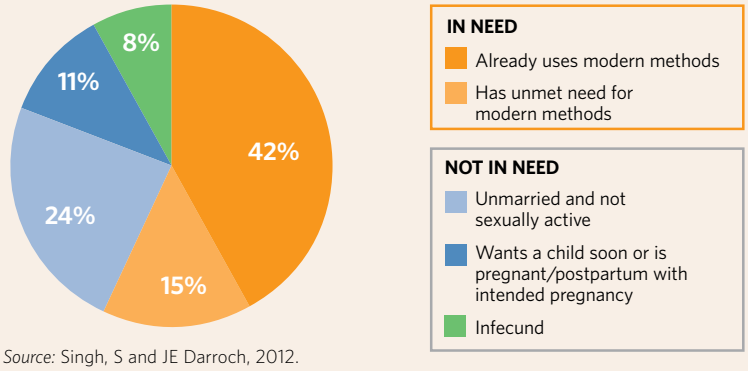
After the ICPD, family planning programmes in the Solomon Islands became more rights-based. New population policy provisions reflected an emphasis on rights, with the government explicitly committing to "…encouraging and supporting parental efforts to make responsible decisions regarding family size…" Family planning was reinvigorated in 2003-2004 with the updating of national guidelines and extensive training of health care workers on various topics, including informed choice and a broader method mix. Contraceptive prevalence rose from 11 per cent to 29 per cent.

No-scalpel vasectomy has been an especially popular method. Success in offering this method has been attributed in part to men being invited for the first time to be more engaged in family planning. In addition, no-scalpel vasectomy is very economical and could take place locally, while tubal ligation required travel to a referral clinic. An additional factor that seems to have made a difference in cultivating men's engagement is that men have been invited to be present during their wives' labour and delivery, building their appreciation for their wives and what is involved in giving birth.

Emergency contraception

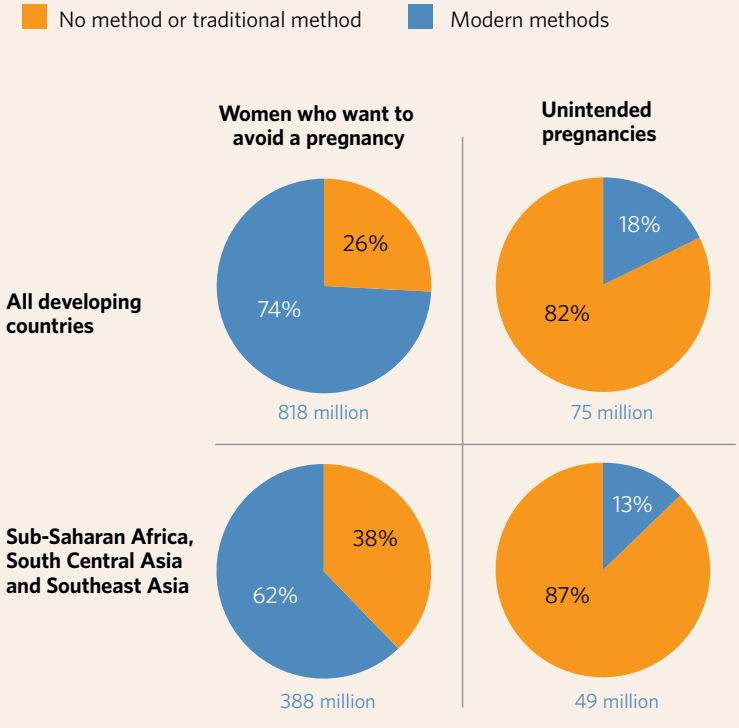
As the name implies, emergency contraception is a backup method to prevent pregnancy in cases of unprotected sex, incorrect method use, condom breakage or slippage, or other method failure. A single emergency contraceptive pill, when taken within up to five days after unprotected intercourse, prevents a fertilized egg from implanting, reducing unintended pregnancy by 60 per cent to 90 per cent. The

MORE THAN HALF OF ALL REPRODUCTIVE-AGE WOMEN IN DEVELOPING COUNTRIES ARE IN NEED OF MODERN CONTRACEPTIVES



Source: Singh, S and JE Darroch, 2012.

WOMEN WHO WANT TO AVOID PREGNANCY BUT DO NOT USE A MODERN METHOD ACCOUNT FOR A DISPROPORTIONATE MAJORITY OF UNINTENDED PREGNANCIES



Sources: Singh S and J Darroch, 2012, and special tabulations of data for Singh S et al., 2009.

sooner the pill is taken, the more effective it is. Emergency contraception is not effective once implantation has begun and does not cause abortion. It is intended for emergency use only and is not appropriate for regular use. For longer-term protection, a copper intrauterine device, when inserted within five days of intercourse, also prevents implantation and can be left in place for up to 10 years (Trussell and Raymond, 2012). Emergency contraception plays a special role in instances of sexual violence, armed conflict, and humanitarian emergencies. Given the unpredictable and often unplanned nature of young people's sexual encounters, emergency contraception is especially important in the range of services provided to adolescents and young adults.

Rights and the unmet need for family planning

According to a 2012 report by the Guttmacher Institute and UNFPA, there are 1.52 billion women of reproductive age in the developing world. An estimated 867 million of them need contraception, but only 645 million are currently using modern contraceptive methods. The remaining 222 million women have an unmet need for contraception.

- An estimated 80 million unintended pregnancies will occur in 2012 in the developing world as a result of contraceptive failure and non-use among women who do not want a pregnancy soon.
- Most—63 million—of the 80 million unintended pregnancies in developing countries in 2012 will occur among the 222 million women with an unmet need for modern contraception.
- 18 per cent of unintended pregnancies occur among the 603 million women who were using a modern contraceptive but had difficulty using it consistently and correctly, or because of method failure.

Why is unmet need for contraception still so high?

The 222 million women who want to avoid becoming pregnant for at least the next two years but are not using a method actually reflect a slight decline in unmet need between 2008 and 2012. During this time, the number of women who wanted to avoid a pregnancy grew by nearly 40 million, and the biggest improvements in reducing unmet need were made in Southeast Asia. Despite the gains, there is a significant need for targeted interventions that reach underserved communities and marginalized sub-populations, where unmet need remains relatively high.

In the developing world as a whole, 18 per cent of married women have an unmet need for modern contraception, yet in Western, Central and Eastern Africa and Western Asia, 30 per cent to 37 per cent of women have an unmet need for contraception. In the Arab region, a significant number of women have unmet need for family planning—that is, they prefer to avoid a pregnancy for at least two years but are not using a family planning method. A survey collected by the Pan-Arab Project for Family Health found that only four in 10 married women of reproductive age living in the Arab countries use modern contraception (Roudi-Fahimi et al., 2012). In most Arab countries, women's ambivalence towards family planning results from a range of factors, including fear of side effects, concern with husbands' reactions, conflicts about family roles and cultural responsibility for bearing children. This ambivalence declines as women grow older.

Particularly in Western and Central Africa, weak health systems and poor services

contribute to high unmet need (Singh and Darroch, 2012). In virtually all developing countries, poor women have more children and lower contraceptive use than wealthier women, underscoring the need for programming in resource-poor communities. In sub-Saharan Africa, women in the top wealth quintile are three times as likely to use contraception as those in the lowest wealth quintile (Gwatkin et al., 2007). The major difference between users and non-users is that some have access to information, have more choices as a consequence of their greater wealth and schooling, and can act on their desire to have fewer children.

Women with unmet need for family planning account for nearly four out of every five unintended pregnancies (Singh and Darroch, 2012). Other factors contributing to unintended pregnancies include incorrect or inconsistent use of a method of contraception, which may be due to inadequate counselling or information, and discontinuation of a method without switching to another method (Singh and Darroch, 2012). Use of modern methods among never-married women in the developing world as a whole is much lower than among married women, except in sub-Saharan Africa, where women have a strong need for dual protection from pregnancy and sexually transmitted infections, including HIV, and condoms are the predominant method used by unmarried women (Singh and Darroch, 2012).

Data also support the need for adolescent- and youth-friendly services. Pregnancies among adolescents between the ages of 15 and 19 from poor families are more than twice as common than they are among the same age group from wealthy families (Gwatkin et al., 2007). These disparities are compounded by the fact that poor girls are more likely than wealthy girls to be married, to be uneducated and malnourished and to have preterm or underweight infants. Little improvement in access among adolescents over the past 10 years can be observed in 22 sub-Saharan African countries where one in four adolescent girls has unmet need for family planning (United Nations, 2011c). Married adolescents in all regions have greater difficulty than older women in meeting their need for contraceptive services (Ortayli and Malarcher, 2010). But young never-married women also face difficulties in obtaining contraceptives, largely because of the stigma attached to being sexually active before marriage (Singh and Darroch, 2012).

Contraceptive use lowers abortion rates

According to a recent Guttmacher Institute study (Singh and Darroch, 2012), an estimated 80 million unintended pregnancies will take place in 2012 in the developing world, and 40 million of them will likely end in abortion.

▼ *Mobile health educator in Gabarone, Botswana visits home.*
©Panos/Giacomo Pirozzi

Most unintended pregnancies ending in abortion result from non-use of a contraceptive method or from method failure, particularly of a traditional method such as withdrawal. Despite their lower rate of effectiveness, 11 per cent of all contraceptive users globally (less than 7 per cent of all married women) rely on withdrawal, rhythm, and other traditional methods (Rogow, 1995). While lack of access to modern methods is often a factor in this choice, many prefer so-called "natural" methods because of the absence of side effects, their lack of cost, and the fact that they can be used at home with no trip to a clinic.

"All countries should, over the next several years, assess the extent of national unmet need for good-quality family planning services and its integration in the reproductive health context, paying particular attention to the most vulnerable and underserved groups in the population."

— ICPD Programme of Action 1994, Paragraph 7.16

Addressing women's concerns about modern methods and helping women who stop using one method to find a new and effective one could reduce unintended pregnancies in sub-Saharan Africa, South Central Asia and Southeast Asia by 60 per cent, and reduce abortions in those regions by more than half (Cohen, 2011). Addressing unmet need globally would avert 54 million unintended pregnancies and result in 26 million fewer abortions—a decline from 40 million to 14 million abortions (Singh and Darroch, 2012).

A study of abortion in 12 countries in Central Asia and Eastern Europe found that many women had used modern contraceptives but had discontinued for a variety of reasons (Westoff, 2005). The majority of pregnancies resulting from discontinuation of a modern method ended in abortions. This highlights the importance of offering a range of methods from which to choose, of providing high-quality counselling and "accompaniment" to clients, and of providers helping women who are dissatisfied with a method to switch to another method before an unintended pregnancy occurs.

In the Ukraine, fertility rates have been declining as more women have an opportunity to have careers outside of the home, and more couples are choosing to have fewer children. Immediately after the dissolution of the Soviet Union, couples relied on abortions as family planning. Today, however, because family planning is more readily available and understood, there are fewer unplanned pregnancies, and therefore fewer abortions.

In Latin America and the Caribbean, abortion rates have fallen from 37 per 1,000 women between the ages of 15 and 44 in 1995 to 31 per 1,000 in 2008 (Kulcycki, 2011), as use of modern contraceptive methods has risen throughout the region to about 67 per cent among married women (United Nations, Department of Economic and Social Affairs, 2011). However, access to contraceptives remains difficult in some regions and for some groups, especially the poor and adolescents. High rates of unintended pregnancy lead many women to seek abortion, which is restricted in most countries in the region. In a number of countries, abortion is permitted only to save a woman's life. As a consequence, almost all of the 4.2 million abortions annually in the region are performed clandestinely or under unsafe conditions; the rates of abortion and the proportion that are unsafe are the highest in the world (United Nations, Economic Commission for Latin America and the Carribean, 2011). While wealthier women can seek private providers, poor women more often suffer the medical and legal consequences of their limited choices (World Health Organization, 2011a). Unsafe

abortions in the region lead to more than 1,000 deaths and 500,000 hospitalizations each year (Kulcycki, 2011).

Women in developed and developing regions of the world have abortions at similar rates: 29 abortions per 1,000 women in developing countries, compared with 26 per 1,000 women in developed countries (World Health Organization, 2011). Though contraceptive prevalence is higher in developed countries, some women may discontinue use or do not have regular access to contraceptive methods.

Unsafe abortions account for almost half of all abortions (Sedgh, Singh and Shah, 2012). Nearly all (98 per cent) of unsafe abortions—among all age groups—take place in developing countries, with the greatest number occurring in sub-Saharan Africa. The World Health Organization has estimated that 21.6 million unsafe abortions occur each year (World Health Organization, 2011). The number is steadily increasing as the number of women of reproductive age (15-44) increases worldwide.

CASE STUDY

Unsafe abortion in Mozambique

Some young women in Mozambique resort to dangerous and illegal practices to terminate unwanted pregnancies. The Associação Moçambicana para o Desenvolvimento da Família (AMODEFA) and now other non-governmental organizations have organized "Women's Caucus" discussion groups that meet for two hours each week to talk about this and related issues (United Nations Population Fund, 2011a). The members choose the topics, which revolve around contraception, partners, unsafe abortion, gender equality, small business opportunities and violence against women. Young women from AMODEFA with training in human rights, sexual and reproductive health and gender equality coordinate the forum. Young women report greater confidence in reproductive health decision-making and more knowledge of sexual and reproductive health services and where to find them. ■

▲ *By 2020, if an additional 120 million women who want contraceptives could get them, this would mean 200,000 fewer women and girls dying in pregnancy and childbirth—that's saving a woman's life every 20 minutes. Access to contraceptives would mean nearly 3 million fewer babies dying in their first year of life.*
©Lindsay Mgbor/UK Department for International Development

Greater contraceptive use, fewer abortions

The evidence is strong that as modern contraception becomes more widely used, abortion rates fall (Westoff, 2008). For example, in Russia, as the use of the intrauterine device and the pill increased by 74 per cent between 1991 and 2001, abortion, which had been the primary means of fertility control for decades, fell by 61 per cent. Similar patterns are seen throughout the Eastern Europe and Central Asian countries where women previously lacked access to modern contraception (Westoff, 2005).

According to the most recent data, adolescents and youth account for approximately 40 per cent of unsafe abortions worldwide (Shah and Ahman, 2004). Adolescents may have higher rates of death and disability than adult women due to delays in seeking abortion services and failure to seek care for complications. Abortion rates increase with limits to contraception, increased demand for smaller families or delayed childbearing.

Family planning aimed at young people can help prevent the leading causes of death among girls between the ages of 15 and 19: complications related to pregnancy, delivery and unsafe abortion (Patton et al., 2009). Almost all maternal deaths occur in developing countries, with more than half of these deaths occurring in sub-Saharan Africa and almost one-third in South Asia (World Health Organization, 2012).

A comparative study of hospitalizations across 13 developing countries estimated that nearly one-fourth of women (8.5 million) who have an abortion each year experience complications that require medical attention, with about 3 million of them unable to receive the care they need (Singh, 2006).

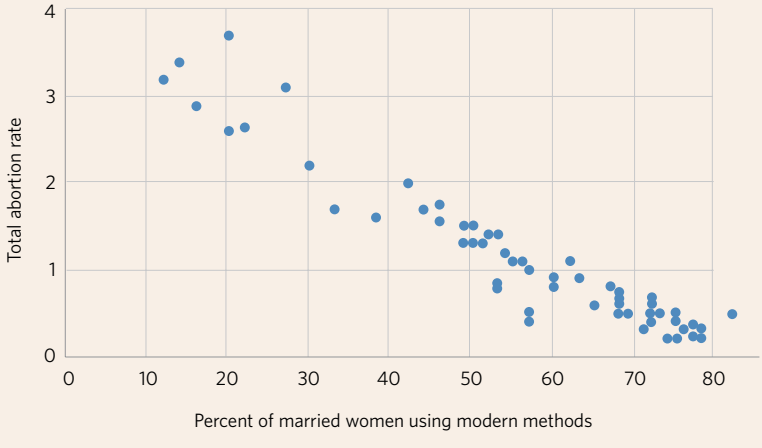
Young girls face greater risks than adults of complications and death as a result of pregnancy. Compared to adult women, younger mothers are two-to-five times more likely to die during childbirth, and the risk of maternal death is highest among girls who have children before their fifteenth birthdays (World Health Organization, 2006). Pregnant girls age 18 or younger are at up to four times greater risk of maternal death than women who are at least 20 years old (Greene and Merrick, n.d.).

Often overlooked, maternal morbidities are also a concern for young people. Young mothers who survive childbirth are at greater risk of suffering from pregnancy-related injuries and infections, including obstetric fistula. In sub-Saharan Africa and Asia, the United Nations estimates that more than 2 million young women live with untreated obstetric fistula, a condition associated with disability and social exclusion (World Health Organization, 2010).

In most settings, high levels of maternal death and disability reflect inequalities in access to health services and the social disadvantage and exclusion that young people face—both a cause and consequence of health risk that young people face as a consequence of pregnancy (Swann et al., 2003; Greene and Merrick, n.d.).

Nearly 95 per cent of births among adolescents take place in developing countries, and in these countries, about 90 per cent of births to adolescents 15-19 occur within marriage (World Health Organization, 2008). Child marriage—marriage that takes place before the age of 18—is increasingly recognized as a violation of a girl's human rights, including the right to be protected from traditional harmful practices

TOTAL ABORTION RATES AND THE PREVALENCE OF MODERN CONTRACEPTIVE METHODS IN 59 COUNTRIES



Source: Westoff, 2005.

(as stated in the Convention on the Rights of the Child), but it remains all too common, particularly in Africa and South Asia, where approximately half of all girls are married before age 18 (Hervish, 2011). Most married girls become pregnant not long after marriage (Godha, Hotchkiss and Gage, 2011).

Even though 75 per cent of all births among adolescents are described as "intended," (World Health Organization, 2008), such intentions may be strongly influenced by social pressures and cultural norms, for example, that a woman prove her fertility to her husband and his family soon after marriage (Godha, Hotchkiss and Gage, 2011). For unmarried girls, pregnancy is far more likely to be unintended and to end in abortion (World Health Organization, 2008).

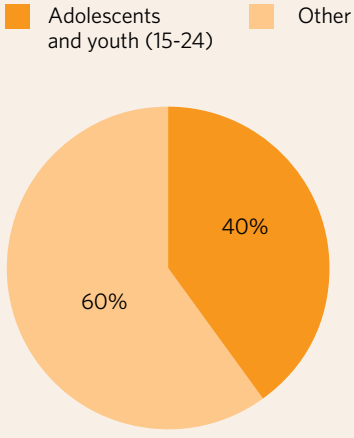
In Latin America, births among adolescents have declined more rapidly, but remain high, averaging 80 births per 1,000 young women per year. In a few countries, such as Ecuador, Honduras, Nicaragua, and Venezuela, adolescent birth rates are above 100 births per 1,000 women ages 15 to 19, approaching those of most sub-Saharan countries (UNFPA 2011). Adolescent pregnancy and childbearing are much higher among indigenous groups in these countries; these groups tend to be socioeconomically and educationally disadvantaged (Lewis and Lockheed, 2007). In the United States, birth rates among adolescents have recently declined among all ethnic groups to an historic low level of 34 births per 1,000 women but are still higher than they are in Western Europe (UNFPA, 2010a).

Births among adolescents are declining in most regions, but the rate of decline has slowed in some parts of the world, even reversed in some countries in sub-Saharan Africa where births among adolescents are the highest in the

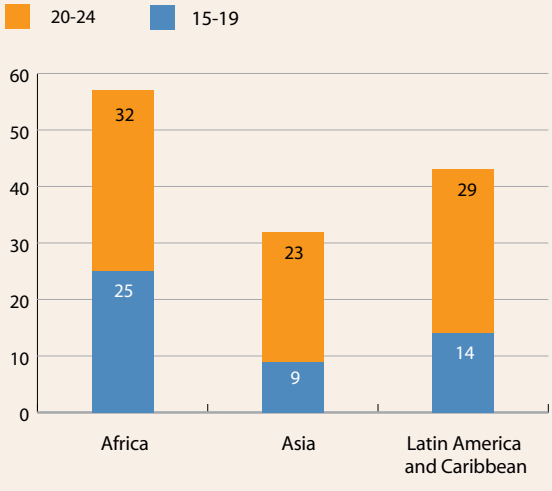
UNSAFE ABORTIONS AMONG ADOLESCENTS AND YOUTH

PERCENTAGE OF TOTAL UNSAFE ABORTIONS IN DEVELOPING COUNTRIES AND PROPORTION AS A PERCENTAGE OF UNSAFE ABORTION BY REGION

Percentage among adolescents and youth, as a percentage of total unsafe abortions worldwide



Breakdown, as a percentage of unsafe abortions (15-24 years) in their region



Source: Shah, I., Ahman, E (2004). "Age Patterns of Unsafe Abortion in Developing Country Regions. *Reproductive Health Matters*. 12(24 Supplement):9-17.

world (United Nations Population Division, 2012). In sub-Saharan Africa, adolescents between the ages of 15 and 19 have, on average, 120 births per 1,000 per year, ranging from a high of 199 per 1,000 girls in Niger to a low of 43 per 1,000 girls in Rwanda. Over half of young women give birth before age 20 (Godha, Hotchkiss and Gage, 2011), and adolescent fertility in most countries in sub-Saharan Africa has shown little decline since 1990 (Loaiza and Blake, 2010). In the Caucasus and Central Asia, fertility among adolescents has leveled off over the past 10 years, perhaps because the region has achieved such high levels of girls' schooling, with gender parity at the secondary level and more girls studying at the tertiary level than boys (United Nations, 2012). The only region where adolescent fertility increased between 2000 and 2010 was Southeast Asia.

The need for comprehensive data

Protecting the right to family planning first requires a baseline understanding of who currently has access to family planning and who does not. Ensuring rights also requires an understanding of how young people and adults view sex, sexuality, and the decision to have children. New technologies make it possible for States to gain a greater understanding of demographic trends and the environmental factors that motivate people to have sex and influence fertility rates. Digital and mobile communications make it possible for people to more easily access information about their rights and their governments' obligations to uphold them.

An assessment of family planning trends requires a nuanced analysis of who is most vulnerable, whose needs have been neglected, and what factors contribute to peoples' vulnerabilities and their inability to realize their rights to family planning throughout their lives (UNFPA, 2010).

Good demographic measures tell a complex and evolving narrative. Stakeholders increasingly need to analyse these data in concert with information about the social, cultural, and political conditions that shape health and cause patterns in health to evolve. The World Health Organization asserts that these *social determinants of health drive* "most of the global burden of disease and the bulk of health inequalities" (World Health Organization, 2005). At all levels—individual, community, and national—social determinants of health establish conditions that influence the ability of women, men, and young people to access quality family planning when they want to prevent or delay pregnancy at different stages of their lives.

Policymakers must therefore use comprehensive data across sectors on population dynamics, including age structures and the rate of urbanization, as well as other trends. Simply increasing the availability of family planning may do little to reduce unintended pregnancy without analyses of where unmet need is greatest, where efforts to uphold reproductive rights have been weak, or where cultural, social, economic or logistical

DATA-DRIVEN ADVOCACY RESULTS IN POLITICAL AND FINANCIAL SUPPORT FOR FAMILY PLANNING IN ECUADOR

Fertility rates in Ecuador vary among population groups. Women in the lowest income quintile, for example, have an average of five children, compared to women in the highest income quintile who have about two. These disparities reflect inequalities in access to sexual and reproductive health services. In response, UNFPA partnered with the Ministry of Health and other bilateral and multinational organizations to collect and analyse data to document the disparities and to advocate for changes that would rectify these inequalities. The data made the case in 2009 for a new strategy for family planning and for the prevention of adolescent pregnancy, and as a result, Ecuador stepped up its investments in reproductive health supplies, including contraceptives, by more than 700 per cent between 2010 and 2012, to $57 million.

▲ *A couple with their baby in Vulcan. Romania.*
©Panos/Petrut Calinescu

barriers prevent individuals from accessing information and high quality services.

The Programme of Action highlights the interrelation of human sexuality, age and gender relations, and how they together affect the ability of men and women to achieve and maintain sexual health and manage their reproductive lives. Family planning programmes must therefore be based on an analysis of data in ways that take into account the continuum of sexual activity, as well as the gender- and age-specific consequences of sexual activity.

Conclusion

Fertility, unmet need, rates of discontinuation among those who are using contraception and levels of unsafe abortion are highest in the poorest countries, and among disadvantaged populations within every country. Lingering high levels of unintended pregnancy persist in some developed countries. Persistent inequalities can be seen in access to and use of family planning between the educated and wealthy elites and everyone else. When it comes to using family planning, therefore, those who can, do, while those with more limited access experience unmet need and unintended pregnancy.

In contemplating the need around the world for family planning information and services, policymakers need access to comprehensive data and should consider patterns of sexual activity and not just fertility rates.

CHAPTER THREE

Challenges in extending access to everyone

A large and unsatisfied desire exists for family planning around the world among people of many ages, ethnic groups and places of residence. Nations vary greatly in their ability to help their populations fulfil this desire and uphold individuals' rights. In many countries national legislation exists to translate international rights commitments into reality (Robison and Ross, eds, 2007). But in far too many settings, the rights of some—not all—are guaranteed only in principle.

Despite a range of legal protections, barriers to access—and to rights—persist. Some barriers are related to costs and affordability. Others are related to difficulties in making quality supplies and services reliably available in remote areas or to the distances individuals must travel to obtain family planning. Other obstacles are related to social norms, customs or gender inequality. And still others are related to policy or legislative environments.

Many groups, therefore, are not able to exercise their right to decide whether, when and under what conditions to have children. The challenge is often related to direct and indirect discrimination and the unequal *implementation* of existing legislation, policies and programming.

Worldwide, specific sub-populations face the greatest challenges in accessing the information and services they need to plan their families. As a result, access to family planning is more akin to a privilege enjoyed by some rather than a universal right exercised by all.

Brenda, 16, (left) and her older sister Atupele, 18, (right) had to drop out of school because their family could not afford the fees. Both are now young mothers.

Confronting social and economic barriers to family planning

The United Nations Common Understanding on a Human Rights-Based Approach emphasizes the importance of building the capacities of individuals to claim their rights as well as of duty-bearers to meet their obligations, including service provision. Consequently increased access and use of basic family planning services require the development of capacities for empowerment, in particular of marginalized and discriminated rights-holders, and capacities for duty-bearers responsiveness and accountability. Many varied institutions can and do address these barriers to the realization of the right to family planning.

Social, cultural and economic factors can enable or impede the realization of rights including access to and provision of family planning information and services. These factors may mean that ethnicity, age, marital status, refugee status, sex, disability, poverty, mental health and other characteristics are

all barriers to individuals' access to family planning. However, in the sexual and reproductive health arena, gender inequality, gender-based discrimination and women's disempowerment stand out as posing obstacles to women in particular as they pursue and claim their health and rights.

Achieving States' family planning obligations requires a focus on gender equality

In many settings, gender norms condone specific beliefs, behaviours, and expectations of adult women and men, contributing to the health risks and vulnerabilities that affect women and men throughout their lives. Relative to men, women and girls are often socialized to be passive and under-educated about their sexual and reproductive health. Sexuality—a topic that encompasses a diverse set of desires, experiences, and needs—is typically confined to notions of purity and virginity for women and girls. Women live with pressures to conform to social norms that uniformly restrict their sexual activity within the context of marriage. They are often discouraged from taking the initiative to bring up topics related to sexual relations, to refuse to have sex or to communicate about family planning.

> As part of the effort to meet unmet needs, all countries should seek to identify and remove *all the major remaining barriers* to the utilization of family planning services.
>
> — Programme of Action of the International Conference on Population and Development, ICPD

A dominant masculinity teaches boys and men that sexuality and sexual performance are key to masculinity. The enjoyment of sexual relations is viewed as their prerogative and they are taught to take the lead in their sexual relationships, creating significant pressure (and insecurity). Traditional views of what it means to be a man can encourage men to seek out multiple sexual partnerships and to take sexual risks. Around the world, men are taught that they are not primarily responsible for family planning and are often not held responsible for pregnancies outside of marriage.

The differing treatment of boys and girls as they grow up begins early, and it continues throughout their lives. The result is that everyone—children, young people, adults—generally absorb messages about how they ought or ought not to behave or think, and early on, begin to establish divergent expectations of themselves and others as females and males. Often, these expectations unfortunately translate into practices that can harm sexual and reproductive health.

Although women more consistently suffer the negative effects of harmful gender norms across their lifetimes, societies also socialize their men, male adolescents, and boys in ways that drive poor sexual and reproductive health outcomes. In many societies, men are encouraged to assert their manhood by taking risks, asserting their toughness, enduring pain, being independent providers, and having multiple sex partners. The roles and responsibilities of breadwinner and head of the household are inculcated into boys and men; fulfilling these behaviours and roles are dominant ways to affirm one's manhood.

If gender norms simply dictated *difference* and not *hierarchy*, we might not be talking about them here. But gender norms as a rule establish and reinforce women's subordination to men and drive poor sexual and reproductive health outcomes for both men and women. Women are often prevented from learning about their rights and from obtaining the resources that could help them plan their lives and families, sustain their advancement in school, and support their participation in the formal economy (Greene and Levack, 2010). Men are often not offered most

sources of sexual and reproductive health information and services and develop the sense that planning their childbearing is not their domain: it is women's responsibility.

Gender inequality in family planning programmes

Gender inequality is a profound obstacle to women's—and men's—ability to realize their right to family planning. It is also an impediment to sustainable development. While gender equality refers to the overarching *goal* of equal rights, access, opportunities and lack of gender discrimination, gender equity refers to fairness in the *distribution* of resources and services (UNFPA, 2012b; Caro, 2009). To ensure fairness and justice, governments must pursue gender equality, adopting strategies and measures to compensate for historical and social disadvantages that prevent women and men from enjoying equal opportunities (UNICEF, 2010).

The legal, economic, social and cultural barriers to health and access to health services are reinforced by the physiological realities of reproduction: women bear the consequences of poor sexual and reproductive health choices and pay for these consequences with their health and sometimes their lives. Empowered with appropriate information, methods, and services, vulnerable populations are in a better position to avoid many of the harmful sexual and reproductive health outcomes affecting them. A focus on gender equality can make it easier for both women and men of all ages across diverse social settings to plan the timing and spacing of their children.

The rigid ideals about appropriate attitudes and behaviours for men and women are learned, socially constructed norms that vary across local contexts and interact with sociocultural factors such as class or caste (Barker, 2005; Barker, Ricardo and Nascimento, 2007). These social and gender norms are carried out and reinforced on multiple levels, among individuals in peer groups and families, through community-wide attitudes and practices, and within institutions.

Couple at antenatal care service for couples in Venezuela.
©UNFPA/Raúl Corredor

CASE STUDY

Addressing gender-based violence in Tanzania

The Jijenge! programme in Tanzania recognized the harm gender inequality was causing to women, including to their sexual and reproductive health (Michau, Naker and Swalehe, 2002). Going beyond a typically biomedical approach to sexual and reproductive health, the

ASSOCIATION OF GENDER EQUITABLE ATTITUDES AND BEHAVIOURS RELATED TO SEXUAL AND REPRODUCTIVE HEALTH

		Percentage of men who say the following are important			
	SCORE ON GENDER EQUITABLE MEN SCALE	COUPLE COMMUNICATION	SEXUAL SATISFACTION	ACCOMPANIED TO PRENATAL VISIT	GETTING AN HIV TEST
BRAZIL	LOW	87	80	58	28
	MODERATE	84	91	68	31
	HIGH	87	95	87	38
CHILE	LOW	50	50	27	21
	MODERATE	86	83	83	24
	HIGH	90	88	89	31
CROATIA	LOW	70	61	69	5
	MODERATE	88	67	84	3
	HIGH	95	79	94	13
INDIA	LOW	73	98	91	20
	MODERATE	65	98	91	12
	HIGH	64	98	93	6
MEXICO	LOW	71	86	75	16
	MODERATE	85	91	87	15
	HIGH	91	96	94	31
RWANDA	LOW	--	83	--	85
	MODERATE	--	85	--	87
	HIGH	--	90	--	89

Source: International Center for Research on Women and Promundo, 2011.

programme integrated gender equality into sexual and reproductive health via three strategies:

- Providing information and clinical services for women, information, services and counselling that helped women identify the root causes of the sexual health problems in their communities;
- Training community workers to create more gender-sensitive service agencies and providers, including teachers, police, judges, church groups and so on who could develop more woman-friendly practices;
- Changing gender attitudes in communities by stimulating public debate on the situation of women through brochures, street theatre, community meetings and other ways of disseminating information.

The programme found that a specific focus on gender-based violence (particularly when

messages were delivered via a number of routes) turned out to be more effective than a broader approach to gender inequality. Men's involvement in discussions was key, as was the endorsement of influential members of the community.

If more traditional, dominant male gender attitudes are related to poorer health outcomes, it is logical that more gender equitable attitudes can lead to improvements in sexual and reproductive health-related attitudes and practices (Pulerwitz and Barker 2006; Barker, Ricardo and Nascimento, 2007). The International Men and Gender Equality Survey, for example, has shown more healthful practices to be associated with higher scores on the "gender equitable man" or GEM Scale for measuring attitudes towards gender equality (International Center for Research on Women and Promundo, 2010).

What these data tell us is that men with more respectful attitudes are likely to have better individual and couple outcomes as reflected in improved couple communication, more sexual satisfaction, greater chances of accompanying their female partners to antenatal visits, and greater likelihood of having sought an HIV test.

In the past 15 years, non-governmental organizations, United Nations agencies and governments have invested in programmes that bring together efforts to change gender norms with health interventions. Recent research has shown that efforts to strengthen more gender equitable attitudes among men can influence sexual and reproductive health-related attitudes and practices (Pulerwitz and Barker, 2006; Barker, Ricardo and Nascimento, 2007). Recent global reviews of sexual and reproductive health programmes have found that those that integrated gender considerations achieved better outcomes (Rottach, Schuler and Hardee, 2011; Barker, Ricardo and Nascimento, 2007).

Olivia Adelaide, lab technician at Mozambique's Boane Health Center, which offers primary care and sexual and reproductive health services, including family planning and HIV testing.

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV/AIDS

HIV status does not necessarily repress the desire to have children, and HIV-positive women may decide to have children in spite of their HIV status, or they may decide not to have children (Rutenberg et al., 2006). Women living with HIV are unable to exercise their *right to decide the number, timing and spacing of their children* when discriminatory practices deprive these women of the necessary means and services to fulfil their decisions, such as accessing contraception, family planning, maternal health care, and drugs and services to prevent mother-to-child transmission.

The right to health and the right to sexual and reproductive health entitle women living with HIV to the treatment, care and services necessary for them to prevent mother-to-child transmission when they are pregnant. The risk of perinatal transmission of HIV is below 2 per cent when coupled with antiretroviral treatments, safe delivery and safe infant feeding. Absent these critical services, the risk ranges from 20 per cent to 45 per cent (World Health Organization, 2004a).

In low- and middle-income countries, an estimated 45 per cent of HIV-positive pregnant women receive at least some antiretroviral drugs to prevent mother-to-child transmission of HIV (World Health Organization, UNAIDS and UNICEF, 2010).

Cultural attitudes and expectations regarding virginity, marriage and family roles remain rigid in many places, reinforced by anxieties about female sexuality, power and independence and the very real dangers girls may face (Greene and Merrick, n.d.). As more girls stay in school for longer, they are statistically more likely to mature sexually while they are enrolled; they face risks that few schools address adequately, including sexual violence, exposure to sexually transmitted infections and HIV, early pregnancy and childbearing, and unsafe abortion (Lloyd 2009). Of course not all of these risks are new, or occur just at school; out-of-school girls also marry, and continue to have children as teens in great number. What is new is the greater possibility of friction between the parts of girls' roles that remain stable (domestic chores, expectations about virginity, the management of their sexuality, and aspirations for marriage) and those that are changing (schooling, exposure to peers, greater mobility in some cases).

Unsafe abortion is "a procedure for terminating an unintended pregnancy that is carried out either by a person lacking the necessary skills or in an environment that does not conform to the minimal medical standards, or both."

— World Health Organization (1992).

An analysis in five African countries of the experience of 12-to-19 year-olds who were in school at age 12 shows that girls are less likely than boys at every age to continue in primary or secondary school, and less likely than boys to make the transition from primary to secondary school (Biddlecom et al., 2008). Girls are much more vulnerable to dropping out once they are sexually mature and once they experience premarital sex; early pregnancy is even more disastrous for girls. Some recent research suggests that pregnancy and early marriage are more likely consequences rather than causes of girls failing to complete their secondary education (Biddlecom et al., 2008; Lloyd and Mensch, 2008).

Redefining what it means to be a "real man"

Like women and girls, men and boys feel social pressures to adopt rigid ideals about how they should behave, feel, and interact to be considered real men. These ideals are learned, not a result of simply their sex (Connell, 1987; Connell, 1998). When given the opportunity to critically reflect on these ideals, men and boys can often describe the pressures they feel to be *real men*—a term usually ascribed to taking risks, enduring pain, being tough, being a provider, and having multiple sex partners (Flood, 2007).

Real men usually refers to hegemonic masculinity—the prevailing measure of masculinity by which men assess themselves and others. Dominant concepts of masculinity are complex and different across societies, influenced by several factors including culture, race, social class, and sexuality (Kimmel, 2000). For example, a group with one version of masculinity within a social class or ethnic group may exert greater power over another, just as heterosexual masculinity is often dominant over homosexual and bisexual masculinity (Marsiglio, 1998). In many societies, hegemonic masculinity is associated with heterosexuality, marriage, authority, professional success, ethnic dominance, and/or physical toughness (Barker, Ricardo and Nascimento, 2007).

Men and boys who deviate from dominant male norms in their attitudes and behaviours are susceptible to ridicule and criticism (Barker and

Ricardo, 2005). Moreover, young and adult men who adhere to these traditional views of manhood are more likely to engage in riskier sexual practices (Sonenstein, ed, 2000). Results from the Gender Equitable Men Scale have found that men who adhere to more rigid views about masculinity are more likely to hold attitudes or practice behaviours that compromise their sexual health and their partners' health (Pulerwitz and Barker, 2008).

Not all boys and men identify with dominant versions of masculinity within their communities. For example, young men of higher socioeconomic status often hold more power and access to goods and opportunities than young men of lower socioeconomic classes (Barker, 2005). The evolution of who they are within their peer groups, families, and communities is a dynamic process that changes over time (Connell, 1994). Men's attitudes and experiences, particularly the conclusions they draw about what is socially acceptable behaviour, have implications for men's and boys' willingness to access family planning services and to be active participants in planning families with their partners.

A global review conducted by the World Health Organization found that culturally dominant forms of masculinity, which often urge men to practice strict emotional control and cultivate a sense of invulnerability, serve as barriers to health—and health-seeking behaviour: they discourage some men and boys from visiting health facilities or from supporting their partners' health (Barker, Ricardo and Nascimento, 2007).

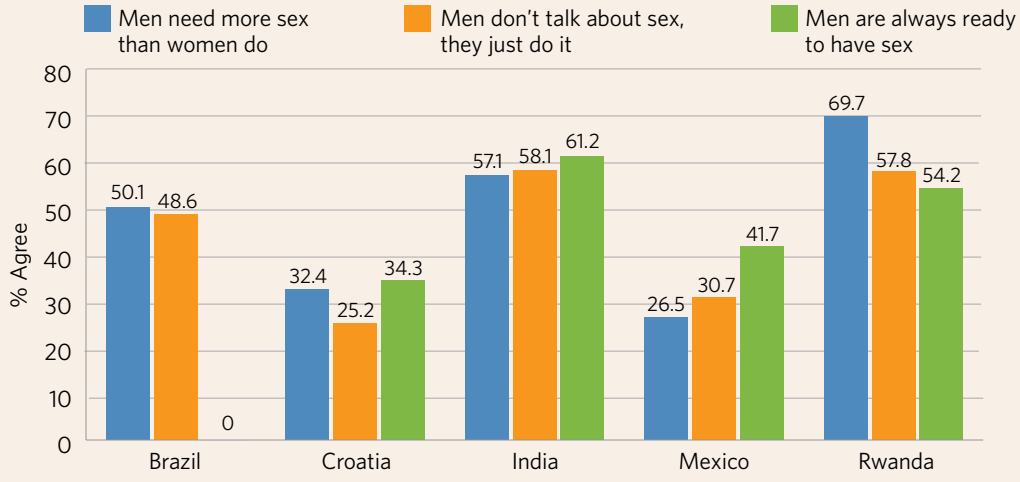
Men often have no opportunity to question these male norms or to reflect on how their views of manhood affect their health and their partner's health. However, tailored programmes have demonstrated that young and adult men can adopt equitable attitudes and behaviours—attitudes associated with better sexual and reproductive health outcomes (International Center for Research on Women and Promundo, 2010; UN Women, 2008).

▲ *Young men in Cairo's Tahrir Square.*
©UNFPA/Matthew Cassel

Prevailing attitudes and norms about sex impede access for young people, unmarried people of all ages, men and boys and marginalized groups

Social and cultural norms dictate who, when, with whom, and for what purpose women and men should have sex. Sexual activity is widely viewed as acceptable only when the "right" people engage in it under the "right" conditions. The perspectives of excluded groups are not closely reflected in the design, implementation, and evaluation of family planning policies and programmes. The impediments to their access

RELATIONSHIP BETWEEN ADHERENCE TO DOMINANT MASCULINITIES AND SEXUALITY



Source: International Men and Gender Equality Survey, International Center for Research on Women & Instituto Promundo 2011

are taken for granted following patterns of exclusion specific to each setting.

Across societies worldwide, expectations dictate that sex should take place only among married individuals who are healthy, heterosexual, monogamous, not too young, not too old, and whose childbearing fulfils expectations in their families and communities. When any person's sexual activity violates any of these rigid requirements, society makes it more difficult for that person to access family planning education, methods and services.

> Human sexuality and gender relations are closely interrelated and together affect the ability of men and women to achieve and maintain sexual health and manage their reproductive lives... Responsible sexual behaviour, sensitivity and equity in gender relations, particularly when instilled during the formative years, enhance and promote respectful and harmonious partnerships between men and women.
>
> — Programme of Action of the ICPD, paragraph 7.34

Reinforced over time by longstanding cultural attitudes and practices, social norms underpin the dialogue, or the absence thereof, around individuals' sexual desires, their motivations and reservations about accessing family planning, and the stigma and discrimination they experience. To take the example of unmarried adolescents, despite copious evidence that many are sexually active and that it makes complete public health sense to prepare them to manage the experience, social norms preclude discussing sexual relationships or providing sexual and reproductive health and family planning information to them.

Social conditions under which sexual activity is deemed "unacceptable" do not excuse States from fulfilling their obligations and commitment to public health. Governments alone cannot change discriminatory attitudes and norms about sex. However, they can structure and coordinate processes that mitigate social barriers to access, build capacities of marginalized groups to exercise their rights and provide these persons with adequate

information and services, including comprehensive and objective sexuality education.

Marginalizing the rights of a number of populations undermines national development goals. These population groups are often the most vulnerable to neglect and discrimination, and in many countries, are those with greatest unmet need. Those whose sexual activity may challenge prevailing social norms and whose access to reliable, quality family planning may be impeded include *1) young people, 2) unmarried people of all ages, 3) males and 4) other marginalized or discriminated against groups.*

Without integrating family planning policies that promote social inclusion and applying a rights-based framework, institutions responsible for equitable delivery of information and services may systematically neglect the needs of entire segments of their population.

1 Young people

Despite the international commitments to remove barriers to family planning for all population groups, research finds that young people's needs remain largely neglected. The consequence is that the largest generation of young people in history is unable to fully exercise their reproductive rights and prevent unintended pregnancies, mitigate the risks of school dropout, or protect themselves from sexually transmitted infections, including HIV. This reality and its harmful consequences are largely preventable.

People younger than 25 years now account for 44 per cent of the world's total population, and in developing countries, the numbers of children and youth are at all-time highs—1.6 billion and 1 billion, respectively. Girls aged 10 to 19 alone account for nearly one-fifth of all women of reproductive age (Guttmacher Institute and International Planned Parenthood Federation, 2010; Guttmacher Institute and International Planned Parenthood Federation, 2010a).

As these young people mature into adulthood, their political, economic, and sociocultural realities will shape the opportunities and risks they face in planning their childbearing. In many societies, these factors continue to reinforce attitudes and practices that restrict or deter young people from accessing education and services, resources that would empower them with information to choose when they want to become parents.

Unmet need is highest among the 300 million adolescent women between the ages of 15 and 19. The risks of childbearing for both mother and infant are highest for adolescent mothers, and intensive efforts are needed to ensure that adolescent rights to sexual and reproductive health information and services, including for protection against sexually transmitted infections and HIV, are respected (UNICEF et al., 2011a). Each day, 2,500 youth, the majority of them female, become newly infected with HIV. Young women, whether married or unmarried, often need the dual protection of a condom plus a modern contraceptive to protect them from both pregnancy and disease.

In sub-Saharan Africa and South Central and Southeast Asia, more than 60 per cent of adolescents who wish to avoid a pregnancy have an unmet need for modern contraception. These adolescents who do not use modern contraception or rely on a traditional method account for more than 80 per cent of unintended pregnancies in this age group.

A comparative analysis of Demographic and Health Survey data from 40 countries by the Guttmacher Institute found that the proportion of adolescent women who reported discontinuing their method while still in need of contraception ranged from 4 per cent in Morocco to 28

per cent in Guatemala. Across all countries, the discontinuation rates for adolescents are about 25 per cent higher than those for older women, with regional variations (Blanc et al., 2009). In all countries except Ethiopia, a greater proportion of adolescents than older women discontinued method use while still wishing to avoid pregnancy. The same analysis noted higher rates of contraceptive failure among young people during the first year of contraceptive use.

Very few young people are able to explore their sexuality in healthy environments aligned with age-appropriate sexuality education and services that empower them to make informed decisions about their sexual behaviours and reproductive health. Family planning programmes can reflect the belief that young people are *supposed* to remain abstinent until marriage. This sociocultural standard no longer reflects the diverse realities of young peoples' sex lives.

Young people explore their sexuality and negotiate their sex lives influenced by family members, religious practices, community leaders and their peers. Male and female adolescents everywhere are exposed to gendered attitudes and behaviours that shape their perceptions of sex, sexuality, and relationships, as well as their behaviour. The quality and content of the information young people receive varies widely, and is strongly influenced by adolescent peer groups (Kinsman, Nyanzi and Pool, 2000; Jaccard, Blanton and Dodge, 2005). Where young people are especially vulnerable to gender-based violence, adolescent girls in particular are at increased risk that their first sexual experience is coerced or forced. Coercion is common in

DISPARITIES IN ADOLESCENT FERTILITY RATES: EDUCATION AND HOUSEHOLD INCOME MATTER

Age-specific fertility rates (live births per 1,000 girls) for 15-19 year-olds by income quintile and region

Region	No. of surveys per countries in the region	Regional average	Poorest quintile	Richest quintile	Ratio of fertility rates Poor-Rich	% children of lower secondary school age out of school^
East Asia	4 of 7	42.4	75.6	17.6	4.3	10.0
Europe, Central Asia	6 of 8	52.7	7.0	31.3	2.3	9.6, 4.9
Latin America, Caribbean	9 of 17	95.7	169.5	39.2	4.3	5.5
Middle East, North Africa	4 of 6	57.8	68.2	35.1	1.9	19.5
South Asia	4 of 8	107.0	142.0	57.9	2.5	*27.3
Sub-Saharan Africa	29 of 49	129.7	168.1	75.4	2.2	36.8
All country average	56 of 95	103.0	142.5	56.6	2.5	18.3

Source of fertility data: Gwatkin et al 2007.
Source of education data: UNESCO Institute for Statistics 2010.
*Includes South and West Asia
^ Includes children approximately ages 11-14, varies by country

▲ *Just-married couple, Paris.*
©Panos/Martin Roemers

instances of early sexual initiation: more than a third of girls in some countries report that coercion was involved in their early sexual experiences (World Health Organization, 2012a).

Recent analyses of data on sexual behaviour among young people in 59 countries found no universal trend towards sex at younger ages; trends are complex and vary significantly by region and marital status (Lloyd, 2005). At the same time, global trends towards later marriage have contributed to a diminishing proportion of young women who report having had sex before the age of 15 (Lloyd, 2005; Greene and Merrick, n.d.). Notwithstanding, where child marriage is especially prevalent—South Asia, and Central, West, and East Africa—the median age at first intercourse for women is lower than in Latin America and the Caribbean, for example. For young men, age at first intercourse is not linked to their marital status. These differences between young peoples' experiences are most pronounced in developing countries.

Comparative assessments of adolescent sexual health between the United States and Europe find that young people begin to have sex at similar times, though with rather divergent outcomes. In the United States, 46 per cent of all high school age students have had sex (Centers for Disease Control and Prevention, 2010). Despite similar levels of adolescent sexual activity in several European countries, such as France, Germany and the Netherlands, sexually active adolescents are significantly less likely to experience pregnancy, birth, or abortion. Pregnancy, birth, and abortion rates among teenage girls in the United States are approximately three, eight, and two times as high as their European peers (Advocates for Youth, 2011). The differences are attributable to European policies that facilitate easier access to sexual health information and services for school-aged girls and boys and that respect young peoples' rights and support their health: young people in Europe have greater access to comprehensive sexuality education and sexual health services, including family planning; there also tends to be more open discussion of sexual activity with parents and in the society more broadly.

Globally, marriage patterns are changing. Young women and men are marrying later, and the number of countries where first sexual intercourse and marriage coincide for those under

25 has decreased compared to earlier generations (Lloyd, ed, 2005; Greene and Merrick, n.d.). These trends have led to an increase in the prevalence of premarital sex among young people. In developed countries, there has been a clear increase in the number of years between first intercourse and marriage (Mensch, Grant and Blanc, 2005). The time between first sexual intercourse and living with a partner is longer for men (three to six years) than for women (up to two years).

The increased time interval between age at first sex and age at first marriage have implications for the sexual health risks and needs of young people, particularly for school-aged girls. A recent cross-country analysis of 39 countries found that—with the exceptions of Benin and Mali—unmarried girls (ages 15 to 17) who attend school are considerably less likely to have had premarital sex, as compared to their out-of-school peers (Biddlecom et al., 2008; Lloyd, 2010). Even though individual, familial, and social factors influence sexual behaviour and school participation, these findings underscore the protective effects that an education confers against adolescent pregnancy and its adverse outcomes. Evidence from five countries in West Africa suggests that pregnancy and early marriage may be consequences, rather than causes, of girls dropping out of school in some settings (Lloyd and Mensch, 2008).

▼ *Teenager in Madagascar listens to a talk about safe sex.* ©Panos/Piers Benatar

Millions of young people have sex before their parents acknowledge it or before institutions respond to their needs. These young people—married and unmarried—also need services to avoid unintended pregnancy and prevent sexually transmitted infections including HIV but often do not have access.

Young people's sexual activity challenges the emphasis on abstinence and the view that sex should occur strictly for procreation. The reality is that many young people are *not* abstinent, and their sexual activity is *not* motivated by a desire to have children. Qualitative assessments in sub-Saharan Africa suggest that sexually active unmarried young people are generally not seeking to become pregnant (Cleland, Ali and Shah, 2006). Furthermore, married young people do not necessarily wish to become pregnant at a young age or, if they have already had a child, some wish to delay a second pregnancy.

Given young people's desire to delay childbearing and prevent disease, the term "family planning" may seem irrelevant to their needs. Recent research touches upon this key point: Many young people can be interested in contraception to prevent unwanted pregnancy and to protect against sexually transmitted infections,

but conventional family planning messages about planning their families are irrelevant. Addressing their needs and overcoming barriers to their access to family planning requires emphasis on contraception and disease prevention as well as comprehensive sexuality education, which is grounded in human rights including equality and non-discrimination, reflection about gender roles, sexual attitudes and behaviour (Cottingham, Germain and Hunt, 2010).

2 Unmarried people of all ages

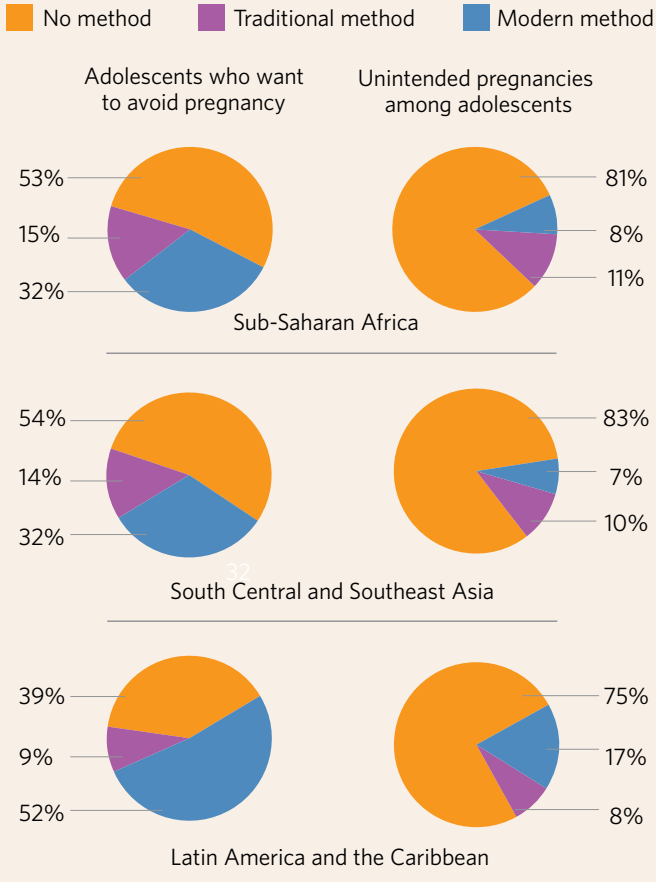
Relative to previous generations, greater numbers of young people and adults of reproductive age are having sex outside of marriage, with no immediate desire to have children (Ortega, 2012). Ensuring their access to family planning regardless of their marital status requires an acknowledgement of sexual activity for pleasure and intimacy *before* and *after* marriage as well as within it.

Most people in the world marry, and most sexual activity does take place within marriage (United Nations, Department of Economic and Social Affairs, 2009). Yet many people who have never married or whose marriages have ended are sexually active and wish to use family planning. Recent data highlight that interpersonal communication among adults about family planning—and actual family planning use—is increasingly taking place while they are single, separated, widowed or divorced.

When State family planning programmes exclude these non-married groups, family planning marginalizes a growing portion of the population. Though religious practices and social norms suggest that marriage is a pre-requisite for sexual activity, the State has an obligation to ensure access to family planning to all people irrespective of their religious beliefs and sexual practices without discrimination.

In some countries, the proportion of never-married adults is increasing (United Nations, Department of Economic and Social Affairs, 2009). Over the last 40 years, the number of countries where at least 10 per cent of women have never married by age 50 has increased from 33 to 41. Larger proportions of men are also not marrying. Between 1970 and 2000, the number of countries where at least 10 per cent of men do not marry before their 50th birthday increased from 31 to 49.

USE AND UNMET NEED AMONG ADOLESCENTS WHO WISH TO AVOID PREGNANCY IN THE DEVELOPING WORLD

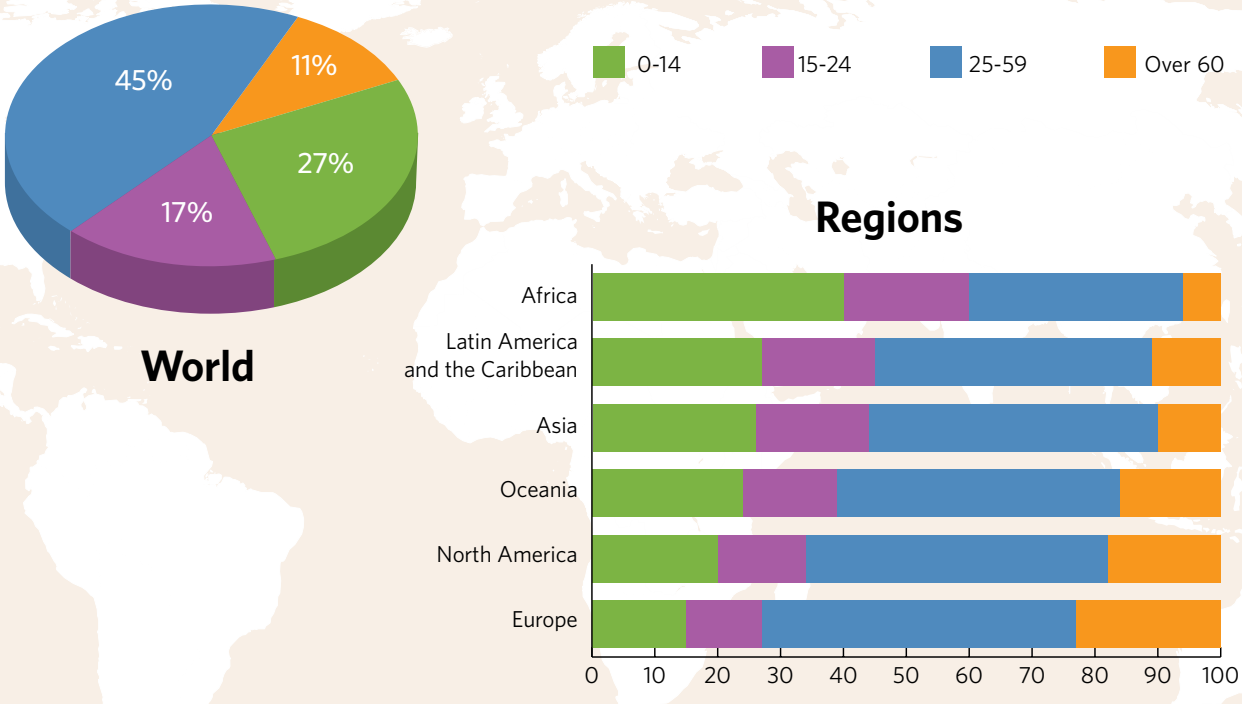


Source: Guttmacher Institute and International Planned Parenthood Federation, 2010a.

Consensual unions account for an increasing proportion of live-in partnerships, which tend to be less stable than formal marriages. In Latin America and the Caribbean, more than one in four women between the ages 20 and 34 live in a consensual union (United Nations, Department of Economic and Social Affairs, 2009). This arrangement is less common in sub-Saharan Africa and Asia where about 10 per cent and 2 per cent of women live in consensual unions, respectively. The percentage of women in consensual unions ranges from nearly zero to 30 in 16 developed countries. In a majority of countries with available data, the percentage of women in consensual unions peaks between ages 25-29 (United Nations, Department of Economic and Social Affairs, 2009).

Globally, the proportion of adults who are divorced or separated doubled (from 2 per cent to 4 per cent) between 1970 and 2000. Divorce and separation are more common in developed countries than in developing countries. According to the World Marriage Data for 2008, 11 per cent of women were divorced or separated in developed countries whereas only 2 per cent of women of the same age were divorced or separated from their husbands in developing countries (United Nations, Department of Economic and

WE'RE HERE! PER CENT DISTRIBUTION OF YOUNG PEOPLE, AS PER CENT OF WORLD POPULATION BY REGION



Source: United Nations, Department of Economic and Social Affairs, Population Division (2011).

Social Affairs, 2009). Data from 15 industrialized countries between 2006 and 2008 suggest the average duration of marriage ranges from 10 to 17 years. Additionally, approximately one in four registered marriages in countries belonging to the Organisation for Economic Co-operation and Development is a remarriage.

Adults are entering, staying, and ending partnerships very differently from previous generations, and their needs for family planning education and services have taken on new characteristics. Family planning policies and programmes have an opportunity to rethink their focus so as not to exclude unmarried people, whether they are never-married, divorced, separated—temporarily or permanently—or widowed.

In both developed and developing countries, social norms—to varying degrees—promote abstaining from sexual activity until marriage. Despite broader support for comprehensive sex education in many settings, the abstinence-until-marriage approach to family planning can compromise the effectiveness of in-school sexuality education programmes and neglects the sexual health needs of single, sexually active adolescents and young adults. Evidence shows that the abstinence-only-until-marriage style of sexuality education is not effective (Kirby, 2008).

"Family planning" usually focuses on the needs of younger married persons, generally the most fertile. Yet a growing number of older women and men have to negotiate contraceptive use and protect themselves from sexually transmitted infections later in life, often *after* marriage (Organisation for Economic Co-operation and Development, 2010). The desire for sexual relationships among older people (over age 49) is largely overlooked in policy and programme design. This omission compromises the rights of sexually active elders who wish to protect themselves from harmful sexual and reproductive health outcomes, including higher-risk unintended pregnancies and protection from sexually transmitted infections, including HIV. Meeting their family planning needs requires challenging the pervasive assumption that older people are not sexually active and do not need to exercise the right to family planning.

▲ *Contraceptives at the Egyptian Family Planning Association in Abo Attwa town, near Ismailiyah.*
©UNFPA/Matthew Cassel

Greater numbers of older women and men are entering their late reproductive years as single, divorced, or widowed, creating a large population of people who are "post-marriage." Research in Thailand has described the vulnerability of older men to HIV (Van Landingham and Knodel, 2007), but family planning research has not touched on this area. The sexual health needs of older women and men are often neglected because, like adolescence, sex outside marriage for pleasure and intimacy challenges social norms about who should have sex and

when. The proportion of never-married adults is steadily increasing in all parts of the world, placing new obligations on States to meet the family planning needs of older people (United Nations, Department of Economic and Social Affairs, 2009). In their older years, women and men have unmet need for "mature-friendly" services.

Male fertility declines very gradually over a period of many years (Guttmacher Institute, 2003, cited in Barker and Pawlak, 2011). Fertile long after females, older men often lack support for preventing high-risk pregnancies in their relationships, many of which occur with younger women. With greater numbers of single men and women having sex *after* marriage and marital dissolution, a complementary focus on educating older men about the benefits and availability of *all* methods, including condoms and no-scalpel vasectomy, could empower elders with resources to prevent unintended, high-risk pregnancies in older age, thereby protecting older women's right to health.

LOW RATES OF UNINTENDED PREGNANCY AND ABORTION AMONG YOUNG PEOPLE IN THE NETHERLANDS

The Netherlands has addressed the obstacles to young people's access in a variety of ways (Greene, Rasekh and Amen, 2002). Among the changes of note were: Comprehensive sex education in primary and secondary schools that includes instruction on relationships, values clarification, sexual development, skills for managing healthy sexuality, and tolerance for diversity, for which teachers receive regular training in content and instructional approaches; the provision of quality information to parents, family doctors, youth-friendly clinics and the media; patient-doctor confidentiality, even among young adolescents; and explicit and humorous national campaigns on sexual health. The theme running through the policy commitment to youth sexual and reproductive health in the Netherlands is that laws should address reality, not ideology (Ketting, 1994). In short, the government responded to the needs and rights of young people with policies that ensure their access to information and services. The Netherlands now has among the lowest rates of unintended pregnancy and abortion in the world.

3 Males

Men and women in heterosexual relationships can be partners in discussing the timing and spacing of children. Nonetheless, the needs and participation of men and boys in family planning has received little attention relative to their roles as supportive partners for women's health (Barker and Pawlak, 2011). Considering the evidence and the increased awareness about the importance of engaging men and boys in health and gender equality, national responses to the interlinked family planning needs of both women and men remain limited in scale and in scope (Barker et al., 2010).

A growing body of evidence over the last 20 years has demonstrated that harmful gender norms influence attitudes and behaviours among boys and men, with negative consequences for women and girls and men and boys themselves (Barker, Ricardo and Nascimento, 2007; Barker et al., 2011). This same programme research across diverse settings has noted that boys and men can and often do adopt gender-equitable attitudes and behaviours that support improved health for themselves, their partners, and their families. This insight is increasingly informing family planning policies and programmes.

In addition, several international conventions and agreements including the Programme of Action of the ICPD affirm the importance of men's participation in family life, including sexual and reproductive health and family planning. More governments now engage in policy dialogue around men's roles in sexual and reproductive health, and greater numbers of development practitioners integrate gender into programme designs.

The international community has acknowledged that male partners can exert considerable influence in couples' fertility preferences (UNFPA, 1994; Bankole and Singh, 1998).

Many institutions, providers, and civil society organizations must, however, still overcome the persistent, common perception that boys and men are merely disinterested in family planning. Men and boys are often trained from an early age to view fertility matters as women's responsibility. And even when men do want to play more of a role, they are often sidelined by services. Research into the ways gender norms influence boys and men has challenged stereotypes about their attitudes and behaviours, highlighting opportunities for health promotion and efforts to achieve gender equality.

Men's sexual behaviours vary considerably across regions. For example, men vary in the timing of their sexual activity. The latest available demographic and household survey data from 30 countries suggest that young men continue to have sex years before they marry (IFC Macro DHS Statcompiler). The gaps between age at first intercourse and age at marriage range from 1.1 years in South and Southeast Asia to 6.8 years in Latin America and the Caribbean. In sub-Saharan Africa, young men marry 4.8 years after they first have sex.

When adolescents and male youth are not reached with appropriate information and services during this interval between first intercourse and when they enter a formal union, they—like their partners—are at increased risk of sexually transmitted infections and unintended pregnancy. Couples-based family planning programmes that heavily rely on links to maternal health are less likely to reach these men.

Partly because of HIV prevention efforts, young men have become increasingly aware of contraceptive methods available to them (Abraham, Adamu and Deresse, 2010). Men in unions are more likely to know about the contraceptive methods available to them; in recent years they have become more aware of condoms, while vasectomy remains relatively unknown.

Even though men are increasingly aware of male methods of contraception, women still account for 75 per cent of global contraceptive use (United Nations, 2011). In 2009, the United Nations reported that only 9 per cent of married women in developing regions relied on methods of contraception that required male participation, such as condoms and male sterilization (United Nations, 2009).

Men's fertility preferences have changed over time. Today, young men generally wish to have smaller families. As a result, young and adult men may have an increasing desire for information and services that help them choose when to have children (Guttmacher Institute, 2003).

Contraceptive use among young men (ages 15 to 24) worldwide varies significantly, with

▼ *Man in Kinaaba, Uganda holds his child while his wife receives injection of long-acting contraceptive.*
©UNFPA/Omar Gharzeddine

63 per cent to 93 per cent of young men reporting using contraception in parts of North America, Europe, and Latin America and the Caribbean (United Nations, 2007). These figures stand in stark contrast with most sub-Saharan African countries, where less than 50 per cent of young, sexually active men used a condom at last sex. Globally, female sterilization remains the most commonly used method, chosen by 20 per cent of married women (United Nations, 2011). The figure is much higher in some countries depending on fertility patterns and the range of reversible methods available to women.

> Countries, with the support of the international community, should protect and promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies ... Governments, in collaboration with non-governmental organizations, are urged to meet the special needs of adolescents and to establish appropriate programmes to respond to those needs. Such programmes should include support mechanisms for the education and counseling of adolescents in the areas of gender relations and equality, violence against adolescents, responsible sexual behaviour, responsible family-planning practice, family life, reproductive health, sexually transmitted diseases, HIV infection and AIDS prevention.
>
> — ICPD Programme of Action, paragraphs 7.46 and 7.47.

The international community has more thoroughly cultivated men's engagement in the context of HIV prevention, and community-based prevention efforts have contributed to increased uptake of male condoms. Yet the World Health Organization reports that less than a third (31 per cent) of young men in developing countries have a "thorough and accurate" understanding of HIV, suggesting that more support for men's sexual and reproductive health, including sexuality education and contraceptives, is needed (United Nations, 2009b).

Men are increasingly expressing a desire to be more engaged in planning their families, including reducing the number of unplanned pregnancies (Barker and Pawlak, 2011). Up to 50 per cent of men in some countries—Brazil, Germany, Mexico, Spain, and the United States—would consider hormone-based contraception if such male methods became available (Glasier, 2010). Involving men of reproductive age in family planning programmes from an early age can promote more constructive communication between couples about the timing and spacing of children.

4 Other marginalized groups

Indigenous people and ethnic minorities. Indigenous peoples and ethnic minorities often lack access to family planning. Results from qualitative interviews find that providers themselves express difficulties assisting ethnic and indigenous women, often because of an inability to adequately communicate or understand their cultural practices (Silva and Batista, 2010; Cooper, 2005). Prejudice against these groups can lead to lower levels of investment in their sexual and reproductive health (United Nations Economic and Social Council, 2009).

The harmful consequences of government under-investment are reflected in large disparities between indigenous and non-indigenous women on key reproductive and maternal health indicators. These include maternal mortality rates, total fertility rates and unmet need for family planning (Silva and Batista, 2010).

Significant health-related inequalities exist between indigenous and non-indigenous groups in several countries around the world. In Guatemala, for example, where indigenous

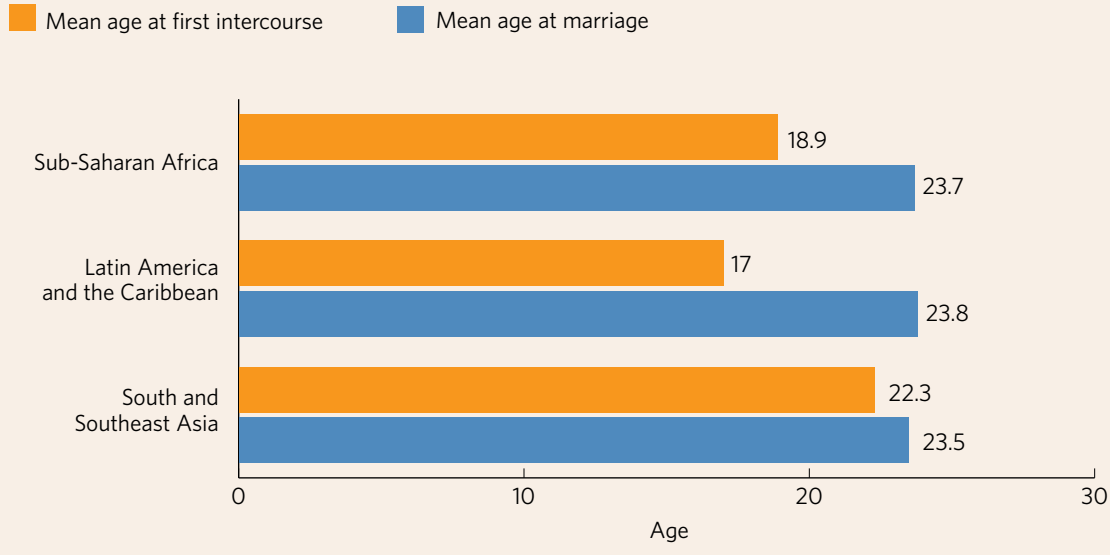
groups (Maya, Xinka, and Garifuna) account for nearly 40 per cent of the total population and 75 per cent of its poor, 39 per cent of married indigenous women ages 15–49 have an unmet need for family planning and are therefore unable to exercise their right to family planning (Guatemala Ministry of Public Health and Social Assistance, 2003). In contrast, 22 per cent of non-indigenous women have an unmet need for family planning. These disparities in access to services contribute to the high fertility rate (6.1) among indigenous women who are also at greater risk of maternal death compared to non-indigenous women.

CASE STUDY

UNFPA and indigenous groups in Latin America

In order to address the high maternal and infant mortality among indigenous women, youth and adolescent girls, UNFPA has been working to increase their access to quality, safe and culturally acceptable maternal, newborn and reproductive health services, including family planning (UNFPA, 2012d). In so doing, UNFPA has been promoting intercultural dialogue among traditional health systems with national, predominantly Western allopathic health systems,

NEED FOR FAMILY PLANNING REFLECTED IN MULTI-YEAR GAP BETWEEN MEN'S AGE AT FIRST INTERCOURSE AND AGE AT MARRIAGE



- In sub-Saharan Africa, young men have sex approximately five years before they marry
- In Latin America and the Caribbean, young men on average have sex before their 18th birthday, and then wait nearly seven years before marrying
- In South and Southeast Asia, the gap (1.1 years) between men's self-reported age at first intercourse and their age at marriage is significantly less compared to other regions.

Source: Select countries with latest available demographic and health survey data, data: IFC Macro DHS Statcompiler

FAMILY PLANNING IN HUMANITARIAN SETTINGS: SOMALIA

Women in Somalia have the highest fertility rates in the world, averaging more than six children each (United Nations Population Fund, 2012b). In spite of conflict, famine and high maternal, infant and child mortality rates, the country's population has nearly tripled in the past 50 years. In this pastoralist society, where so many have been lost to war, children have enormous value.

Throughout the past two decades of conflict in Somalia and the lack of a functioning central government since 1991, international attention has centred on resolving the political crisis and delivering emergency relief. In this context, developing the programmes and healthcare infrastructure necessary to generate and fulfil a demand for family planning has not been a priority.

Some believe that the only way to effectively communicate about family planning to Somalis, most of them devout sunni Muslims, is through religion. Partnering with faith-based organizations can alleviate the religious and social pressures on women who practice child spacing. Traditional methods such as withdrawal and exclusive breastfeeding are most easily accepted in Somali society. UNFPA is collaborating with non-governmental and governmental organizations to deliver essential reproductive health supplies and services. With the worst of the famine now over, Somalia faces an opportunity to focus on family planning programmes as a way to safeguard the well-being of future generations.

while also supporting community-based interventions that mobilize communities to save women's lives. The "cultural brokerage" roles that indigenous authorities and leaders, including traditional birth attendants, play are fundamental in this process.

UNFPA has also contributed to advancing knowledge on indigenous peoples at the regional and country level through qualitative and quantitative studies, advocating for the inclusion of indigenous peoples issues in population and housing censuses, and assisting in the improvement of health registries and other administrative records.

Persons with disabilities. The Convention on the Rights of Persons with Disabilities recognizes their specific rights and outlines corresponding State obligations. The Convention specifies that persons with disabilities enjoy legal capacity on an equal basis with others (Article 12), have the right to marry and found a family and retain their fertility (Article 23), and have access to sexual and reproductive health care (Article 25).

Research finds that persons with disabilities experience discrimination that violates their rights and social biases that restrict their abilities to academically, professionally, and personally excel (World Health Organization, 2011). Furthermore, disabled persons experience poorer socioeconomic outcomes and poverty (Scheer et al., 2003; European Commission, 2008).

Worldwide, the belief that disabled persons are asexual or should have their sexuality and fertility controlled is commonplace (World Health Organization, 2009). But persons with disabilities are sexually active, and studies have documented significant other unmet needs for family planning (Maart and Jelsma, 2010; World Health Organization, 2009). Despite legal prohibitions that grant disabled persons the right to plan and time pregnancies, disabled persons are more likely to be excluded from sex education programmes (Rohleder et al., 2009; Tanzanian Commission for AIDS, 2009). Studies have also documented cases of involuntary sterilizations of disabled women (Servais, 2006; Grover, 2002). Non-consensual sterilization is against international human rights standards.

People living with HIV. Research in both developed and developing countries suggests that HIV status does not repress the desire to have children (Rutenberg et al., 2006). The specific considerations of women and men

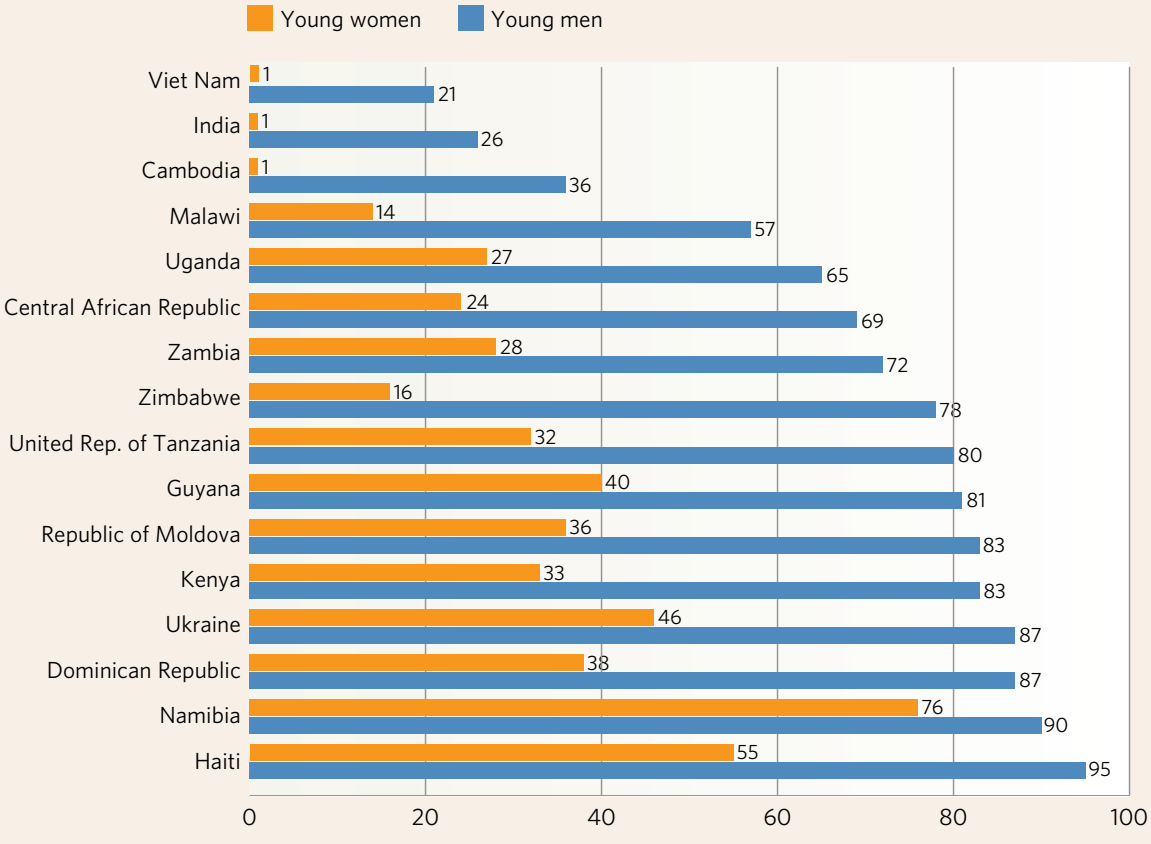
who are living with HIV and are considering pregnancy remain linked to the stigma and discrimination they encounter from their families, community or health system (Oosterhoff et al., 2008).

For women and men with access to antiretroviral treatment, a diagnosis of HIV can now be managed largely as a chronic disease. Even though universal access to life-saving treatments has not been achieved in all parts of the world, the international community has made considerable progress towards expanding access. In low- and middle-income countries, the number of people receiving treatment has reached 6.65 million, representing a 16-fold increase within seven years (World Health Organization, 2011). As progress towards universal access to antiretroviral treatment continues, more people who live

YOUNG MEN ARE MORE LIKELY THAN YOUNG WOMEN TO HAVE HIGH-RISK SEX WITH A NON-MARITAL, NON-COHABITING PARTNER IN THE LAST 12 MONTHS

(PER CENT OF YOUNG PEOPLE 15-24)

Implications for family planning: married and unmarried people need access to contraception to prevent unintended pregnancies



Source: AIS, DHS, MICS and other national household surveys, 2005-2009. For each country, data refer to the most recent year available in the specified period.

Patience Mapfumo, 37, from Zimbabwe, with her five-year-old son Josphat who was born HIV free.

POLICIES LIMITING FAMILY PLANNING

Criminalization of emergency contraception in Honduras

In April of 2012, the Honduran Congress passed a law imposing criminal punishment on medical personnel who distribute emergency contraception, including information about emergency contraception. Any woman who uses or attempts to use emergency contraception to prevent an unintended pregnancy is in violation of the law. The legislation applies to all women, including female rape survivors.

Restrictions on family planning in Manila City

For over 10 years, a ban on modern contraception in the city of Manila, the Philippines, denied women access to family planning. The mayor of Manila passed an executive order in 2000 discouraging the use of artificial methods of contraception like condoms, pills, intrauterine devices, surgical sterilization, and other methods. Health care centres that receive funding from the city are prohibited from providing modern contraception.

In 2008, plaintiffs brought a case against the city, challenging the constitutionality of the ban and arguing that it violates the Philippines' obligations under international law. The case was dismissed, appealed and then dismissed again by the Supreme Court. The case was re-filed in April 2009 at the Regional Trial Court in Manila City.

Sources: International Consortium for Emergency Contraception, 2012; Center for Reproductive Rights, 2012; Center for Reproductive Rights, 2010; EnGendeRights, 2009.

with HIV will seek ways to express their sexuality and to plan their families.

Women and men who live with HIV report intense pressure from family, community leaders, and health providers to abandon their desire to have children. Most justifications for this pressure are related to concerns about the risk of perinatal HIV transmission or about the welfare of children, whose parents may prematurely die of AIDS (Cooper et al., 2005; IPPF, 2005). As people with HIV increasingly live longer lives, more are considering becoming parents. In most societies, childbearing is a pivotal component of social identity for women and men; "healthy people" are often expected to have children as part of familial or community pressures.

Stigma about the pregnancy intentions of HIV-positive people varies in different contexts. Studies in Zimbabwe, for example, find that women may want children but do not feel safe enough to realize their desires, fearing potential backlash from the community in particular because of potential transmission of HIV to their children (Feldman and Maposhere, 2003; Craft et al., 2007). Other studies from Côte d'Ivoire and South Africa have shown that some women want to become pregnant precisely to avoid the stigma of childlessness, based not only on social expectations that women should become mothers, but also because avoiding pregnancy is often interpreted as a sign of HIV-positive status (Aka-Dago-Akribi et al., 1999).

Because condoms are the most widely available contraceptive method that also protects against HIV transmission, the World Health Organization recommends that men and women with HIV who are seeking to avoid pregnancy use condoms, with or without another contraceptive method (World Health Organization, 2012; Cooper et al., 2007).

Studies suggest that HIV may have adverse effects on both male and female fertility (Lyerly, Drapkin and Anderson, 2001). Moreover, among discordant couples—relationships in which one person is HIV positive and the other is not—the ways to safely pursue having children vary. Artificial insemination can reduce the risk of infection when the woman is HIV-positive. When the male partner lives with HIV, pursuing pregnancy can be more complicated, problematic, and costly (Semprini, Fiore and Pardi, 1997).

"Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed."

— ICPD Programme of Action, 1994, paragraph 7.3

The poor. Although sexual and reproductive health outcomes have improved over the last 20 years, they vary according to income levels (UNFPA, 2010). This widening gap has increased the number of people who are unable to exercise the right to family planning. Moreover, research finds that a disproportionate amount of public spending on health and education is allocated towards wealthier sectors of society, thereby exacerbating the likelihood that present-day inequalities will continue to widen among and within countries (Gwatkin, Wagstaff and Yazbeck, 2005).

Demographic and Health Surveys from 24 sub-Saharan African countries find that the poorest and least educated women have "lost ground," with poor adolescent girls having the lowest levels of sustained contraceptive use and the highest unmet need for family planning (UNFPA, 2010). For example, only 10 per cent of those belonging to the poorest households use contraception, compared to 38 per cent of women belonging to the wealthiest households.

Social exclusion makes it harder for poor people to access family planning information and services, compared to individuals of higher socioeconomic status. These disparities compromise women's health, men's and women's rights, and undermine poverty reduction efforts (Greene and Merrick, 2005). For example, research finds that birth rates have increased among the least educated, poor adolescent girls who often live in rural communities (UNFPA, 2010). In contrast, more educated adolescent girls who live in the wealthiest 60 per cent of households in urban areas have experienced low and declining birth rates since 2000.

Hard-to-reach persons in rural or urban communities. In most developing countries, national measures of poverty are highly correlated with place of residence; urban households tend to be weathier than rural households (Bloom and Canning, 2003a). Hard-to-reach communities vary across countries, but where people live influences their ability to access family planning.

In some settings, women and men in rural areas are unable to routinely access quality family planning information and services. On average, for example, poor women in rural sub-Saharan Africa have a contraceptive prevalence rate of 17 per cent, compared to 34 per cent for their urban peers (United Nations Population Fund, 2010). Relative differences

"... culture influences the status of women's reproductive health through determination of the age and modalities of sexuality, marriage patterns, the spacing and number of children, puberty rites, decision-making mechanisms and their ability to control resources, among others. Societal and cultural gender stereotypes and roles also explain why so many adolescent boys and men remain on the fringes of sexual and reproductive health policies and programmes, despite their key role in this realm and their own needs for information and services."

— UNFPA Family Planning Strategy, 2012

also exist within rural communities, and national income quintile assessments can mask the relative disparities within rural and urban communities. For example, research from Latin America and sub-Saharan Africa finds that when adjusted quintiles for rural communities are used to examine family planning indicators, women from the wealthiest quintiles within their rural communities are more able to access family planning services (Foreit, 2012).

In other settings, the rapid expansion of urban areas has also outpaced governments' abilities to develop the infrastructure to provide the urban poor with quality family planning. More than half of the world's population now lives in urban areas, and in the coming decades, almost all global population growth will occur in towns and cities, with most urban growth concentrated in Africa and Asia (United Nations Population Fund, 2007). Two-thirds of Africa's urban population lives in informal settlements, where a lack of infrastructure and the threat of violence impede women's use of transportation and health services (UN Habitat, 2003; Taylor, 2011). Many urban pregnancies in developing countries are unintended; there is a 30 per cent to 40 per cent difference in contraceptive prevalence between women in the richest and poorest urban households (Ezeh, Kodzi and Emina, 2010).

Stock-outs, disruptions in supply chains, and costs contribute to unmet need in hard-to-reach, underserved communities in both urban and rural settings. Additionally, a lack of targeted information relating to the needs of people who live in isolated rural areas and densely populated urban communities are among key factors contributing to lower levels of contraceptive use and higher unmet need (Ezeh, Kodzi and Emina, 2010).

Migrants, refugees and displaced people. Migration and displacement, the movement of persons from one area to another has become increasingly commonplace. The total number of international migrants has increased over the last eight years from an estimated 150 million in 2000 to 214 million persons in 2008 (UN Department of Economic and Social Affairs, 2008a). The reasons for migration and displacement within and across borders vary, but whether forced or voluntary, for political, economic, social or environmental reasons, the World Health Organization notes that the large numbers of people whose place of residence has shifted present the international community

STRENGTHENING INTEGRATION OF HIV AND SEXUAL AND REPRODUCTIVE HEALTH IN ZIMBABWE

Women and girls of reproductive age have been hardest hit by the HIV epidemic in Zimbabwe: prevalence among pregnant women is high, and HIV and AIDS are responsible for about one in four maternal deaths. In 2010, an assessment of sexual and reproductive health and HIV/AIDS policies and programmes found that inadequate integration of sexual and reproductive health and HIV programmes diminished health providers' capacities to respond to women's and girls' unmet need for family planning. In collaboration with UNFPA, the World Health Organization and UNICEF, the Ministry of Health and Child Welfare is closing the gap by developing new integrated service-delivery guidelines and training service providers.

with a public health challenge (World Health Organization, 2003).

International human rights instruments explicitly recognize that human rights, including the right to health and family planning, apply to all persons including migrants, refugees and other non-nationals (World Health Organization, 2003). The denial of these rights for socially excluded migrants and displaced persons makes them unable to fully benefit from health services, including family planning. Women (and men, as evidence is starting to show) are also vulnerable to sexual violence from soldiers, guards, recipient community members and other refugees and are therefore at risk of unwanted pregnancy (United Nation's High Commissioner for Refugees and Women's Refugee Commission, 2011).

According to migrants and displaced persons in developed and developing countries, a lack of information about their rights and available services is among the key reasons given for not accessing health services (Braunschweig and Carballo, 2001). For example, a national review of several Western European countries noted that the rates of maternal mortality and morbidity are higher among immigrant women—outcomes are associated with lower levels of access to contraceptives (Kamphausen, 2000).

A study by the United Nations High Commissioner for Refugees and the Women's Refugee Commission in Djibouti, Jordan, Kenya, Malaysia and Uganda in 2011 found that people who live in refugee settings report lower contraceptive use and greater difficulty accessing information and services, especially adolescent girls and boys (United Nations High Commissioner for Refugees and Women's Refugee Commission, 2011).

FAMILY PLANNING AND A SATISFYING SEX LIFE

According to paragraph 7.2 of the Programme of Action of the International Conference on Population and Development, reproductive health implies "that people are able to have a satisfying and safe sex life... It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases." This comprehensive notion of reproductive health—one that includes a satisfying and safe sex life—has been taken into account in a number of family planning programmes.

CASE STUDY

Family planning classes in Iran

The Islamic Republic of Iran has required that all couples intending to marry attend a pre-marital counselling course and undergo medical examinations. In order for couples to obtain the results of these exams and register their marriages, couples must attend a two-hour class that covers issues of family planning, disease prevention and most importantly, the emotional and social relationships involved in marriage. The Islamic Republic of Iran has prioritized discussion of "sexual and emotional issues," in part as a consequence of having observed high divorce rates. Since its inception, the family planning programme in the Islamic Republic of Iran has been one of the most successful in the world, achieving a contraceptive prevalence rate of about 81.6 per cent.

CASE STUDY

Fear of unintended pregnancy in Mexico

According to a 2008 study of one traditional community in Mexico (Hirsch 2008: 101), women's religious beliefs prevented them from using family planning (sterilization was the main method available to them) for most of their reproductive lives. These women were therefore often worried about unintended pregnancies. Only late in life, after their reproductive years, did the women have the "possibility of enjoying sexual intimacy free from the worry of an unintended or unwanted pregnancy."

CASE STUDY

HIV, sex and condom use

Some men's resistance to using condoms has been recognized as an obstacle to use of this method of contraception and HIV prevention (UNAIDS 2000). But the approach to encouraging women to use the method has shifted considerably since the beginning of the HIV/AIDS epidemic (Higgins and Hirsch 2007). Many programmes emphasize building women's negotiation skills, in recognition of men's resistance. But we know little about *women's* sexual resistance to male condoms. Research in the United States, however, found that *more women than men disliked the feeling of male condoms* (Higgins and Hirsch 2008).

CASE STUDY

Expanding family planning in humanitarian settings

As part of the emergency response in South Sudan, UNFPA delivered supplies for oral and injectable contraception and insertion of intrauterine devices and other family planning commodities (United Nations Population Fund, 2011a). And in collaboration with the American Refugee Committee, UNFPA contributed to training health care workers, community distribution workers and peer educators on family planning.

Strategies and programmes often fail to fulfil the family planning needs of refugees and internally displaced populations who take refuge away from home for varying lengths of time. A focus on the emergency provision of shelter, food, and basic health services has not always included targeted programming to deliver essential reproductive health information and services. In recent years however, humanitarian inter-agency working groups have developed resources and tools to help humanitarian personnel generate demand for family planning and ensure refugees' right to family planning is met.

Sex workers. Sex workers not only have a right to time and space their children, but also to rely on condoms as a means of protecting themselves from sexually transmitted infections including HIV. However, sex workers often face social stigma and discrimination, which subsequently inhibit them from accessing family planning information and services (Lin, 2007).

Social norms often classify sex work as being immoral, and the institutions and individuals responsible for law enforcement and health may reinforce discriminatory attitudes and practices, with harmful effects on sex workers. For example, in some countries such as Lebanon and the Philippines, stigma against sex work and non-marital sex has been used to pass legislation that prevents people from freely possessing condoms (Human Rights Watch, 2004; World Health Organization, 2005). As a result, sex workers often perceive that health systems are non-responsive to their needs, including denying them access to the full range of available contraceptives.

Studies affirm that when sex workers access family planning services, they often do so reluctantly and fall victim to the biases of health-care workers who neglect their sexual and reproductive health needs, focusing primarily on the risk of HIV and sexually transmitted infections (Lin, 2007; Human Rights Watch, 2004). There are documented cases of providers in South Asia and South East Asia being accused of exposing HIV statuses and threatening to report those with HIV to the authorities (Mgbako et al., 2008).

The consequences of the stigmatization of sex workers violate universal human rights. According to the World Health Organization, "interventions to promote safer sex among sex workers must be part of an overall effort to ensure their safety, promote their health and well-being more broadly and protect their human rights" (World Health Organization, 2005).

Lesbian, gay, bisexual and transgendered people. State-run family planning programmes largely neglect the needs of those who identify themselves as lesbian, gay, bisexual and transgendered. The United Nations High Commissioner for Human Rights has affirmed that, "discrimination on the basis of sexual orientation is contrary to international human rights law" (United Nations High Commissioner for Human Rights, 2008). However, in most places it is heterosexuals who are privileged in

▲ *Nujoud, Sana'a, Yemen, was married to her husband, more than 20 years her senior, when she was only 10 years old. They are now divorced.*
©VII/Stephanie Sinclair

State-run family planning programmes. Some of these individuals may seek to prevent unintended pregnancies. For example, men who have sex with men and bisexuals may choose to engage in heterosexual sex without wishing to have children. In other situations, lesbians and gay men may wish to plan families. Sexual violence against people based on their perceived or actual sexual orientation makes women vulnerable to unintended pregnancy as a result of rape, requiring access to emergency contraception.

Child brides. Despite declines in rates of early marriage, the practice of marrying girls before the age of 18—the internationally agreed age of adulthood—remains widespread sub-Saharan Africa and South Asia. It remains relatively uncommon for young men. Estimates suggest that 34 per cent of women between the ages of 20 and 24 in developing countries were married or in a union before their eighteenth birthday. In 2010, this was equivalent to almost 67 million women. Social expectations, including the expectation that girls will marry early, shape girls' sexual behaviour, compromising their school performance, and making them vulnerable to early marriage.

Child marriage leads to the initiation of sexual activity during a period when girls know little about their bodies, their sexual and reproductive health, and their right to family planning. Child wives are also under intense social pressure to prove their fertility, which makes them more likely to have early and closely-spaced pregnancies. Even when child wives have accurate, comprehensive knowledge about how to prevent early

pregnancy, their inability to negotiate contraceptive use with their (usually older) husbands, or to access services contribute to high levels of childbearing in adolescence.

Few family planning programmes include strategies for reaching child brides who are often isolated, without well-developed social networks, and vulnerable to many adverse maternal health outcomes associated with early pregnancy and childbirth. This is another important area for investment. (Malhotra et al., 2011; Bruce and Clark, 2003; UNFPA, 2009; Lloyd, 2009; World Health Organization, 2008; Lam, Marteleto and Ranchhod, 2009; Levine et al, 2008; Mensch, Bruce and Greene, 1999.)

COUNTRIES WITH THE HIGHEST RATES OF CHILD MARRIAGE

Country	Per cent girls married before age 18
Niger	75%
Chad	72%
Bangladesh	66%
Guinea	63%
Central African Republic	61%
Mali	55%
Mozambique	52%
Malawi	50%
Madagascar	48%
Sierra Leone	48%
Burkina Faso	48%
India	47%
Eritrea	47%
Uganda	46%
Somalia	45%
Nicaragua	43%
Zambia	42%
Ethiopia	41%
Nepal	41%
Dominican Republic	40%

Source: UNFPA, 2012

Poor quality as an obstacle to family planning use

When services are unreliable or delivered by untrained personnel, or when a full range of contraceptives and information is unavailable, people with unmet need may choose not to take advantage of family planning and are therefore unable to exercise their right to it.

Health systems in many countries struggle to meet the challenge of managing their human resources effectively, making sure that infrastructure is adequate to the task of providing services and ensuring the supply of adequate materials and equipment of all kinds. People living in rural areas are especially vulnerable to weaknesses in the health system that can leave them beyond the reach of services available to people in towns and cities.

One consequence of poor guidance on a rights-based approach to health and weak management of staff can be the biased and discriminatory attitudes of health workers. Some providers internalize social biases towards minority populations. Health workers' attitudes can affect the quality of information given to specific clients, resulting in a lack of informed choice and options.

A lack of privacy and inability to communicate are barriers to service delivery for some groups. A recent multi-country study found that health programmes in refugee camps did not ensure the right to privacy, confidentiality, and non-discrimination to all, particularly for adolescents and unmarried persons (United Nations High Commissioner for Refugees, 2011). In some settings, internally displaced persons or refugees are often unable to access quality services due to limited commitment to helping

people in mobile, temporary, and resource-poor settings manage their fertility (United Nations High Commissioner for Refugees, 2011).

Potential beneficiaries of family planning services may feel alienated by their providers at moments that compromise their long-term health. For example, in communities with high levels of HIV, alienating experiences among young people from select castes or ethnic groups can dissuade them from accessing services at critical moments in their sexual and reproductive lives (United Nations, Economic and Social Council, 2009a). Ethnic minorities, people from lower castes, and sex workers who may spend considerable portions of their lives in poor, hard-to-reach, or other stigmatized communities do not always benefit from the full range of approaches to distribution (UNHCR, 2011). These include the safe, community-based provision of injectables and intrauterine devices that the World Health Organization has approved for use (World Health Organization, USAID and Family Health International, 2009).

CASE STUDY

Tajikistan

Tajikistan has worked to overcome a lack of information and services, particularly in rural areas. Through the joint efforts of UNFPA and the Ministry of Health, Tajikistan has improved the access of vulnerable populations to family planning. Family planning information and services are being provided in the context of comprehensive and quality reproductive health services and information, a key stipulation of the ICPD Programme of Action. Tajikistan has accomplished this shift through building capacity, conducting awareness-raising campaigns, providing contraceptives and ensuring there is adequate equipment to support quality services. ■

Health extension worker dispenses family planning in an Ethiopian village.
©UNFPA/Antonio Fiorente

CASE STUDY

India

In keeping with its demographic goals, India's family planning programme had in the 1970s established targets for a narrow range of methods and relied on health workers to promote these methods. Many people were pressured or even coerced into using long-term or permanent methods of family planning, and the approach restricted access to the full range of methods. Evidence existed, however, that unmet need could be addressed without resorting to targets by making supply respond more effectively to local needs. In response, the Government developed a new framework that provided family planning in the context of broader reproductive and child health services, and that built on planning at the local level based on an assessment of women's need for services (Murthy et al., 2002). Though shifting a massive national programme is a slow process, increasing the range of methods, managing health workers in a less directive way, and making the programme more responsive to local needs has contributed to increasing demand for family planning. ■

Laws that block family planning can compromise rights and health

Laws and policies that restrict peoples' access and prohibit health professionals from providing sexual and reproductive health services, including family planning, can compromise women's right to health and institutionalize cycles of stigma and discrimination according to Anand Grover, the Human Rights Council's Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. A State that uses laws to regulate peoples' family planning options "coercively substitutes its will for that of the individual."

In the *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Grover called on States to, among other things, remove criminal and other laws restricting access to comprehensive education and information on sexual and reproductive health. He also said that laws and other legal restrictions that reduced or denied access to family planning goods and services, including emergency contraception, violated the right to health and reflected discriminatory notions of women's roles in the family and society.

EXPANDING ACCESS THROUGH CULTURALLY APPROPRIATE, LOCAL SERVICES IN LAO PEOPLE'S DEMOCRATIC REPUBLIC

The Lao People's Democratic Republic is a culturally and ethnically diverse country. Its indigenous communities, which speak four unique languages, account for 40 per cent of the country's total population. The unmet need for family planning among these indigenous populations is significant. With support from UNFPA, the Mother and Child Health Center within the Ministry of Health launched an initiative to provide culturally appropriate and client-friendly family planning services in 2006. The programme has trained villagers to serve as community-based family planning service providers who work with adolescents, young people and married couples. In these communities, contraception use increased from 12 per cent of the population in 2007 to 45 per cent in 2011.

TRAINING FOR PHARMACISTS RESULTS IN MORE RELIABLE SUPPLY OF CONTRACEPTIVES IN MONGOLIA

A lack of specialized training for pharmacists had been a major constraint to reliable supplies of contraceptives and other reproductive health supplies in Mongolia until UNFPA began collaborating with the Ministry of Health and the School of Pharmacy at the Health Sciences University of Mongolia in revising the training curriculum for young pharmacists. Today, more than 350 pharmacists graduate each year with skills needed to dispense contraceptives and help reduce unmet need for family planning.

Conclusion

A number of important population groups are neglected by family planning systems or face sometimes insurmountable barriers: young people, unmarried adults in their central reproductive years, people who are separated from their partners, older men, people with disabilities, refugees, people living with HIV/AIDS, ethnic minorities and other disadvantaged groups. An enormous need exists to provide more systematically and more generously the means to delay and prevent unintended pregnancy.

A human rights-based approach to health and to family planning points to this reorientation. A human-rights framework for policy and programming calls for a focus on fairness and non-discrimination to achieve equality; on reaching the most neglected, often marginalized and vulnerable groups; and on building mechanisms that strengthen monitoring and accountability (UNFPA, 2010). Applying a human rights-based approach requires not only having laws and policies that prohibit and sanction discriminatory practices, but also the

systems and civic participation to implement them and to ensure accountability.

Sexual activity is increasingly taking place in ways that challenge social norms that dictate under what circumstances sex *should* take place. Families, communities, institutions, and governments will have to modify their strategies to ensure that all people, as entitled rights-holders with the right to family planning under international conventions, are able to realize it.

Adolescents, unmarried people of all ages, men and boys, and other socially marginalized groups with restricted access to information and services are among key sub-populations that have not equally benefited from the recent gains in family planning. As a result, unmet need remains relatively high among key populations, and access to family planning is still more akin to a privilege enjoyed by *some* rather than a universal right exercised by *all*.

▲ *British Prime Minister David Cameron and Melinda Gates talk about family planning issues and volunteering with young people at the London Summit on Family Planning.*
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CHAPTER FOUR

The social and economic impact of family planning

Being able to exercise the right to family planning—and more broadly the right to sexual and reproductive health—is instrumental for the realization of other rights and also yields many economic benefits to individuals, households, communities and whole countries. Better reproductive health, including family planning, affects the economy—and therefore sustainable development—in numerous ways. Women who have fewer risky births, healthier pregnancies and safer deliveries face lower risks of mortality and improved overall health. Their babies are born healthier and their children's health is better early in life. These improvements in health produce an array of economic benefits: greater investments in schooling, greater productivity, greater labour force participation and eventually increased income, savings, investment and asset accumulation. There is little evidence, however, about the impact on the lives of men.

Researchers attempting to document the magnitude of these relationships face several hurdles, partly because the use of family planning depends on a variety of other variables, including income, education (particularly female education), opportunities for female employment, the pace of industrialization and urbanization, cultural and social norms and the cost of raising children. These variables are difficult to measure and have strong effects on each other.

Eduardo Mondlane University. Geography class. ©UNFPA/Pedro Sá da Bandeira

Family planning and the well-being of women

Health impact

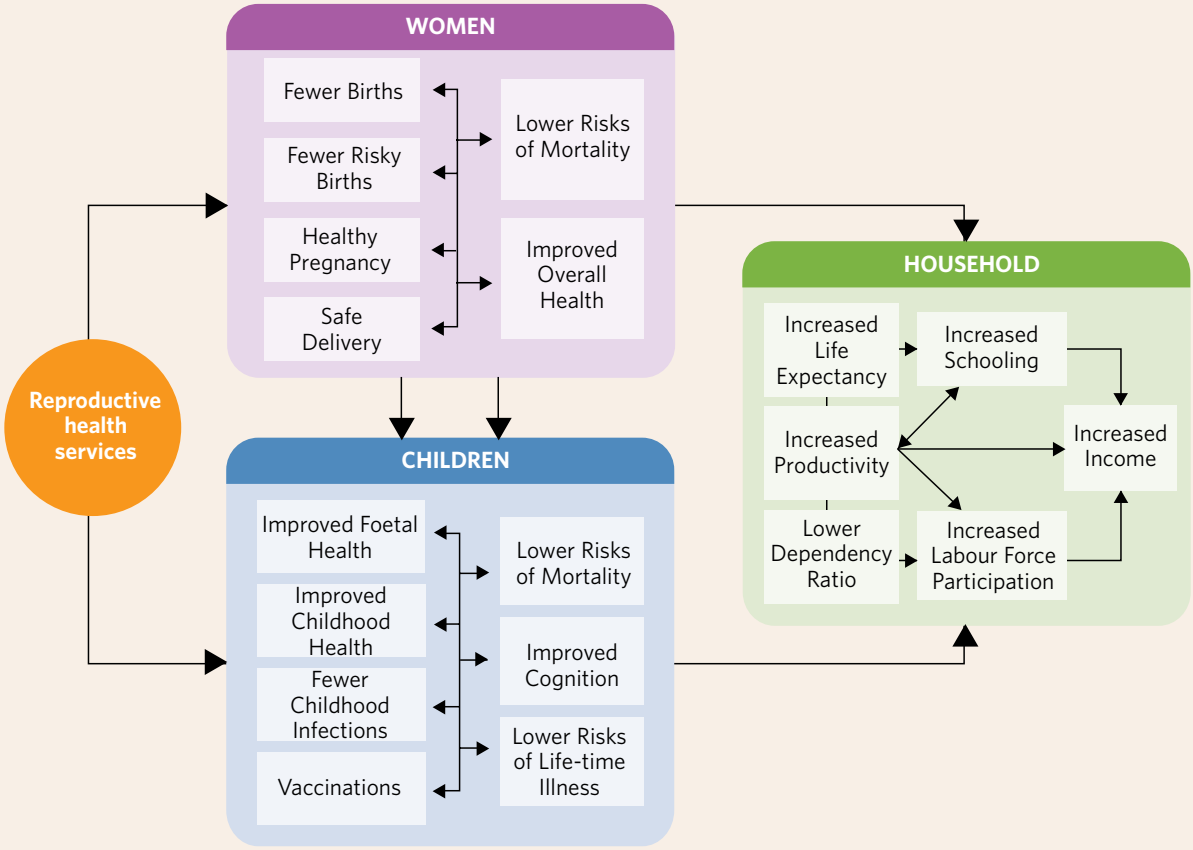
The economic impact of improved reproductive health on women's lives begins with improvements in their own health, in which access to family planning plays a key role. Access to family planning reduces overall fertility, the numbers of unintended pregnancies as well as the number of risky pregnancies, which then reduces the risks of maternal mortality and long-term morbidity (Maine et al., 1996). Access to family planning can also lead to more optimal birth spacing, which in turn improves overall maternal health by lowering maternal depletion syndrome and the risks of premature delivery and complications (Conde-Agudelo, Rosas-Bermudez and Kafury-Goeta, 2007).

In Sri Lanka for example, the sharpest declines in maternal mortality occurred during its period of fertility decline. Today, Sri Lanka has one of the highest contraceptive prevalence

rates, lowest fertility rates, lowest maternal mortality rates and some of the best maternal and child health indicators in the world (Seneviratne and Rajapaksa, 2000).

Some of the most rigorous evidence of the effect of fertility decline on improvements in women's health comes from Matlab, Bangladesh, where a long-term maternal and child-health programme provided doorstep-delivery of contraceptives, pre-natal care, vaccinations, safe-delivery kits and a variety of other health services to women in their homes. Over the course of 30 years, the programme not only reduced fertility by about 15 per cent and improved maternal and child mortality rates, but also had a variety of spillover effects on women's health. Women who were exposed to the programme throughout their reproductive lives experienced increases in their weight, body mass and general health status (Phillips et al., 1988; Muhuri and Preston, 1991; Muhuri, 1995; Muhuri, 1996; Ronsmans and Khlat, 1999; Chowdhury et al., 2007). Studies found that the body-mass index of women who participated in the programme crossed a threshold of 18.5, which is associated with lower mortality risks (World Health Organization, 1995). A recent study argues that a one-point increase in body mass index around this value of 18.5 lowers the hazard of death by 17 per cent (Joshi and Schultz, 2007).

LINKAGES BETWEEN REPRODUCTIVE HEALTH AND ECONOMIC OUTCOMES



Community education in Caracas, Venezuela.
©Panos/Dermot Tatlow

The health benefits of family planning are particularly significant for younger women and adolescents. Women ages 15 to 19 are twice as likely to die from maternal causes as older women as a consequence of their physical immaturity and increased risk of obstetric complications such as obstetric fistula (Miller et al., 2005; Raj et al., 2009).

By averting early pregnancies, reducing risky pregnancies and reducing the risks of premature mortality or long-term morbidity, improved access to family planning can extend life spans, increase the time horizons for the returns to human capital investments and also enable women to reallocate their time towards other economic activities. One research study found that women in Europe and North America have gone from spending 70 per cent of their adult lives bearing and rearing children before the demographic transition, to spending about 14 per cent of it more recently (Lee, 2003).

Impact on schooling

In Colombia, the drop in fertility induced by the Profamilia family planning programme was associated with nearly 0.15 more years of schooling (Miller, 2009). In Sri Lanka, the reduction in maternal mortality risk between 1946 and 1953 increased female life expectancy by 1.5 years (approximately 4 per cent), and this increased female literacy among the affected cohorts by 2.5 per cent (one percentage point) and increased years of schooling by 4 per cent (0.17 years) (Jayachandran and Lleras-Muney, 2009).

The trade-off between schooling and childbearing is particularly important for adolescents, since childbearing can disrupt education and preparation for the labour force. The relationship

▲ *Returning from the field, Kiribati.*
©UNFPA/Ariela Zibiah

between marriage and childbearing differs depending on the setting or country, and the causal relationship between adolescent pregnancies and early school dropout can be difficult to disentangle.

Research using the United States National Longitudinal Survey of Youth found that early sexual intercourse had detrimental effects on girls' performance in school and educational attainment, even when socioeconomic background variables were controlled (Steward, Farkas and Bingenheimer, 2009). Another study in the United States confirms that motherhood during adolescence reduces a girl's chances of obtaining a high school diploma by up to 10 per cent, reduces annual income as a young adult by $1,000 to $2,400, and decreases years of schooling (Fletcher and Wolfe, 2008).

Adolescent pregnancy also obstructs girls' educational achievement in developing countries. Lloyd and Mensch (2008) calculated the cumulative risks in five West African countries of girls' dropping out of school before completing their secondary education. They estimate the cumulative risks of dropping out as a result of adolescent pregnancy (or marriage) to range between 20 per cent in Burkina Faso, Côte d'Ivoire, Guinea and Togo to nearly 40 per cent in Cameroon. One analysis of the impact of adolescent motherhood on high school attendance and completion in Chile finds that being a mother reduces girls' likelihood of attending and completing high school by between 24 per cent and 37 per cent (Kruger et al., 2009).

While some studies find that girls appear more vulnerable to leaving school once they become sexually mature and once they engage in premarital sex, others have concluded that girls are more likely to drop out for reasons other than pregnancy (Biddlecom et al., 2008). In some cases, pregnancy is more likely to be the consequence of early school exit. Evidence from South Africa for example, suggests that poor performance in school is associated with a heightened risk of pregnancy and then a higher risk of dropping out of school. This leads to long-term negative impacts on a woman's education, skills, employment and income (Grant and Hallman, 2006).

Impact on women's labour force participation

Access to reproductive health services, including family planning, also improves women's opportunities to enter the labour force. First, access allows women to control the timing of births and thus expand their participation in labour markets. This is illustrated by the release of Enovid, the first birth control pill, in the United

ESTIMATES OF TOTAL FERTILITY

2010-2015 MEDIAN PROJECTION

Region	Total fertility (children per woman), 2010-2015
World	2.45
More developed regions	1.71
Less developed regions	2.57
Least developed countries	4.10
Less developed regions, excluding least developed countries	2.31
Less developed regions, excluding China	2.86
Africa	4.37
Eastern Africa	4.74
Middle Africa	5.16
Northern Africa	2.75
Southern Africa	2.46
Western Africa	5.22
Asia	2.18
Eastern Asia	1.56
South-Central Asia	2.56
Central Asia	2.46
Southern Asia	2.57
South-Eastern Asia	2.13
Western Asia	2.85
Europe	1.59
Eastern Europe	1.49
Northern Europe	1.86
Southern Europe	1.49
Western Europe	1.69
Latin America and the Caribbean	2.17
Caribbean	2.25
Central America	2.41
South America	2.06
Northern America	2.04
Oceania	2.45

United Nations data estimate that the total fertility rate has fallen below replacement level (2.1 children per woman) in more than 83 countries. Some governments in countries where each generation is now smaller than the one before it are concerned about having fewer workers to tax and greater numbers of elders to support. As greater numbers of individuals and families are able to exercise their right to family planning, national dialogue about family policy, including parental leave, support for care-giving services, and the elimination of discriminatory employment practices against people with young children may be productive. Any adjustments to public policy, however, should not dilute governments' financial and political commitment to ensuring that women and men of all ages have reliable access to quality family planning information and services.

In societies where total fertility has dipped to below replacement levels, individuals and families are not refraining from having children *because* they merely have access to family planning. Rather, they are achieving their desired small family sizes because they have the means of doing so. Access to family planning has increasingly empowered women in particular with the information and services to assert their rights and to carry out their fertility preferences.

States in 1960. The pill afforded American women unprecedented freedom to make simultaneous decisions about childbearing as well as their careers. A causal analysis of the impact of the pill on the timing of first births and women's labour force participation suggests that legal access to the pill before age 21 significantly reduced the likelihood of a first birth before age 22, increased the number of women in the paid labour force, and raised the number of annual hours worked. The effects are significant: from 1970 to 1990 early access to the pill accounted for three of the 20 percentage-point increase (14 per cent) in labour force participation rates and 67 of the 450 increase in annual hours worked (15 per cent) among women between the ages of 16 and 30 (Bailey, 2006).

Access to family planning services also affects labour market participation through the reduction of morbidity and improvement in overall health. Family planning contributes to the reduction of risky and complicated births, and this reduces the risk of maternal morbidity and increases women's productivity.

There are some exceptions to these patterns. In some contexts, female labour force participation can *decrease* as fertility declines or as educational attainment and socioeconomic status increase. In the Matlab project in Bangladesh, for example, the provision of family planning and reproductive health services to adult women in their homes for a period of 20 years resulted in significant improvements in well-being, but female participation in wage employment actually declined. Researchers attribute this phenomenon to strong patriarchal mores and restrictions on female mobility, particularly for wealthy and high-status women, causing some women to work at home instead of performing manual or wage labour outside the home. Estimates indicated, however, that women who did work in paid jobs received wages that were more than one-third higher than their counterparts who had not received programme services. These wage gains were largely driven by the higher returns women received from their schooling in villages covered by the programme (Schultz, 2009a).

Health and income benefits from family planning also bolster women's rights

Declines in fertility, improvements in health and increased incomes can improve women's rights at home and in their communities. A recent study illustrates that when fertility declines and the importance of human capital in the economy increases, men start to be willing to share power with women to ensure that children get better educated, since women invest more in children's human capital and their bargaining power matters for household decisions (Doepke and Tertlit, 2009). Men face a tradeoff between their own utility and the utility of their children, grandchildren, and future generations. This tilts their preferences towards ceding women greater rights. The evidence for this argument is historical: using parliamentary debates and newspaper editorials, the authors document that in both England and the United States there was a gradual shift during the nineteenth century from arguments that concentrated on the rights of men towards a view that gave first priority to the needs of children.

Family planning and the well-being of children

Improved reproductive health services influence child health in several ways. First, the use of family planning services to achieve a reduction in the number of pregnancies and the better spacing of births create positive spillovers because healthier women give birth to healthier

children, and healthier women also have more resources to invest in the well-being of their children (Alderman et al., 2001).

Impact on infant and child health and survival

Many cross-national studies have found a positive relationship between family planning and child survival: users of family planning programmes are more likely to experience lower mortality risks for themselves and their children (Bongaarts, 1987). The relationships however, cannot be interpreted as causal due to confounding factors such as length and intensity of breastfeeding, prematurity, and as yet unspecified biological, behavioural, environmental, socioeconomic, or health-care effects that are known to cause large infant mortality differences between families. A recent study controlled for many of these factors, however, and found that increasing birth intervals can reduce neonatal mortality, infant mortality and child mortality (Rustein, 2005). This study concluded that birth spacing of three to five years alone could prevent up to 46 per cent of infant mortality in developing countries.

Evidence from country-specific programmes confirms this finding. A study from Colombia, for example, illustrates that the local availability of clinics and hospital beds and increased family planning expenditures per capita are associated with lower child mortality as well as lower fertility across women in urban areas (Rosenzweig and Schultz, 1982). In the Philippines, the presence of a family planning programme had direct effects on children's health (Rosenzweig and Wolpin, 1986). Improved access to reproductive health, improved spacing of pregnancies, and a reduction in the number of risky pregnancies in Bangladesh all combined to reduce child mortality and improve child survival (Phillips et al., 1998; Muhuri and Preston, 1991; Muhuri, 1995; Muhuri, 1996; Joshi and Schultz, 2007). Similar impact was seen in a programme in Navrongo, Ghana (Binka, Nazzar and Phillips, 1995; Pence et al., 2001; Phillips et al., 2006; Pence, Nyarko and Phillips, 2007).

▲ *At a family planning workshop in Costa Rica.* ©UNFPA/Alvaro Monge

Recent research has used anthropometric measures of lifetime health as a measure of early-childhood health. An individual's height is a particularly interesting example of this. Adult height is considered as a latent indicator of early nutrition and lifetime health status: children with low birth-weights, for example, achieve lower heights even if they receive additional nutrition in childhood. Though height is determined by genetic makeup, it is realized in part through satisfactory nutrition and health-related care and conditions, particularly in early

childhood. It has increased in recent decades in populations where per capita national income has increased and public health activities have grown. A study from the Laguna province of the Philippines that collected information on heights, weights and exposure to family planning programmes between 1975 and 1979 found that exposure to health programmes and family planning programmes improved children's height-for-age as well as weight-for-age. Their estimates indicate that the height of a child for whom no health clinic existed would be 5 per cent below that for a child always exposed to a clinic, while exposure to a family planning clinic increases height by 7 per cent.

Another important mechanism linking improved family planning services and early-childhood health is the improvement in maternal nutrition that occurs as a result of better-spaced and fewer overall pregnancies. A vast literature in medicine, public health and the social sciences now argues that improved maternal nutrition plays a critical role in child development. Many studies show that maternal under-nutrition—as measured by stunting, wasting, chronic energy deficiencies, essential micronutrient deficiencies and body mass indexes below 18.5 are associated with increased risk of intrauterine growth retardation as well as complications at birth and birth defects (Bhutta et al., 2008). Poor foetal growth can contribute indirectly to neonatal deaths, particularly those due to birth asphyxia and infections (sepsis, pneumonia, and diarrhoea), which together account for more than half of neonatal deaths in the world today.

Declines in fertility and improvements in maternal health are known to be associated with healthier babies with higher birth weights and lower risks of neonatal death. This was seen in community-sampled prospective birth cohorts in Nepal, India, Pakistan and Brazil. The study found that infants born at term weighing 1500–1999 grams were 8.1 times more likely to die, while those weighing 2000–2499 grams were 2.8 times more likely to die from all causes during the neonatal period than were those weighing more than 2499 grams at birth (Bhutta et al., 2008).

Children's schooling

Improved reproductive health and access to family planning can also affect investment in human capital in children. This occurs through several channels. Increases in life expectancy create new incentives and opportunities for investments in schooling. Moreover, improved reproductive health improves overall health of mothers during pregnancy, which has favourable impacts on children's cognitive development. Finally, declines in fertility free up women's resources and allow them to increase investments in schooling for their children.

The best evidence for the relationship between fertility decline, improved reproductive health and children's schooling again comes from Matlab, Bangladesh. Declines in fertility and improved maternal health not only increased investment in the schooling of children but also impacted the trade-offs between children's schooling and labour (Sinha, 2003; Joshi and Schultz, 2007; Schultz, 2010). There is also evidence that the programme also positively impacted children's test scores and cognitive development (Barham, 2009).

Children's future labour force participation

Declines in a mother's fertility, improvements in her health and greater investments in children's human capital should ultimately impact their participation in the labour force. While this link is intuitive and appears to be obvious,

empirical evidence supporting this theory has so far proved to be elusive, largely because of the long time lags between the times that these outcomes are observed.

Further evidence in support of the relationship between mother's health, a child's health and his or her participation in the labour force comes from the studies of maternal nutrition. These studies demonstrate that declines in fertility and improvements in maternal health are associated with not only improved child health, improved cognitive test scores and schooling attainment but also improved occupational status and earnings, reduced non-participation in the labour force, reduced chronic disease and disability before the age of 50, and more notably thereafter (Miguel and Kremer, 2004; Almond 2006; Almond, Edlund, et al., 2007; Almond and Mazumder, 2008; Almond and Currie, 2011).

One recent study used data on monozygotic twins to estimate the effect of intrauterine nutrient intake on adult health and earnings found that health conditions play a major role in determining the world distribution of income (Behrman and Rosenzweig, 2004). The study showed considerable variation in the incidence of low birth weight across countries, and that there are real payoffs to increasing body weight at birth. Increasing birth weight increases adult schooling attainment and adult height for babies at most levels of birth weight. They also find evidence that augmenting birth weight among lower-birth weight babies, but not among higher-birth weight babies, has significant labour market payoffs.

Reproductive health and the wealth and well-being of households

There are several routes through which fertility decline and improved health may be translated into better household social and economic well-being (Bloom and Canning, 2000; Birdsall, Kelley and Sinding, 2001; Schultz, 2008; Sinding, 2009). First, as documented earlier, healthier people work more and are physically and cognitively stronger, and, thus more productive and earn higher incomes and accumulate more assets. Second, healthier people enjoy a longer life expectancy, and thus have greater opportunities to invest in, and reap returns from, their schooling and human capital more broadly. This positive relationship between health and wealth is further reinforced by low fertility and the quantity-quality

▲ *Mobile health clinic in Sri Lanka.*
©UNFPA/FPASL

tradeoff that induces parents to invest more resources into each child when the number of children falls.

Household savings, income and assets

Improved health and longer life-expectancies that can result from better access to reproductive health services, including family planning, alter decisions not only about education, but also about expenditures and savings over an individual's lifetime. With declines in fertility, individuals are less likely to rely on children for old age-support and insurance. They are thus more inclined to save for their own retirement. The impetus to save is further reinforced by improved health and increased life expectancy since retirement becomes a reasonable prospect, and the length of retirement also increases. There is ample evidence to support this relationship between fertility decline and savings rates (Bloom and Canning, 2008). Many studies find a positive correlation between declines in fertility or increases in life expectancy on the one hand, and savings rates on the other.

In Taiwan, Province of China, for example, the private savings rate rose from 5 per cent in the 1950s to over 20 per cent in the 1980s, almost synchronously with improvements in life expectancy (Tsai, Chu and Chung, 2000). This effect is amplified with the adoption of welfare and social security systems.

Some of the best micro-level evidence of the relationship between lower fertility, improved reproductive health, and income comes again from Matlab, Bangladesh (Joshi and Schultz, 2007; Schultz, 2008; Barham, 2009; Schultz, 2009). The overall evidence suggests that declines in fertility and child mortality contributed to poverty alleviation: sons received significantly more schooling, daughters had a better nutritional status, and better educated women had proportionately higher wage rates and lived in households with proportionately greater assets. Households in villages covered by the programme reported 25 per cent more assets per adult, and held smaller shares of household assets in forms which complement child labour, such as livestock and fishing or even land for agricultural annual cultivation. They held a larger share of their assets in financial savings, jewelry, orchards and ponds, housing, and consumer durables, which may be assets that are better substitutes for old age support provided traditionally by children.

Improved access to family planning, declines in fertility, the reduction of maternal mortality and maternal morbidity and the improvement of child health also increase savings and income through the reduction of spending to cope with "health shocks," such as a sudden loss of earnings, the dissolution of households and a reduction in the health of surviving household members, particularly children. Improved health also contributes to economic productivity.

Shifts in intra-household decision-making

The availability of reproductive health services, particularly family planning, also alters power structures within households. In contexts where men and women differ in their fertility preferences, and where family planning services are accessible to women independently, greater control over their fertility translates into greater bargaining power, autonomy and decision-making capacity within the family.

An example of this at the country level comes from Bangladesh. The rapid decline in fertility, from approximately six children per woman in the 1970s to under three children per woman

by the 1990s was accompanied by increases in women's education and labour force participation, particularly in the garment industry (Kabeer 1997; Kabeer 2000). Access to labour markets, credit markets and society more generally allowed these women to renegotiate the norms of *purdah* (female seclusion) that had confined women in previous generations to their homes and limited their voice in patriarchal households.

These processes are also illustrated in a micro-level study of community health-workers in Matlab, Bangladesh, who played a key role in the delivery of reproductive health care and also benefited from employment in the programme. Their own declines in fertility, improvements in health, new employment opportunities and wages combined to increase their status and bargaining power in their homes and their communities (Simmons, 1996).

Access to contraception itself can alter women's bargaining position in their households. This is best illustrated in the case of sub-Saharan Africa. Men and women in this region have historically had divergent preferences regarding ideal numbers of children. While women incur direct physical and economic costs for bearing and supporting children, for men the practice of polygyny and child-fostering spread these costs across multiple households. As a result, women may prefer smaller families than their husbands. Their ability to exercise their preferences however, may be constrained by social norms that favor high fertility and laws that require husband's consent to access contraception.

Declines in fertility and improved health not only provide women opportunities to reallocate time away from child-bearing towards the labour force, but also towards caring for other family members, such as the

Couple waiting for family planning counselling at regional hospital in Cameroon.
© UNFPA/Alain Sibenaler

▲ *Ricardo and Sara in Mexico City say they have decided to wait until they finish school and find jobs before they marry and have children.*
©UNFPA/Ricardo Ramirez Arriola

elderly, as was documented in another study from Matlab, Bangladesh (Chaudhuri, 2005; Chaudhuri, 2009).

Family planning and the well-being of boys and men

The impact of family planning on men's physical health is likely not significant. However, delaying and preventing unintended pregnancies and births can have an impact on their schooling and employment opportunities (Montgomery, 1996). Where a man is obliged to take responsibility for a woman's pregnancy, he may be forced to leave school (though without facing the same social stigma a woman would) in order to work and support the woman. Like most mothers, a responsible father may have to give up opportunities for lucrative employment, accept jobs that are less than ideal, and give up opportunities for career growth and development.

Outside or within marriage, an unintended pregnancy can have an effect on the mental health of both parents, particularly when partners differ in their commitment towards a pregnancy (Leathers and Kelley, 2000). Evidence indicates that the incidence of depression, physical abuse, and other mental health problems are all higher among those who experience unintended pregnancies than where pregnancies are intended. These issues affect not only the men and women concerned, but their children and families (Korenman et al., 2002).

Evidence also suggests that unwanted pregnancies are often associated with higher levels of marital dissolution, lower household incomes, and a variety of negative psychosocial effects on child-development (McLanahan and Sandefur, 1994).

Health, demographic change, the wealth of nations and sustainable development

The impact of improved sexual and reproductive health, including family planning, and

gender equality is much stronger and more direct at the household level than the micro-economic level or the macroeconomic level. But the individual and household impacts of family planning services—lower fertility, improved health, decreased mortality, greater investment in human capital, greater participation in the labour force and increased income and savings—also scale up at the more aggregate levels of communities and countries. These macro-level effects are sometimes difficult to identify because these variables are interrelated and are influenced by an enormous number of additional variables such as the institutional environment, the influence of policy, wars and other major social, economic and political events. Though conclusive evidence of the magnitude of the relationships does not yet exist, some areas of consensus have emerged.

One such area of consensus among economists, demographers and policymakers is recognition of the role of population age structures in economic development. Declines in fertility initially reduce the share of a country's population that is young. For some time, the initial decline in the youth population that is dependent others for their basic needs is not offset by increases in the share of the population that is older and dependent on others. At this point in the demographic transition, the relative size of a country's working-age population increases. This one-time increase in the proportion of the working-age population that coincides with a one-time decrease in "dependency ratios" creates favorable conditions for economic development and is called the "demographic dividend."

At the macroeconomic level, the demographic transition reduces a number of challenges in countries that cannot easily keep up with investing in health and education of a large and rapidly growing youth population, and managing an essentially unlimited supply of labour. The demographic dividend also provides countries with opportunities to increase labour force participation, income, saving, investment, and social change, if policies are in place to invest in the human capital of this young group (via higher per-capita spending on health and education, greater investment in physical infrastructure and institutional development, and support for civic participation, among other things).

"After fertility rates steadily decline over the course of 20 or 30 years, the number of income-generating adults grows relative to the number people who depend on them for support, thus creating more favourable conditions for economic growth and sustainable development."

Demographic dividends have been observed in East and Southeast Asia, Latin America, the Middle East and North Africa, and the Pacific Islands (Lee et al., 2010; Lee, 2003; Lee et al., 2001; Mason and Lee, 2004; Lee and Mason, 2006; Bloom et al., 2009; Schultz, 2009). The dividend began in East Asia in the 1970s, in South Asia in the 1980s and in sub-Saharan Africa in the new millennium.

Macro-level impact of family planning on savings, investment and growth

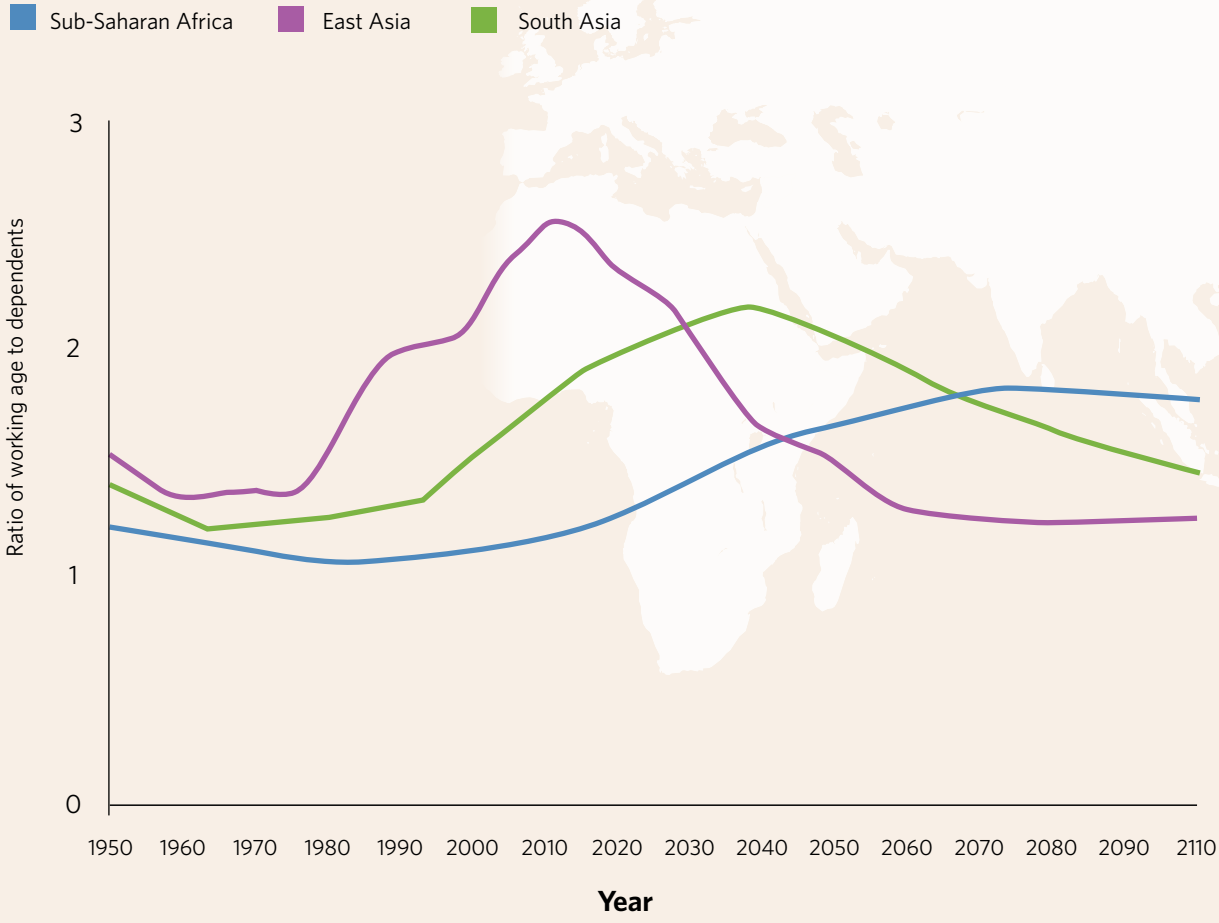
Dependency ratios and the demographic dividend can affect economies and societies in numerous ways. In early stages of the demographic transition—when the share of the population that is young starts to grow—countries may be required to spend more on schools, health clinics, housing, and other infrastructure

to secure the future population's well-being and productivity. This relocation of resources towards the young, who consume but do not produce, may not be conducive to immediate improvements in economic growth rates (Coale and Hoover, 1958). But after fertility rates steadily decline over the course of 20 or 30 years, the number of income-generating adults grows relative to the number people who depend on them for support, thus creating more favourable conditions for economic growth and sustainable development.

One of the key drivers of improved economic growth during the demographic transition is the increase in the level of savings and investment in the economy. Adults with fewer children may be able to reallocate more of their resources towards saving for their own retirement. This increases the amount of capital available for investment.

Improvements in general health and reduction in the burden of disease also increase the attractiveness of investment opportunities. Declines in dependency ratios in East Asia since the 1960s, for example, increased savings rates

RATIO OF WORKING AGE TO DEPENDENT POPULATION



Source: United Nations World Population Prospects 2010 Medium Fertility Variant

substantially, created new opportunities for investment and helped Asian countries reduce their reliance on foreign capital (Higgins and Williamson 1996; Higgins and Williamson, 1997). The rise in savings rates also contributed to the establishment of pension systems and social welfare systems: ever-increasing populations of working-age adults were able to finance the benefits of a relatively small group of elderly citizens (Reher, 2011).

Improved health, improved investments in schooling, higher savings rates and more investment ultimately translate into economic growth. The rapid growth of East Asian economies since 1975 has been shown to be related to its demographic dividend. One study finds that changes in age structure account for as much as one-third of the Asian "tiger" economies (Bloom, Canning and Malaney, 2000; Williamson, 2001).

Research also shows that the initial health of a population is one of the most robust and potent drivers of economic growth. One study found that one extra year of life expectancy raises GDP per capita by about 4 per cent (Bloom, Canning and Silva, 2001; Bloom, Canning and Silva, 2003).

Conclusion

Greater access to family planning can improve the well-being of women, men, children, their households and communities by increasing life expectancy, decreasing morbidity and improving health more broadly. It increases opportunities to invest in schooling and other forms of human capital and to participate in labour markets, increasing productivity and raising incomes, savings, investment and asset accumulation.

Declines in mortality, followed by declines in fertility, lead to changes in the age-structure of the population and also produces an aggregate "demographic dividend" at the level of countries. This leads to improvements in economic growth and development.

▲ *Youth-friendly services in Egypt.*
© UNFPA/Matthew Cassel

Three main conclusions emerge from this literature. First, improvements in reproductive health not only ensure rights and improve the lives of women and children, but also alleviate poverty and promote economic growth. Second, integrated programmes aimed at improving reproductive health—maternal health, child health, nutrition, and family planning programmes—can result in demographic change as well as economic change. Third, these programmes should not be regarded as substitutes for any other type of policy aimed at increasing growth or sustainable development in a society. Rather, family planning should be regarded as one component of broader strategies to invest in human capital, particularly for women.

CHAPTER FIVE

The costs and savings of upholding the right to family planning

To uphold human rights and to reap the benefits of family planning for the economic and social well-being of individuals, households, communities and nations, expanding access to family planning is essential. But how much will this cost? Treating family planning as a right has important implications for development policy and for the sustainable development framework that will in 2015 succeed the Millennium Development Goals. The normative dimension of human rights brings about a radical shift by moving family planning strategies from the realm of policy commitment and economic pragmatism to the realm of obligations and the setting of red flags in dealing with complex policy tradeoffs.

On the pragmatic economic side, however, it requires a look at the economic and budgetary implications of the obligation of equality and non-discrimination in fiscal and budgetary policies, for example, the impact of user fees or taxes on the affordability on contraceptive services. It also requires a focus on the obligation of progressive realization over time in relation to budgetary allocations across sectors as part of the national budget.

Estimates of the costs have not generally taken this rights perspective, though they are certainly not in conflict with it. They have tended to focus on the demographic characteristics of the population, its age structure and how this in combination with unmet need generates numbers of potential family planning clients.

Mwanasha, along with nearly 200 women, gather under the shade of a Balboab tree. They've come for contraceptives, which for many of them can save their lives and transform their families' futures. In Malawi, one in 36 women die in childbirth compared to one in 4,600 in the UK.

Growing need

The need for family planning will grow as the number of people entering their reproductive years increases in the near future, especially in the poorest countries. About 15 per cent of women of reproductive age in developing countries wish to delay their next birth or cease childbearing but are not currently using modern methods of contraception (Singh and Darroch, 2012). Their right to family planning is therefore at risk.

"Unmet need," according to the widely accepted definition, is not as high in richer countries. Yet "unintendedness" is a term that applies to a significant proportion of births in rich and poor countries alike. The lowest rate of unintendedness is 30 per cent in Western

UNINTENDED PREGNANCIES AND OUTCOMES, 2008

	Total number of pregnancies (millions)	Per cent of pregnancies that were unintended	Percentage distribution of unintended pregnancy outcomes (as % of all pregnancies)		
			Births	Abortions	Miscarriages
World	208.2	41	16	20	5
More developed regions	22.8	47	15	25	6
Less developed regions	185.4	40	16	19	5
Africa	49.1	39	21	13	5
Eastern	17.4	46	25	14	6
Middle	6.9	36	22	8	5
Northern	7.4	38	15	18	5
Southern	2.0	59	34	20	8
Western	15.5	30	16	10	4
Asia	118.8	38	12	21	5
Eastern	31.7	33	4	25	3
South-Central	60.4	38	15	18	5
Southeastern	19.2	48	14	28	6
Western	7.5	44	24	15	6
Europe	13.2	44	11	28	5
Eastern	6.4	48	5	38	5
Northern	1.8	41	17	18	5
Western	2.4	42	17	20	5
Southern	2.7	39	18	16	5
Latin America and Caribbean	17.1	58	28	22	8
Caribbean	1.2	63	31	23	9
Central America	4.6	43	20	17	6
South America	11.3	64	31	24	9
North America	7.2	48	23	18	7
Oceania	0.9	37	16	16	5

Source: Singh, S. et al.. 2010: 244.

Europe; the highest is 64 per cent in South America (Singh, Sedgh and Hussain, 2010). In the United States, an estimated 49 per cent of pregnancies are unintended, a figure that remained unchanged between 1994 and 2001 (Finer and Henshaw, 2006).

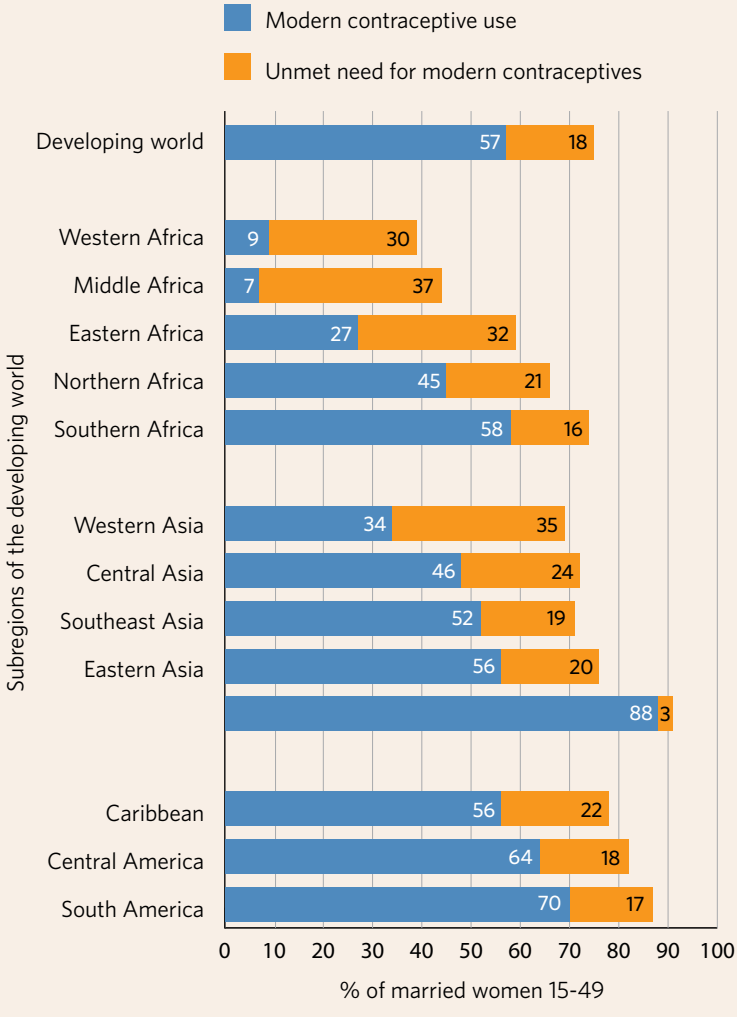
Unintended pregnancies in the United States occur most frequently among young women 18 to 24 who are unmarried, poor, black or Hispanic. Forty-eight per cent of unintended conceptions in 2001 occurred during a month when contraceptives were used (Finer and Henshaw, 2006). This is because some women are more likely to have unprotected sex, even when they are at other times using contraception. In addition, they may be using less effective methods. Finally, women who are cohabiting are more likely to experience unintended pregnancies, in part because they may be ambivalent about using contraception, which may be the preference of their partners, not their own. People of lower socioeconomic status are more likely to experience contraceptive failure, in part because they are more likely to use less effective methods.

Changes in contraceptive use, current levels of use and unmet need

As described in Chapters 2 and 3, there is a strong and growing need for sexual and reproductive health services that include family planning among unmarried people, since age at first marriage has increased as has sexual activity among unmarried people. Unmarried, sexually active women are at greater risk of unintended pregnancy than married women. Cohabiting women are using contraception at rates like those of married women, but tend to have higher levels of sexual activity, being younger; in addition, they may be more fecund.

Contraceptive use by married women in developing and developed countries between the ages of 15 and 49 rose from near zero in the 1960s to approximately 47 per cent in 1990 and to 55 per cent in 2000 and has leveled off since (United Nations Department of Economic and Social Affairs, 2004 and 2011). In East Africa, the rate increased from 20 per cent in

LARGE VARIATIONS IN MARRIED WOMEN'S LEVEL OF UNMET NEED FOR AND USE OF MODERN CONTRACEPTION AMONG SUBREGIONS OF THE DEVELOPING WORLD IN 2012



Source: Singh & Darroch 2012

▲ *Donor Commitments panel at the London Summit on Family Planning.*
©Russell Watkins/ UK Department for International Development

2008 to 27 per cent today. In Southeast Asia, the rate rose from 50 per cent to 56 per cent over the same period. Between 2008 and 2012, an average annual increase of 1.7 per cent in modern-method users translated into 42 million additional married women using family planning.

Singh and Darroch (2012), with their new measures of unmet need, recalibrated to include estimates of sexually active never-married women, calculate that of the 1.52 billion women of reproductive age in developing countries, 867 million have a need for family planning in 2012.

The needs of about three in four of those women are being met. The needs of one in four of them, however, are not.

Funding fails to keep pace with need

Donor and government support for sexual and reproductive health, especially family planning, has been shrinking at a critical time, when nearly 2 billion young people are entering their reproductive years. Meanwhile, many developing countries have not made sexual and reproductive health a priority in their health sectors (Population Council, 2007; Birungi et al., 2006). At the same time, sexual and reproductive health has lost ground to "competing" health issues, such as infectious diseases, because the field has failed to persuade power brokers—such as policymakers and donors—to increase funds.

The Programme of Action of the International Conference on Population and Development, ICPD, called on international donors to cover one-third of the costs for sexual and reproductive health, including family planning, and developing countries themselves to contribute two-thirds of the total.

Both developing countries and donor countries have fallen short of this target. For example, to meet the family planning needs of current users of modern contraception in 2010, donors had been expected to contribute about $1.32 billion but actually contributed $822 million—about one-third less than the target amount.

The shortfall may be attributed to budget cuts in some donor countries but also to changes in the way a country decides to allocate resources. The United States, for example, a major contributor to international family planning, has placed a growing number of countries on a "graduation" list. As countries "graduate," they are seen as no longer requiring the same level of support they once enjoyed. Countries slated for graduation are those with a total fertility rate of 3.0 or less and a modern contraceptive prevalence rate of 55 per cent or more (Bertrand, 2011). Countries in Latin America have been especially affected by the graduation process, since some of the region's ministries of health have not filled the void as United States funding ends or is phased out.

Extending access to meet the unmet need

Providing contraceptives to the current 645 million users in the developing world costs $4 billion a year. Improving the quality of these services would cost an additional $1.1 billion a year, according to the recent Guttmacher Institute estimates. Providing modern methods of contraception, with improved services, to the 222 million women with unmet need would raise costs an additional $3 billion a year. Thus, the cost of fully meeting the needs of all women in developing countries and improving the quality of services would together total $8.1 billion a year. Meeting all need for modern contraception, coupled with improving the quality of services, would raise the average annual cost per user in the developing world from $6.15 to $9.31 (Singh and Darroch, 2012).

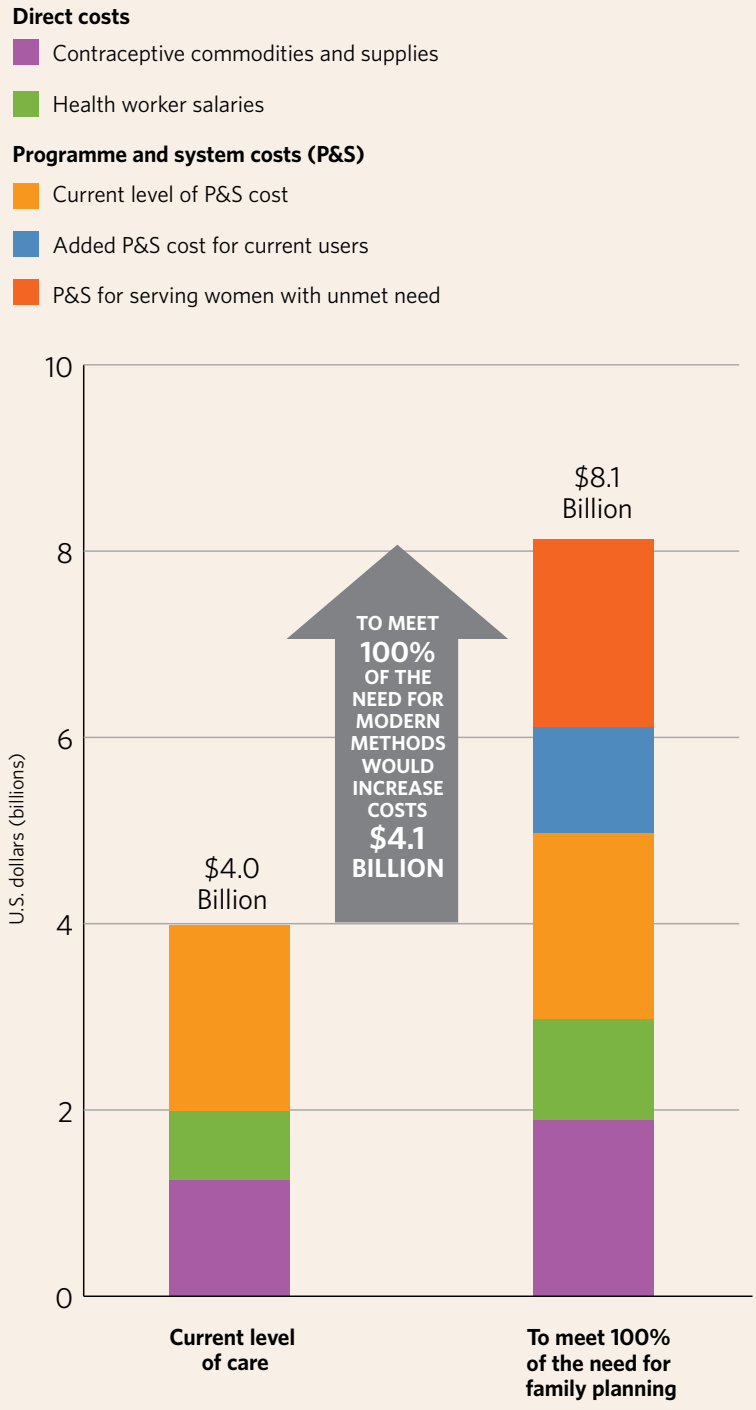
The cost of meeting unmet need is highest in sub-Saharan Africa and the poorest countries of other regions where capacities for delivering services are weakest. Committing to meeting the unmet need would therefore require a shift in the allocation of donor resources. The 69 poorest countries now receive about 36 per cent of donor resources for family planning. That share would need to increase to about 51 per cent.

CASE STUDY

Accountability in Sierra Leone

Corruption is enormously costly to any health system. Before and after the end of Sierra Leone's civil war, more than 50 per cent of drugs and medical supplies destined for public health facilities went unaccounted for (UNFPA, 2011a). The supply chain faced a lack of transparency, poor record keeping, poor management of drugs and theft of drugs from the public system that were then resold to private pharmacies.

PROVIDING MODERN CONTRACEPTIVES TO ALL WHO NEED THEM IN 2012 WOULD MEAN INCREASING CURRENT COSTS BY $4.1 BILLION



Source: Singh & Darroch 2012

UNFPA supports the Health for All coalition, a civil society organization that works towards the establishment of a strong and independent monitoring and evaluation system. The drug monitors now working in the health system have reduced the theft of drugs and dramatically increased accountability with direct effects on people's access to family planning methods.

The savings realized from meeting unmet need

By investing an additional $4.1 billion in modern contraceptive services in developing countries, the world would save approximately $5.7 billion in maternal and newborn health services as a consequence of preventing unintended pregnancies and unsafe abortions (Singh and Darroch, 2012). Family planning is a cost-saving intervention at the individual, household/family and national levels (Cleland et al., 2011; Greene and Merrick, 2005). Recent research estimates that increased contraceptive use over the past two decades has reduced the number of maternal deaths by 40 per cent by reducing unintended pregnancies (Cleland et al., 2012). Thirty per cent more maternal deaths could be prevented simply by fulfilling unmet need for family planning.

The role of "unsafe sex"—a range of sexual and reproductive health-related conditions including HIV—in the global burden of disease is enormous (Ezzati et al., 2002). Sexual and reproductive ill health is the fifth-leading cause of death around the world, and the second contributor to the global burden of disease as measured by disability-adjusted life years (DALYs); the proportion of disability-adjusted life years lost due to "unsafe sex" is much higher for women than for men.

Committing to the right to family planning: cost implications

Costing family planning is challenging because the modes of service delivery are varied, and

Family planning services offer a range of options in Guinea.
© UNFPA/Mariama Sire Kaba.

"family planning" services often offer more than methods of family planning (Janowitz and Bratt, 1994). In addition, the costs associated with an unintended pregnancy or the benefits of avoiding one extend beyond the individual and include the impact on families, communities and nations.

In addition, some costs of family planning are borne by health services; others are borne by individuals. In some settings, specific groups are more or less disadvantaged by having to bear these costs. In general, the costs of providing *information* are not included in most estimates, which focus more on the delivery of supplies and services.

Programmes that have provided family planning to the initial "easy to reach" groups may find that the costs of reaching the next tier of clients are much greater (Janowitz and Bratt, 1994). For one thing, it may be necessary to reach out to people who are more geographically remote or socially isolated. The services may need to be extended or improved to address the rights of marginalized groups.

A commitment to fulfil the right to family planning requires a complete understanding of all costs involved in reaching every individual. Is outreach needed to increase the access of disadvantaged groups? How does a State meet its obligation to prioritize the hardest to reach even when it does not make full economic sense? Are there programmatic components beyond the clinic that will need to be included so that barriers to access are overcome?

The Programme of Action of the ICPD acknowledged social and cultural constraints to health and established a rationale for addressing some of those constraints as part of family planning programmes. Yet these sorts of programmes that go "beyond family planning" can seem removed from services yet have broad health and development consequences (Singh and Darroch, 2012). An example would be efforts to work with men and boys to encourage more equitable gender norms and relationships, including supporting their own or partners' use of family planning.

Activities that support family planning are also essential to rights

Costing has most often focused on health services and on generating the of supplies and services to respond to unmet need. Often neglected is the need to influence the underlying conditions that shape people's perspectives on childbearing and permit them to use family planning.

A human rights-based approach to sustainable development can guide policies and programmes in identifying and addressing the inter-related web of factors that lead to unmet need in a given country or local context. The application of a human rights-based approach as a continuum from situation analysis, to policy formulation and then to programme costing can help ensure that public budgets are more sensitive to various forms of discrimination, and are supportive of human rights.

"A commitment to fulfil the right to family planning requires a complete understanding of all costs involved in reaching every individual."

The Guttmacher Institute's recent costing analysis notes that, "'beyond family planning' interventions are needed to address social factors that inhibit the use of contraception…. Addressing these types of barriers requires commitment to long-term, extensive interventions, such as providing comprehensive sex education and well-designed large-scale public education efforts" (Singh and Darroch, 2012).

▲ *Dr. Babatunde Osotimehin, Executive Director of UNFPA, speaking at the London Summit on Family Planning.*
©Russell Watkins/ UK Department for International Development

Activities that support the right to family planning may include:

- Changing norms to generate long-term change in demand, for example, working with men and boys to delay marriage and support female partners;
- Mobilizing people to demand their rights and to hold providers accountable for the quality of services;
- Overcoming obstacles to access; for example, helping develop community transportation systems.

Some activities aimed at increasing demand for family planning, such as encouraging males to be more supportive of their female partners' family planning use and raising awareness of the health and economic benefits of being able to space and time pregnancies are sometimes included in cost estimates because they are directly related to use of family planning.

Efforts to change gender and other norms ultimately related to sexual and reproductive health outcomes can be costed, but the "credit" they can take for increasing contraceptive use is difficult to measure. This makes it hard to assess their cost in relation to family planning, even though they may ultimately have effects not only on family planning and other aspects of sexual and reproductive health but on other areas of health and development. One example of a norm change intervention with concrete effects on clinical outcomes is the "Stepping Stones" curriculum, developed in sub-Saharan Africa and now adapted for use in dozens of countries around the world (Welbourn, 2003). The curriculum works to alter the balance of power as it plays out in relationships between and among men and women in the community in ways that impact health. Stepping Stones affected gender-related attitudes in ways that reduced HIV incidence and increased condom use, among other outcomes, even measured a year after the intervention.

There has so far been little *rights* discourse in discussions about how much it costs to provide family planning to all who want it. There have, however, been some instances in other fields where the costs of ensuring human rights are factored in to overall costs. A recent study of costs associated with treating HIV, for example, included estimates for supporting activities that would ensure the effectiveness of investment in providing antiretroviral therapies. These activities included actions to protect the human rights of people receiving treatment (Jones et al., 2011).

A recent study attempts to calculate the human rights costs of offering antiretroviral

therapy as an inexpensive preventive intervention (Granich et al., 2012).

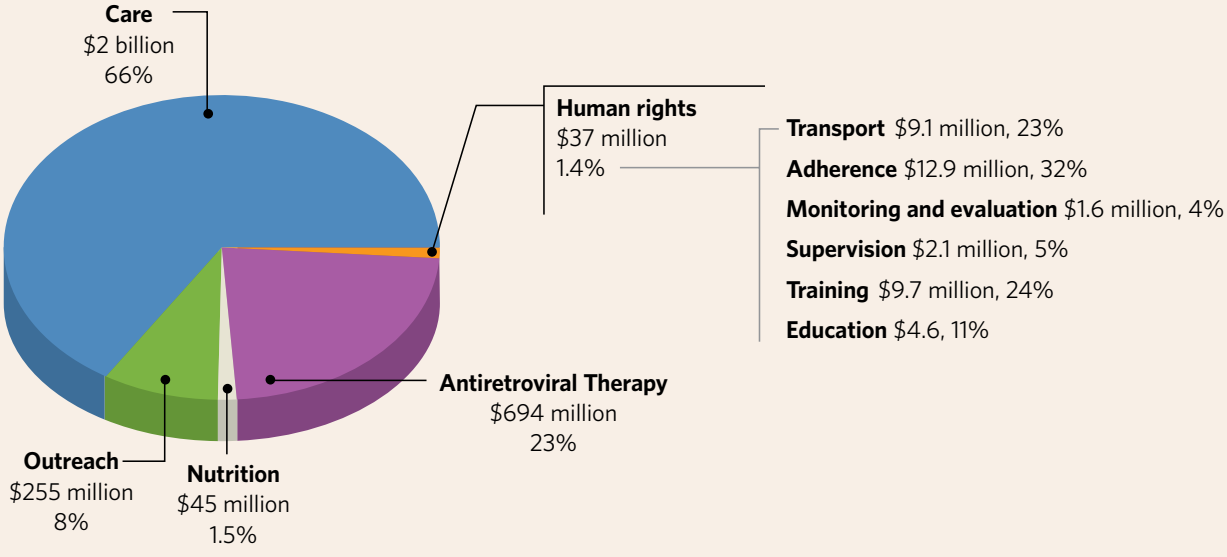
The study finds that without engaging and supporting the community, the programme will be unlikely to achieve its goals. This model supports the importance of ensuring "community engagement in the planning and implementation of the programme so that there is no coercion to be HIV tested or take antiretroviral therapies, and that there is adequate support for individuals with questions and concerns. Contrary to many other similar studies, we included the cost of ensuring many components of a strong human rights framework" (Granich, 2012). The total cost of including these human rights components in the programme overall is 1.4 per cent, a small investment in the long-term success of the programme and its contribution to the achievement of rights.

Conclusion

Recent estimates of unmet need indicate the significant levels of investment necessary to uphold the right of the world's people to family planning. High levels of unmet need for family planning will be increased in the coming years by the large generation of young people entering their reproductive years. Family planning has been shown to be one of the most cost-effective public health interventions ever developed. Thus any decision regarding how to invest in family planning must counterpose its costs against the range of benefits it brings to individuals, households and nations.

AVERAGE COSTS ASSOCIATED WITH TREATMENT FOR HIV BY CATEGORY WITH BREAKDOWN OF HUMAN RIGHTS AND COMMUNITY-SUPPORT COMPONENT

(COSTS SHOWN IN US$)



Source: Granich et al, 2012

CHAPTER SIX

Making the right to family planning universal

Almost 20 years have passed since the 179 governments represented at the International Conference on Population and Development, ICPD, transformed the way the world approaches sexual and reproductive health, including family planning. While some progress has been made, there is still much work to be done to realize the rights-oriented vision of the ICPD.

The ICPD Programme of Action defined sexual and reproductive health and located family planning among a broader interrelated set of rights. It pointed beyond programmes to the social and economic circumstances that shape people's decisions about their sexual and reproductive lives and determine their ability to act on those decisions. It highlighted the roles and needs of adolescents, men and other groups not previously addressed. And it emphasized the need for services to respect individual rights and respond to individual preferences in offering family planning.

For policymakers, international organizations, governments and civil society, this new rights-based approach was seen as revolutionary, partly because it created obligations for governments to make reproductive health services and supplies available to all. But was the shift experienced as revolutionary by ordinary people, the individual women, men, girls and boys the ICPD was intended to help?

Where the right to family planning has been upheld and access to it increased, people have benefited—through better health, higher incomes, reductions in poverty and greater gender equality. But the ICPD has not yet changed daily realities for the hundreds of millions of people who want to avoid or delay pregnancy but are unable to either because they still have no reliable access to quality contraception, information and services or because they face insurmountable social, economic and logistical obstacles.

These individuals have missed out on the improvements in health, empowerment and enjoyment of a range of other rights that family planning can facilitate or catalyse. The challenges are most acute in developing countries but exist also in developed countries, where many women and men are unable to access family planning, are poorly served or are dissatisfied with the methods they use.

The vision of the ICPD has yet to be translated fully into a rights-based approach to sexual and reproductive health policies and programmes, with quality and access for all.

As a consequence, too many individuals still lack the power to make decisions about family size and the timing of their pregnancies.

◀ *A couple with their baby in Brazil.*

When individuals are able to exercise the right to family planning, they are able to make decisions about the timing and spacing of their pregnancies and are also able to exercise—and benefit from—many other rights

The governments that endorsed the ICPD Programme of Action committed to ensuring that individuals have the information, education and means to freely and responsibly decide whether and when to have children and agreed that family planning is a right.

The right to family planning is also explicitly stated in the Convention on the Elimination of All Forms of Discrimination Against Women.

And, family planning is included in Millennium Development Goal 5, especially target 5-B, which aims for universal access to reproductive health by 2015. But progress towards achieving this goal lags behind progress towards the other Millennium Development Goals.

Planning one's family is a fundamental human right, and something that women and men of all ages everywhere in the world yearn to achieve. In 2012, realizing this right for all seems increasingly within our grasp.

So what happens after 2015, after the deadline for achieving the Millennium Development Goals has passed?

The values and principles affirmed in the Millennium Declaration provide a solid foundation for addressing global development challenges. The post-2015 sustainable development agenda will likely be based on the fundamental principles of human rights, equality and sustainability. In the context of these principles, development goals would be pursued along four interdependent dimensions: inclusive social development, environmental sustainability, inclusive economic development and peace and security.

The vision for the post-2015 development agenda is holistic and global and rests on core principles, values and standards that derive from internationally agreed-upon frameworks. These principles will contribute to policy coherence at the global, regional, national and sub-national levels, and ensure that development activities are mutually reinforcing.

Family planning is one such activity. When individuals are able to exercise the right to family planning, they are able to make decisions about the timing and spacing of their pregnancies and are also able to exercise—and benefit from—many other rights, such as rights to education, health and development.

The ability to determine if and when to have children and how many to have reflects the realization of equal rights and opportunities. Family planning is therefore a matter of equity and social justice.

Four broad recommendations for recognizing family planning as a matter of core rights and sustainable development—and specific strategies for achieving these recommendations—are outlined here. They point to the need to *1) take or reinforce a rights-based approach; 2) secure an emphasis on family planning in the post-2015 sustainable development framework; 3) ensure equality by focusing on specific excluded groups; 4) raise the funds to invest fully in family planning.*

1 Expand the reach of family planning and improve services by adopting a human rights-based approach to health

Family planning must be grounded in comprehensive sexual and reproductive health programmes. A human rights-based approach to family planning entails far more than solely protecting the right to access family planning services. The close relationship between the right to choose if, when and how many children to have and other aspects of people's sexual and reproductive lives requires a broad approach to services.

Governments should monitor for and eliminate any use of incentives, targets or fee structures that incentivize health care providers to advocate for adoption of specific methods, or for incentives to use contraception. Service delivery itself must meet human rights standards, and barriers to use must be acknowledged as human rights violations. Poor people with limited schooling are most vulnerable to misunderstandings and misinformation about how contraceptives work and how their choices may be directed.

Go "beyond family planning" to address the social and economic obstacles to sexual and reproductive health. Women and sometimes men must often overcome entrenched gender norms in order to exercise their right to family planning. Ensuring women's access to family planning should be supported by activities that address their social circumstances directly and enhance their decision-making, mobility, autonomy and access to resources. Programmes must address these constraints directly as part of their effort to ensure the right to family planning.

Recognize that men and boys are pivotal to realizing women's right to family planning and their own rights as well. As a human right, family planning is relevant to every person and all potential parents, both female and male. Family planning is especially important to women and their health and well-being, and it is also of great interest and value to men. The sexual and reproductive health field has an opportunity to encourage men's fuller engagement in family planning. Men and boys can help ensure women's right to family planning by being supportive partners, using contraception, avoiding violence and promoting gender equality. They have important roles to play in transforming gender roles and norms in ways that make it easier for everyone to achieve their rights.

▼ *A bus stop in Mumbai, India.*
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Family planning programmes must reflect the reality that contraceptive use occurs in the context of sexual relationships. The family planning field has readily acknowledged the connections between sexual and reproductive health, reproductive rights and sexuality. Research is needed to examine how the desire for a satisfying sex life plays a part in shaping women's and men's views of family planning, their preferences for specific methods, and their ability to negotiate that use. Family planning programmes could more systematically recognize and support their desire to maintain healthy, enjoyable sexual relationships.

Family planning should be made available with abortion services where they are not against the law. Family planning should be readily available to women who have recently *had* abortions to enable them to avoid unplanned pregnancies in the future. Yet, family planning has often been separated from abortion services where they are legal. The world is united in its concern about unsafe abortion, an important cause of maternal morbidity and mortality. Family planning makes a fundamental contribution to addressing this important public health problem by reducing unintended pregnancy.

Ensuring access to emergency contraception is an essential part of fulfilling the right to family planning. The international community needs to emphasize the importance of access to emergency contraception in cases of sexual violence, as well as in contexts of armed conflict and humanitarian emergencies.

Governments, international organizations and civil society should track levels of satisfaction with the quality of available contraceptive methods and services, the impact on health outcomes and the incidence of adolescent pregnancy and the costs of unintended pregnancy. International and non-governmental organizations and governments should consider adopting more refined indicators of unmet need, such as the "proportion of demand satisfied," which shows the share of total demand for contraceptives that is being fulfilled. Taken together, contraceptive use and unmet need only define the total *level* of demand for family planning. Measuring "demand satisfied" serves as a proxy for whether a person's stated desires regarding contraception are being fulfilled and is a more sensitive measure of the extent to which individuals, communities, and health systems support people's right to use family planning.

2 Secure a central place for family planning in the post-2015 sustainable development framework, one that recognizes its contributions to development and to breaking the cycle of poverty and inequality.

Treat family planning not as a "specialty" topic within the health sector, but as one of several key investments that contribute to development. Family planning is a proven, sound economic investment that yields returns to the individual, the household, the community and the nation. The breadth and scale of the benefits to upholding the right to family planning suggest that family planning may be among the most effective—and cost-effective—interventions for human capital accumulation and poverty alleviation. When governments ratify human rights treaties they assume certain obligations to protect a wide

range of rights. Meeting those obligations will often be facilitated through fulfilling the right to family planning.

Family planning plays a central role in the achievement of a broad range of development goals. With its special focus on disparities and inequalities, the post-2015 sustainable development framework will likely be composed of mutually reinforcing elements. Family planning reinforces at least four priorities that reflect the emerging human rights orientation of this new post-2015 development framework:

- **Poverty reduction:** Family planning permits people to prevent unplanned, unwanted, unhealthy pregnancies and helps reduce poverty by creating conditions that make it possible for people to take better advantage of other social sector investments and to invest more in their children.

- **Gender equality:** How can women plan their lives if they are unable to make decisions about childbearing? Development efforts must put women in particular in the position of implementing their life choices. And gender equality calls for men to play a central role in planning their families and supporting women and girls.

- **Youth empowerment:** Family planning contributes to opening up opportunities for youth and highlights *planning for their lives.* Preventing unintended pregnancy protects adolescent girls and boys from being hijacked from their life opportunities. Learning to plan one's family is a skill that is needed for decades of a person's reproductive life. Planning a family contributes to planning many other aspects of one's life: schooling, work, family formation, and other aspects.

- **Health:** family planning is fundamental to women's health as it delays early pregnancies, allows spacing of pregnancies, and reduces high fertility.

Improved access to family planning extends life expectancy for both mothers and children, increases incentives to invest in schooling and other forms of human capital, creates opportunities for participation in labour markets, raises the return to participation in labour markets and results in higher incomes and levels of asset accumulation. These add up to significant benefits, particularly if declines in fertility occur quickly enough to generate a demographic dividend. In addition, almost all studies on this topic confirm that the magnitude of the demographic dividend depends not only on the pace of mortality and fertility decline, but also on the policy environment, particularly in the areas of sexual and reproductive health and family planning, education, labour-market flexibility and openness to trade and savings.

Dr. Awa Marie Coll-Seck, Minister of Health, Senegal, speaking at the London Summit on Family Planning.
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Family planning programmes reinforce the positive impacts of *other* programmes that invest in human capital. By reducing maternal mortality and increasing life expectancy, such programmes raise the return to schooling and thus increase the returns to investment in education, particularly for girls. Governments should regard family planning in the same way they view and prioritize other human-capital investments in education, labour force participation and political participation.

By reducing maternal mortality and increasing life expectancy, such programmes raise the return to schooling and thus increase the returns to investment in education, particularly for girls. Governments should regard family planning in the same way they view and prioritize other human-capital investments in education, labour force participation and political participation.

The close relationship between declines in fertility and improvements in women's rights suggests that governments and multilateral institutions should not only focus on promoting direct legislative changes for women's rights but should also invest in family planning and other programmes that invest in human capital. This is one more way of improving the bargaining position of women in society.

Family planning programmes are not, however, a substitute for other types of investments in human capital. In fact, family planning programmes and declines in fertility have their maximum impact in societies that are making complementary investments in increasing female schooling, expanding labour market opportunities, and experiencing economic changes that fundamentally change the cost-benefit tradeoff of high fertility. Programmes have often been most effective when coupled with other types of maternal and child health inputs.

3 Ensure the right to family planning of specific excluded groups

As an essential part of governments' commitments to rectifying inequalities in health, programmes must address the financial, physical, legal, social and cultural factors that make it difficult for so many people to seek health services and overcome the intersecting forms of discrimination they may face.

Poor women who have no access to family planning have more children than they intend. Meanwhile, wealthy and educated elites, wherever they are, tend to have access to family planning, independent of whether policies or programmes support it. In many countries, even though efforts have been made to overcome health inequities by targeting services for the poor, the benefits are often accrued mainly by those who are already better off (Gwatkin and others, 2007). To improve access to contraceptive information and services for the poor, programmes must often address not just the financial obstacles but also the physical obstacles (such as distance to health facilities and the opportunity costs of lost work time to visit family planning providers) and social and cultural factors (including disrespectful or judgmental treatment by health workers, lack of autonomy in making decisions about health services or family or community opposition to contraceptive use).

In countries where it is needed, new legislation should be introduced to ensure universal access to family planning; in others, steps must be taken to ensure the equitable implementation of existing legislation, policies and programming. Government support for family planning should include actions that make services available to marginalized groups,

▲ *A couple in Botswana learns about contraceptive options.*
© Panos/Giacomo Pirozzi

including indigenous and ethnic minorities and persons who live in hard-to-reach urban and rural communities (United Nations Economic and Social Council, 2009).

Family planning policies and programmes must respond to the needs of unmarried persons of all ages whose numbers are growing worldwide. Young people and adults are entering, staying, and ending partnerships in ways different from previous generations, and education and services must respond to these changes. Young people need services between their first sexual experiences and when they marry. Expanding access to meet young peoples' sexual and reproductive health needs will require advocacy and other actions that shift attitudes about young peoples' sexual and reproductive experiences. Services and information should be made available to adults who are separated from their partners or in new partnerships later in life. As people grow older, they face shifting pressures to fulfil community and familial expectations related to sex, marriage, and childbearing. As their roles evolve, their need for family planning often recedes from the view of policymakers and programme designers.

Family planning programmes should be expanded so that services are available to young, married women and their husbands. Married adolescents face great difficulties in accessing family planning services, and are therefore vulnerable to unintended or unwanted pregnancies and their negative health effects (Ortayli and Malarcher, 2010; Godha, Hotchkiss

and Gage, 2011). The younger a girl is at the time of marriage, the greater the challenges she faces in controlling her own fertility, and the more subject she is to closely spaced and repeated pregnancies (Rutstein 2008).

Adequately meeting the family planning needs of older people requires challenging the pervasive assumption that these individuals do not need to exercise their right to family planning. Often overlooked in the design of family planning policies and programmes are men over the age of 49 whose fertility declines only gradually as they age. This omission compromises the rights of sexually active older people who wish to protect themselves from harmful sexual and reproductive health outcomes. As was affirmed by the Commission on Population and Development in 2012, services and information should be made available to adults who are separated from their partners or in new partnerships later in life.

President of Nigeria Goodluck Jonathan announces plan in September to increase access to life-saving supplies, including family planning. Jonathan co-chairs the UN Commission on Life-Saving Commodities.
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States and the international community should strengthen efforts to collect data about all groups who may face difficulties in accessing family planning: adolescents—including 10-to-14-year-olds—young people, boys and men, married adolescents, unmarried people, older people, ethnic minorities, refugees and migrants, sex workers, people living with HIV/AIDS and women and girls vulnerable to sexual violence in conflict zones or in areas where there have been natural disasters or humanitarian crises. Data should routinely be disaggregated by sex, age and ethnicity, and analysed by wealth quintiles and should show differences between people living in rural and urban areas to shed light on how access varies within and across populations.

Measurement and monitoring of access must reflect everyone's needs and experiences. A combination of indicators would yield greater insights into inequalities in access by population groups. An analysis of the social equality dimensions of health, for example, would help to focus efforts where they are needed (Austveg, 2011). A human rights focus to family planning requires costing of demand-side programming. Singh and Darroch (2012) recommend systematic data collection at the provider and facility level to include indicators such as the number and training of staff, the range of methods offered, the consistency with which a range of contraceptive commodities is supplied and the quality of care.

4 Increase funding for family planning and ensure it is spent wisely

Governments of developing and donor countries, international organizations and foundations need to increase funding to improve the quality and availability of contraception, information and services for all who want them, thus allowing everyone to exercise their right to family planning. Governments—donors and developing countries alike—should also live up to the funding commitments they made at the 1994 International Conference on Population and Development to implement all aspects of the Programme of Action.

About $4 billion is needed each year to continue meeting the need of the 645 million women who are currently using modern methods of family planning in developing countries. Improving the quality of services for these women would add another $1.1 billion. To meet the needs of women who would like to delay pregnancies or end their childbearing but are not currently using family planning, an additional $3 billion would be needed each year. Thus, to fully meet the current and unmet need for family planning among women in developing countries would cost $8.1 billion each year. Developed countries must calculate their own costs of realizing this right with all of its benefits to their citizens and to national development.

In advocating for family planning, governments, international organizations and civil society should underscore the links with other global initiatives, such as those to reduce maternal mortality, to end child marriage, to combat gender-based violence and to prevent adolescent pregnancy. A number of specific initiatives, including Women Deliver (focused on women's and girls' health and well-being), Girls Not Brides (focused on ending child marriage) and MenEngage (a global network of organizations committed to reducing gender inequality and improving the well-being of men, women and children), are natural allies in realizing the right to family planning.

Multisectoral investment and coordination are essential to the efficient use of funds. Informed choices about spacing, number and timing of pregnancies are made more likely where governments invest in a range of policies and programmes, including efforts to eliminate child marriage, promote girls' education and create employment opportunities for young people (Greene, 2000 in Cohen and Burger, 2000). Because a comprehensive approach to development, health, education and rights tends to lead to lower fertility rates, governments must also take a comprehensive approach that includes better coordination and cooperation across ministries. It also requires working with multiple sectors at the community level. For example, working jointly with educators and religious leaders can help eliminate the gender and age biases that make men question family planning, undermine women's rights and downplay or ignore adolescent sexuality.

At a summit in London on 11 July 2012, donor countries and foundations together pledged $2.6 billion to make family planning available to 120 million of the 222 million women in developing countries with unmet need by 2020. At the event, developing countries together pledged $2 billion towards this initiative. Stakeholders called the additional funding "a start," with the aim of eventually mobilizing enough resources to fully eliminate the unmet need in developing countries.

Monitoring ICPD goals: selected indicators

Country, territory or other area	Maternal and Newborn Health				Sexual and Reproductive Health			Education			
	Maternal mortality ratio (deaths per 100,000 live births), 2010	Births attended by skilled health personnel, % 2000/2010	Adolescent birth rate per 1,000 women, aged 15-19, 1991/2010	Under age five mortality rate, per 1,000 live births, 2010-2015	Contraceptive prevalence rate, women aged 15-49, any method, 1990/2011	Contraceptive prevalence rate, women aged 15-49, modern method, 1990/2011	Unmet need for family planning, per cent, 1988/2011	Primary school enrolment, net per cent of school-age children, 1999/2011		Secondary school enrolment, net per cent of school-age children, 1999/2011	
								male	female	male	female
Afghanistan	460	34	90	184	22	16				34	13
Albania	27	99	11	19	69	10	13	80	80	75	73
Algeria	97	95	4	27	61	52		98	96	65	69
Angola	450	49	165	156	6	5		93	78	12	11
Antigua and Barbuda			67					91	84	85	85
Argentina	77	98	68	14	79	70		100	99	78	87
Armenia	30	100	28	27	55	27	19	95	98	85	88
Australia[1]	7	99	16	5	72	68		97	98	85	86
Austria	4	99	10	5	51	47					
Azerbaijan	43	88	41	43	51	13	15	85	84	81	78
Bahamas	47	99	41	18				94	96	82	88
Bahrain	20	97	12	9	62	31		99	100	92	97
Bangladesh	240	27	133	51	56	48	17			45	50
Barbados	51	100	50	14				90	97	81	88
Belarus	4	100	21	9	73	56					
Belgium	8	99	11	5	75	73	3	99	99	90	87
Belize	53	88	90	21	34	31	21	100	91	64	65
Benin	350	74	114	121	17	6	27			27	13
Bhutan	180	58	59	52	66	65	12	88	91	50	57
Bolivia (Plurinational State of)	190	71	89	54	61	34	20	95	96	68	69
Bosnia and Herzegovina	8	99	17	16	36	11					
Botswana	160	95	51	46	53	51	27	87	88	57	65
Brazil	56	99	71	24	80	77	6	95	97		
Brunei Darussalam	24	100	18	6						95	99
Bulgaria	11	99	48	11	63	40	30	99	100	84	82
Burkina Faso	300	67	130	147	16	15	30	65	61	19	16
Burundi	800	60	65	152	22	18	29	91	89	18	15
Cambodia	250	71	48	69	51	35	24	96	95	37	33
Cameroon, Republic of	690	64	127	136	23	14	21				
Canada	12	99	14	6	74	72		100	100		
Cape Verde	79	76	92	22	61	57	17	95	92	61	71
Central African Republic	890	41	133	155	19	9	19	78	60	18	10
Chad	1100	14	193	195	3	2	21	74	51	16	5
Chile	25	100	54	8	64			94	94	81	84
China	37	96	6	24	85	84	2				
Colombia	92	95	85	23	79	73	8	92	91	72	77

Country, territory or other area	Maternal and Newborn Health				Sexual and Reproductive Health			Education			
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								male	female	male	female
Comoros	280	47	95	86	26	19	36	81	75		
Congo, Democratic Republic of the[2]	540	80	135	180	18	6	24	34	32		
Congo, Republic of the	560	83	132	104	44	13	20	92	89		
Costa Rica	40	95	67	11	82	80	5				
Côte d'Ivoire	400	57	111	107	13	8	29	67	56		
Croatia	17	100	13	7				95	97	88	94
Cuba	73	100	51	6	73	72		100	99	87	87
Cyprus	10	98	4	5				99	99	96	96
Czech Republic	5	100	11	4	72	63	11	96	96		
Denmark	12	98	6	5				95	97	88	91
Djibouti	200	78	27	104	18	17		47	42	28	20
Dominica			48					95	96	84	93
Dominican Republic	150	94	98	28	73	70	11	96	90	58	67
Ecuador	110	89	100	23	73	59	7	99	100	58	59
Egypt	66	79	50	25	60	58	12	100	96	71	69
El Salvador	81	85	65	23	73	66	9	95	95	57	59
Equatorial Guinea	240	65	128	151	10	6	29	57	56		
Eritrea	240	28	85	62	8	5		37	33	32	25
Estonia	2	99	21	7	70	56	25	96	96	91	93
Ethiopia	350	10	79	96	29	27		85	80	17	11
Fiji	26	100	31	22				99	99	79	88
Finland	5	99	8	3				98	98	94	94
France	8	98	12	4	77	75	2	99	99	98	99
Gabon	230	86	144	64	33	12	28				
Gambia	360	52	104	93	18	13		68	70		
Georgia	67	100	44	27	47	27	16	96	94	84	80
Germany	7	99	9	4	70	66					
Ghana	350	55	70	63	24	17	36	84	85	51	47
Greece	3		12	5	76	46		98	99	91	90
Grenada	24	100	53	15	54	52		96	99	95	86
Guatemala	120	51	92	34	43	34	28	100	98	43	40
Guinea	610	46	153	134	9	4	22	83	70	36	22
Guinea-Bissau	790	44	137	181	14			77	73	12	7
Guyana	280	87	97	46	43	40	29	82	86	78	83
Haiti	350	26	69	76	32	24	37				
Honduras	100	66	108	33	65	56	17	95	97		
Hungary	21	100	19	7	81	71	7	98	98	91	91
Iceland	5		15	3				99	100	87	89
India	200	58	39	65	55	48	21	99	98		
Indonesia	220	77	52	31	61	57	13	97	93	68	67

Monitoring ICPD goals: selected indicators

Country, territory or other area	Maternal and Newborn Health				Sexual and Reproductive Health			Education			
	Maternal mortality ratio (deaths per 100,000 live births), 2010	Births attended by skilled health personnel, % 2000/2010	Adolescent birth rate per 1,000 women, aged 15-19, 1991/2010	Under age five mortality rate, per 1,000 live births, 2010-2015	Contraceptive prevalence rate, women aged 15-49, any method, 1990/2011	Contraceptive prevalence rate, women aged 15-49, modern method, 1990/2011	Unmet need for family planning, per cent, 1988/2011	Primary school enrolment, net per cent of school-age children, 1999/2011		Secondary school enrolment, net per cent of school-age children, 1999/2011	
								male	female	male	female
Iran (Islamic Republic of)	21	99	31	31	73	59		98	96		
Iraq	63	80	68	41	50	33		94	84	49	39
Ireland	6	100	16	4	65	61		99	100	98	100
Israel	7		14	4				97	97	97	100
Italy	4	100	7	4	63	41	12	100	99	94	94
Jamaica	110	98	72	26	69	66	12	83	81	80	87
Japan	5	100	5	3	54	44				99	100
Jordan	63	99	32	22	59	41	13	91	91	83	88
Kazakhstan	51	99	31	29	51	49	12	99	100	90	89
Kenya	360	44	106	89	46	39	26	84	85	52	48
Kiribati			39	44	36	31	12			65	72
Korea, Democratic People's Republic of	81	100	1	32	69	58					
Korea, Republic of	16	100	2	5	80	70		99	98	96	95
Kuwait	14	99	14	10	52	39		97	100	86	93
Kyrgyzstan	71	97	31	42	48	46		95	95	79	79
Lao People's Democratic Republic	470	37	110	46	38	35	27	98	95	42	38
Latvia	34	99	15	8	68	56	17	95	97	83	84
Lebanon	25	97	18	24	58	34		94	93	71	79
Lesotho	620	62	92	89	47	46	23	72	75	23	37
Liberia	770	46	177	107	11	10	36	52	41		
Libya	58	100	4	15	45	26					
Lithuania	8	100	17	9	51	33	18	96	96	91	91
Luxembourg	20	100	7	3				96	98	84	86
Madagascar	240	44	147	58	40	28	19	79	80	23	24
Malawi	460	71	157	119	46	42	26	91	98	28	27
Malaysia	29	99	14	9	49	32		96	96	65	71
Maldives	60	95	19	12	35	27	29	97	97	46	52
Mali	540	49	190	173	8	6	28	72	63	36	25
Malta	8	100	20	7	86	46		93	94	82	80
Martinique			20	8							
Mauritania	510	57	88	106	9	8	32	73	76	17	15
Mauritius[3]	60	100	31	15	76	39	4	92	94	74	74
Mexico	50	95	87	17	71	67	12	99	100	70	73
Micronesia (Federated States of)	100	100	52	38							
Moldova, Republic of	41	100	26	19	68	43	11	90	90	78	79
Mongolia	63	99	20	37	55	50	14	100	99	77	85
Montenegro	8	100	24	9	39	17					
Morocco	100	74	18	31	63	52	12	97	96	38	32
Mozambique	490	55	193	123	16	12	19	92	88	18	17
Myanmar	200	71	17	57	41	38	19			49	52

Country, territory or other area	Maternal and Newborn Health				Sexual and Reproductive Health			Education			
	Maternal mortality ratio (deaths per 100,000 live births), 2010	Births attended by skilled health personnel, % 2000/2010	Adolescent birth rate per 1,000 women, aged 15-19, 1991/2010	Under age five mortality rate, per 1,000 live births, 2010-2015	Contraceptive prevalence rate, women aged 15-49, any method, 1990/2011	Contraceptive prevalence rate, women aged 15-49, modern method, 1990/2011	Unmet need for family planning, per cent, 1988/2011	Primary school enrolment, net per cent of school-age children, 1999/2011		Secondary school enrolment, net per cent of school-age children, 1999/2011	
								male	female	male	female
Namibia	200	81	74	39	55	54	21	84	89	44	57
Nepal	170	36	81	39	50	43	25	78	64		
Netherlands	6		5	5	69	67		100	99	87	88
New Zealand	15	96	29	6	75	72		99	100	94	95
Nicaragua	95	74	109	22	72	69	8	93	95	43	49
Niger	590	18	199	144	11	5	16	68	57	13	8
Nigeria	630	34	123	141	14	9	19	60	55		
Norway	7	99	10	4	88	82		99	99	94	94
Occupied Palestinian Territory	64		60	22	50	39		90	88	81	87
Oman	32	99	12	11	32	25		100	97		
Pakistan	260	45	16	86	27	19	25	81	67	38	29
Panama	92	89	88	21				99	98	66	72
Papua New Guinea	230	40	70	58	36						
Paraguay	99	85	63	33	79	70	5	86	86	58	62
Peru	67	84	72	28	74	50	7	98	98	77	78
Philippines	99	62	53	27	51	34	22	88	90	56	67
Poland	5	100	16	7	73	28		96	96	90	92
Portugal	8		16	5	87	83		99	100	78	86
Qatar	7	100	15	10	43	32		96	97	76	93
Romania	27	99	41	15	70	38	12	88	87	82	83
Russian Federation	34	100	30	16	80	65		95	96		
Rwanda	340	69	41	114	52	44	19	89	92		
Saint Kitts and Nevis			67					86	86	89	88
Saint Lucia	35	100	49	16				90	89	85	85
Saint Vincent and the Grenadines	48	98	70	25				100	97	85	96
Samoa			29	24	29	27	48	93	97	73	83
São Tomé and Príncipe	70	81	110	69	38	33	38	97	98	44	52
Saudi Arabia	24	100	7	19	24			90	89	78	83
Senegal	370	65	93	85	13	12	29	76	80	24	19
Serbia	12	100	22	13	61	22	7	95	94	89	91
Seychelles			62					96	94	92	100
Sierra Leone	890	31	98	157	8	6	28				
Singapore	3	100	6	2	62	55					
Slovakia	6	100	21	7	80	66					
Slovenia	12	100	5	4	79	63	9	97	97	91	92
Solomon Islands	93	70	70	43	35	27	11	83	81	32	29
Somalia	1000	9	123	162	15	1					
South Africa	300	91	54	64	60	60	14	90	91	59	65
Spain	6		13	4	66	62	12	100	100	94	96
Sri Lanka	35	99	24	13	68	53	7	94	94		

Monitoring ICPD goals: selected indicators

Country, territory or other area	Maternal and Newborn Health				Sexual and Reproductive Health			Education			
	Maternal mortality ratio (deaths per 100,000 live births), 2010	Births attended by skilled health personnel, % 2000/2010	Adolescent birth rate per 1,000 women, aged 15-19, 1991/2010	Under age five mortality rate, per 1,000 live births, 2010-2015	Contraceptive prevalence rate, women aged 15-49, any method, 1990/2011	Contraceptive prevalence rate, women aged 15-49, modern method, 1990/2011	Unmet need for family planning, per cent, 1988/2011	Primary school enrolment, net per cent of school-age children, 1999/2011		Secondary school enrolment, net per cent of school-age children, 1999/2011	
								male	female	male	female
Sudan[4]	730	23	70	87	9		29				
Suriname	130	87	66	27	46	45		91	91	46	55
Swaziland	320	82	111	92	65	63	13	86	85	29	37
Sweden	4		6	3	75	65		100	99	94	94
Switzerland	8	100	4	5	82	78		99	99	84	82
Syrian Arab Republic	70	96	75	16	58	43		100	98	67	67
Tajikistan	65	88	27	65	37	32		99	96	90	80
Tanzania, the United Republic of	460	49	128	81	34	26	25	98	98		
Thailand	48	99	47	13	80	78	3	90	89	70	78
The former Yugoslav Republic of Macedonia	10	100	20	15				97	99	82	81
Timor-Leste, the Democratic Republic of	300	30	54	76	22	21	32	86	86	34	39
Togo	300	60	89	104	15	13	31			33	16
Tonga	110	98	16	25				94	89	67	80
Trinidad and Tobago	46	97	33	31	43	38		98	97	66	70
Tunisia	56	95	6	23	60	52	12	99	96	64	66
Turkey	20	91	38	23	73	46	6	98	97	77	71
Turkmenistan	67	100	21	62	62	45	10				
Turks and Caicos Islands			26		31	22		77	84	72	69
Tuvalu			28				24				
Uganda	310	42	159	114	24	18	38	90	92	17	15
Ukraine	32	99	30	15	67	48	10	91	91	86	86
United Arab Emirates	12	100	34	8	28	24		94	98	80	82
United Kingdom	12		25	6	84	84		100	100	95	97
United States of America	21	99	39	8	79	73	7	95	96	89	90
Uruguay	29	100	60	15	77	75		100	99	66	73
Uzbekistan	28	100	26	53	65	59	14	94	91	93	91
Vanuatu	110	74	92	29	38	37		98	97	46	49
Venezuela (Bolivarian Republic of)	92	95	101	20	70	62	19	95	95	68	76
Viet Nam	59	84	35	23	78	60	4				
Yemen	200	36	80	57	28	19	39	86	70	49	31
Zambia	440	47	151	130	41	27	27	91	94		
Zimbabwe	570	66	115	71	59	57	16				

World and regional data[14]

	Maternal and Newborn Health				Sexual and Reproductive Health			Education			
	Maternal mortality ratio (deaths per 100,000 live births), 2010	Births attended by skilled health personnel, % 2000/2010	Adolescent birth rate per 1,000 women, aged 15-19, 1991/2010	Under age five mortality rate, per 1,000 live births, 2010-2015	Contraceptive prevalence rate, women aged 15-49, any method, 1990/2011	Contraceptive prevalence rate, women aged 15-49, modern method, 1990/2011	Unmet need for family planning, per cent, 1988/2011	Primary school enrolment, net per cent of school-age children, 1999/2011		Secondary school enrolment, net per cent of school-age children, 1999/2011	
								male	female	male	female
World	**210**	**70**	**49**	**60.0**	**63**	**57**	**12**	**92**	**90**	**64**	**61**
More developed regions[6]	**26**		**23**	**7.7**	**72**	**62**		**97**	**97**	**90**	**91**
Less developed regions[7]	**240**	**65**	**52**	**66.1**	**62**	**56**	**13**	**91**	**89**	**60**	**57**
Least developed countries[8]	**430**	**42**	**116**	**112.0**	**35**	**28**	**24**	**82**	**78**	**35**	**29**
Arab States[9]	**140**	**76**	**43**	**49.1**	**51**	**42**	**18**	**89**	**82**	**61**	**58**
Asia and the Pacific[10]	**160**	**69**	**33**	**51.4**	**67**	**62**	**11**	**95**	**94**	**63**	**60**
Eastern Europe and Central Asia[11]	**32**	**97**	**30**	**26.1**	**70**	**54**	**10**	**94**	**94**	**85**	**85**
Latin America and the Caribbean[12]	**81**	**91**	**79**	**23.9**	**73**	**67**	**10**	**96**	**95**	**71**	**76**
Sub-Saharan Africa[13]	**500**	**47**	**120**	**122.6**	**25**	**20**	**25**	**79**	**76**	**33**	**26**

Demographic indicators

Male Female

Country, territory or other area	Total population in millions, 2012	Average annual rate of population change, per cent, 2010-2015	Life expectancy at birth, 2010-2015		Total fertility rate, per woman, 2010-2015
Afghanistan	33.4	3.1	49	49	6.0
Albania	3.2	0.3	74	80	1.5
Algeria	36.5	1.4	72	75	2.1
Angola	20.2	2.7	50	53	5.1
Antigua and Barbuda	0.1	1.0			
Argentina	41.1	0.9	72	80	2.2
Armenia	3.1	0.3	71	77	1.7
Australia[1]	22.9	1.3	80	84	1.9
Austria	8.4	0.2	78	84	1.3
Azerbaijan	9.4	1.2	68	74	2.1
Bahamas	0.4	1.1	73	79	1.9
Bahrain	1.4	2.1	75	76	2.4
Bangladesh	152.4	1.3	69	70	2.2
Barbados	0.3	0.2	74	80	1.6
Belarus	9.5	-0.3	65	76	1.5
Belgium	10.8	0.3	77	83	1.8
Belize	0.3	2.0	75	78	2.7
Benin	9.4	2.7	55	59	5.1
Bhutan	0.8	1.5	66	70	2.3
Bolivia (Plurinational State of)	10.2	1.6	65	69	3.2
Bosnia and Herzegovina	3.7	-0.2	73	78	1.1
Botswana	2.1	1.1	54	51	2.6
Brazil	198.4	0.8	71	77	1.8
Brunei Darussalam	0.4	1.7	76	81	2.0
Bulgaria	7.4	-0.7	70	77	1.5
Burkina Faso	17.5	3.0	55	57	5.8
Burundi	8.7	1.9	50	53	4.1
Cambodia	14.5	1.2	62	65	2.4
Cameroon, Republic of	20.5	2.1	51	54	4.3
Canada	34.7	0.9	79	83	1.7
Cape Verde	0.5	0.9	71	78	2.3
Central African Republic	4.6	2.0	48	51	4.4
Chad	11.8	2.6	49	52	5.7
Chile	17.4	0.9	76	82	1.8
China	1,353.6	0.4	72	76	1.6
Colombia	47.6	1.3	70	78	2.3
Comoros	0.8	2.5	60	63	4.7
Congo, Democratic Republic of the[2]	69.6	2.6	47	51	5.5
Congo, Republic of the	4.2	2.2	57	59	4.4

Country, territory or other area	Total population in millions, 2012	Average annual rate of population change, per cent, 2010-2015	Life expectancy at birth, 2010-2015		Total fertility rate, per woman, 2010-2015
Costa Rica	4.8	1.4	77	82	1.8
Côte d'Ivoire	20.6	2.2	55	58	4.2
Croatia	4.4	-0.2	73	80	1.5
Cuba	11.2	0.0	77	81	1.5
Cyprus	1.1	1.1	78	82	1.5
Czech Republic	10.6	0.3	75	81	1.5
Denmark	5.6	0.3	77	81	1.9
Djibouti	0.9	1.9	57	60	3.6
Dominica	0.1	0.0			
Dominican Republic	10.2	1.2	71	77	2.5
Ecuador	14.9	1.3	73	79	2.42
Egypt	84.0	1.7	72	76	2.6
El Salvador	6.3	0.6	68	77	2.2
Equatorial Guinea	0.7	2.7	50	53	5.0
Eritrea	5.6	2.9	60	64	4.2
Estonia	1.3	-0.1	70	80	1.7
Ethiopia	86.5	2.1	58	62	3.8
Fiji	0.9	0.8	67	72	2.6
Finland	5.4	0.3	77	83	1.9
France	63.5	0.5	78	85	2.0
Gabon	1.6	1.9	62	64	3.2
Gambia	1.8	2.7	58	60	4.7
Georgia	4.3	-0.6	71	77	1.5
Germany	82.0	-0.2	78	83	1.5
Ghana	25.5	2.3	64	66	4.0
Greece	11.4	0.2	78	83	1.5
Grenada	0.1	0.4	74	78	2.2
Guatemala	15.1	2.5	68	75	3.8
Guinea	10.5	2.5	53	56	5.0
Guinea-Bissau	1.6	2.1	47	50	4.9
Guyana	0.8	0.2	67	73	2.2
Haiti	10.3	1.3	61	64	3.2
Honduras	7.9	2.0	71	76	3.0
Hungary	9.9	-0.2	71	78	1.4
Iceland	0.3	1.2	80	84	2.1
India	1,258.4	1.3	64	68	2.5
Indonesia	244.8	1.0	68	72	2.1
Iran (Islamic Republic of)	75.6	1.0	72	75	1.6
Iraq	33.7	3.1	68	73	4.5

Male Female

Country, territory or other area	Total population in millions, 2012	Average annual rate of population change, per cent, 2010-2015	Life expectancy at birth, 2010-2015		Total fertility rate, per woman, 2010-2015
Ireland	4.6	1.1	78	83	2.1
Israel	7.7	1.7	80	84	2.9
Italy	61.0	0.2	79	85	1.5
Jamaica	2.8	0.4	71	76	2.3
Japan	126.4	-0.1	80	87	1.4
Jordan	6.5	1.9	72	75	2.9
Kazakhstan	16.4	1.0	62	73	2.5
Kenya	42.7	2.7	57	59	4.6
Kiribati	0.1	1.5	66	71	2.9
Korea, Democratic People's Republic of	24.6	0.4	66	72	2.0
Korea, Republic of	48.6	0.4	77	84	1.4
Kuwait	2.9	2.4	74	76	2.3
Kyrgyzstan	5.4	1.1	64	72	2.6
Lao People's Democratic Republic	6.4	1.3	66	69	2.5
Latvia	2.2	-0.4	69	79	1.5
Lebanon	4.3	0.7	71	75	1.8
Lesotho	2.2	1.0	50	48	3.1
Liberia	4.2	2.6	56	59	5.0
Libya	6.5	0.8	73	78	2.4
Lithuania	3.3	-0.4	67	78	1.5
Luxembourg	0.5	1.4	78	83	1.7
Madagascar	21.9	2.8	65	69	4.5
Malawi	15.9	3.2	55	55	6.0
Malaysia	29.3	1.6	73	77	2.6
Maldives	0.3	1.3	76	79	1.7
Mali	16.3	3.0	51	53	6.1
Malta	0.4	0.3	78	82	1.3
Martinique	0.4	0.3	77	84	1.8
Mauritania	3.6	2.2	57	61	4.4
Mauritius[3]	1.3	0.5	70	77	1.6
Mexico	116.1	1.1	75	80	2.2
Micronesia (Federated States of)	0.1	0.5	68	70	3.3
Moldova, Republic of	3.5	-0.7	66	73	1.4
Mongolia	2.8	1.5	65	73	2.4
Montenegro	0.6	0.1	73	77	1.6
Morocco	32.6	1.0	70	75	2.2
Mozambique	24.5	2.2	50	52	4.7
Myanmar	48.7	0.8	64	68	1.9
Namibia	2.4	1.7	62	63	3.1

Country, territory or other area	Total population in millions, 2012	Average annual rate of population change, per cent, 2010-2015	Life expectancy at birth, 2010-2015		Total fertility rate, per woman, 2010-2015
Nepal	31.0	1.7	68	70	2.6
Netherlands	16.7	0.3	79	83	1.8
New Zealand	4.5	1.0	79	83	2.1
Nicaragua	6.0	1.4	71	77	2.5
Niger	16.6	3.5	55	56	6.9
Nigeria	166.6	2.5	52	53	5.4
Norway	5.0	0.7	79	83	1.9
Occupied Palestinian Territory	4.3	2.8	72	75	4.3
Oman	2.9	1.9	71	76	2.1
Pakistan	180.0	1.8	65	67	3.2
Panama	3.6	1.5	74	79	2.4
Papua New Guinea	7.2	2.2	61	66	3.8
Paraguay	6.7	1.7	71	75	2.9
Peru	29.7	1.1	72	77	2.4
Philippines	96.5	1.7	66	73	3.1
Poland	38.3	0.0	72	81	1.4
Portugal	10.7	0.0	77	83	1.3
Qatar	1.9	2.9	79	78	2.2
Romania	21.4	-0.2	71	78	1.4
Russian Federation	142.7	-0.1	63	75	1.5
Rwanda	11.3	2.9	54	57	5.3
Saint Kitts and Nevis	0.1	1.2			
Saint Lucia	0.2	1.0	72	78	1.9
St. Vincent and the Grenadines	0.1	0.0	70	75	2.0
Samoa	0.2	0.5	70	76	3.8
São Tomé and Príncipe	0.2	2.0	64	66	3.5
Saudi Arabia	28.7	2.1	73	76	2.6
Senegal	13.1	2.6	59	61	4.6
Serbia	9.8	-0.1	72	77	1.6
Seychelles	0.1	0.3			
Sierra Leone	6.1	2.1	48	49	4.7
Singapore	5.3	1.1	79	84	1.4
Slovakia	5.5	0.2	72	80	1.4
Slovenia	2.0	0.2	76	83	1.5
Solomon Islands	0.6	2.5	67	70	4.0
Somalia	9.8	2.6	50	53	6.3
South Africa	50.7	0.5	53	54	2.4
South Sudan	10.7	3.2			
Spain	46.8	0.6	79	85	1.5

Demographic indicators

Male Female

Country, territory or other area	Total population in millions, 2012	Average annual rate of population change, per cent, 2010-2015	Life expectancy at birth, 2010-2015		Total fertility rate, per woman, 2010-2015
Sri Lanka	21.2	0.8	72	78	2.2
Sudan[5]	35.0	2.2			
Suriname	0.5	0.9	68	74	2.3
Swaziland	1.2	1.4	50	49	3.2
Sweden	9.5	0.6	80	84	1.9
Switzerland	7.7	0.4	80	85	1.5
Syrian Arab Republic	21.1	1.7	74	78	2.8
Tajikistan	7.1	1.5	65	71	3.2
Tanzania, United Republic of	47.7	3.1	58	60	5.5
Thailand	69.9	0.5	71	78	1.5
The former Yugoslav Republic of Macedonia	2.1	0.1	73	77	1.4
Timor-Leste, Democratic Republic of	1.2	2.9	62	64	5.9
Togo	6.3	2.0	56	59	3.9
Tonga	0.1	0.4	70	75	3.8
Trinidad and Tobago	1.4	0.3	67	74	1.6
Tunisia	10.7	1.0	73	77	1.9
Turkey	74.5	1.1	72	77	2.0
Turkmenistan	5.2	1.2	61	69	2.3
Turks and Caicos Islands	0.0	1.2			
Tuvalu	0.0	0.2			
Uganda	35.6	3.1	54	55	5.9
Ukraine	44.9	-0.5	64	75	1.5
United Arab Emirates	8.1	2.2	76	78	1.7
United Kingdom	62.8	0.6	78	82	1.9
United States of America	315.8	0.9	76	81	2.1
Uruguay	3.4	0.3	74	81	2.0
Uzbekistan	28.1	1.1	66	72	2.3
Vanuatu	0.3	2.4	70	74	3.7
Venezuela (Bolivarian Republic of)	29.9	1.5	72	78	2.4
Viet Nam	89.7	1.0	73	77	1.7
Yemen	25.6	3.0	65	68	4.9
Zambia	13.9	3.0	49	50	6.3
Zimbabwe	13.0	2.2	54	53	3.1

World and regional data[14]	Total population in millions, 2012	Average annual rate of population change, per cent, 2010-2015	Life expectancy at birth, 2010-2015		Total fertility rate, per woman, 2010-2015
World	**7,052.1**	**1.1**	**67**	**72**	**2**
More developed regions[6]	**1,244.6**	**0.3**	**75**	**81**	**2**
Less developed regions[7]	**5,807.6**	**1.3**	**66**	**69**	**3**
Least developed countries[8]	**870.4**	**2.2**	**58**	**60**	**4**
Arab States[9]	**318.5**	**1.9**	**68**	**72**	**3**
Asia and the Pacific[10]	**3,744.5**	**1.0**	**68**	**71**	**2**
Eastern Europe and Central Asia[11]	**401.9**	**0.3**	**66**	**75**	**2**
Latin America and the Caribbean[12]	**598.3**	**1.1**	**72**	**78**	**2**
Sub-Saharan Africa[13]	**841.8**	**2.4**	**54**	**56**	**5**

Notes for indicators

* Most recent data available used for each country in the period specified.

1 Including Christmas Island, Cocos (Keeling) Islands and Norfolk Island.

2 Formerly Zaire.

3 Including Agalesa, Rodrigues and St. Brandon.

4 Due to the formation in July 2011 of the Republic of South Sudan and its subsequent admission to the United Nations on 14 July 2011, disaggregated data for Sudan and South Sudan as separate States are not yet available for most indicators. Aggregated data presented are for Sudan prior to the independence of South Sudan.

5 Does not include South Sudan

6 More-developed regions comprise North America, Japan, Europe and Australia-New Zealand.

7 Less-developed regions comprise all regions of Africa, Latin America and Caribbean, Asia (excluding Japan), and Melanesia, Micronesia and Polynesia.

8 Least-developed countries according to standard United Nations designation.

9 Comprising Algeria, Bahrain, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Morocco, Occupied Palestinian Territory, Oman, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen.

10 Includes only UNFPA programme countries, territories or other areas: Afghanistan, Bangladesh, Bhutan, Cambodia, China, Cook Islands, Democratic People's Republic of Korea, Fiji, India, Indonesia, Iran (Islamic Republic of), Kiribati, Lao People's Democratic Republic, Malaysia, Maldives, Marshall Islands, Micronesia, Mongolia, Myanmar, Nauru, Nepal, Niue, Pakistan, Palau, Papua New Guinea, Philippines, Samoa, Solomon Islands, Sri Lanka, Thailand, Timor-Leste, Tokelau, Tonga, Tuvalu, Vanuatu, Viet Nam.

11 Includes only UNFPA programme countries, territories or other areas: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Romania, Russian Federation, Serbia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkmenistan, Ukraine, Uzbekistan.

12 Includes only UNFPA programme countries, territories or other areas: Anguilla, Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bermuda, Bolivia (Plurinational State of), Brazil, British Virgin Islands, Cayman Islands, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Montserrat, Netherlands Antilles, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, Turks and Caicos, Uruguay, Venezuela (Bolivarian Republic of).

13 Includes only UNFPA programme countries, territories or other areas: Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.

14 Regional aggregations are weighted averages based on countries with available data.

Technical notes: Data sources and definitions

The statistical tables in *The State of World Population 2012* include indicators that track progress toward the goals of the Programme of Action of the International Conference on Population and Development (ICPD) and the Millennium Development Goals (MDGs) in the areas of maternal health, access to education, reproductive and sexual health. In addition, these tables include a variety of demographic indicators.

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, especially the Population Division of the United Nations Department of Economic and Social Affairs. In some instances, therefore, the data in these tables differ from those generated by national authorities.

Regional averages are based on data about countries and territories where UNFPA works, rather than on strict geographical definitions employed by the Population Division of the United Nations Department of Economic and Social Affairs. For a list of countries included in each regional category in this report, see the "Notes for indicators."

Monitoring ICPD Goals

Maternal and Newborn Health

Maternal mortality ratio, per 100,000 live births. Source: World Health Organization (WHO), UNICEF, UNFPA and World Bank. 2010. *Trends in maternal mortality: 1990 to 2010:* WHO. This indicator presents the number of deaths to women per 100,000 live births which result from conditions related to pregnancy, delivery, the postpartum period, and related complications. Estimates between 100-999 are rounded to the nearest 10, and above 1,000 to the nearest 100. Several of the estimates differ from official government figures. The estimates are based on reported figures wherever possible, using approaches that improve the comparability of information from different sources. See the source for details on the origin of particular national estimates. Estimates and methodologies are reviewed regularly by WHO, UNICEF, UNFPA, academic institutions and other agencies and are revised where necessary, as part of the ongoing process of improving maternal mortality data. Because of changes in methods, prior estimates for 1995 and 2000 may not be strictly comparable with these estimates. Maternal mortality estimates reported here are based on the global database on maternal mortality, which is updated periodically.

Births attended by skilled health personnel, per cent, 2000/2010 Source: *WHO global database on maternal health indicators, 2012 update. Geneva, World Health Organization (http://www.who.int/gho).* 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.

Adolescent birth rate, per 1,000 women aged 15-19, 1991/2010 Source: United Nations, Department of Economic and Social Affairs, Population Division (2012). *2012 Update for the MDG Database: Adolescent Birth Rate* (POP/DB/Fert/A/MDG2012). The adolescent

birth rate measures the annual number of births to women 15 to 19 years of age per 1,000 women in that age group. It 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.

Under age 5 mortality, per 1,000 live births. Source: United Nations, Department of Economic and Social Affairs, Population Division (2011). *World Population Prospects: The 2010 Revision. DVD Edition - Extended Dataset in Excel and ASCII formats (United Nations publication, ST/ESA/SER.A/306)*. Under age 5 mortality is the probability (expressed as a rate per 1,000 live births) of a child born in a specified year dying before reaching the age of five if subject to current age-specific mortality rates.

Sexual and reproductive health

Contraceptive prevalence. Source: United Nations, Department of Economic and Social Affairs, Population Division (2012). *2012 Update for the MDG Database: Contraceptive Prevalence* (POP/DB/CP/A/MDG2012). These data are derived from sample survey reports and 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. These numbers are roughly but not completely comparable across countries due to variation in the timing of the surveys and in the details of the questions. All country and regional data refer to women aged 15-49. The most recent survey data available are cited, ranging from 1990-2011.

Unmet need for family planning. Source: United Nations, Department of Economic and Social Affairs, Population Division (2012). *2012 Update for the MDG Database: Unmet Need for Family Planning (POP/DB/CP/B/MDG2012).* Women with unmet need for spacing births are those who are fecund and sexually active but are not using any method of contraception, and report wanting to delay the next child. This is a subcategory of total unmet need for family planning, which also includes unmet need for limiting births. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior. For MDG monitoring, unmet need is expressed as a percentage based on women who are married or in a consensual union. For further analysis, see also *Adding it Up: Cost and Benefits of Contraceptive Services: Estimates for 2012.* Guttmacher Institute and UNFPA.

Education

Male and female net enrolment rate in primary education (adjusted), male and female net enrolment rate in secondary education, 2010 or latest year. Source: UNESCO Institute for Statistics, data release of May 2012. Accessible through: stats.uis.unesco.org. The net enrolment rates indicate the enrolment of the official age group for a given level of education expressed as a percentage of the corresponding population. The adjusted net enrolment rate in primary also includes children of official primary school age enrolled in secondary education. Data presented are the most recent year estimates available for the period 1999-2011.

Demographic indicators

Total population, 2012. Source: United Nations, Department of Economic and Social Affairs, Population Division (2011). *World Population Prospects: The 2010 Revision. DVD Edition - Extended Dataset in Excel and ASCII formats* (United Nations publication, ST/ESA/SER.A/306) These indicators present the estimated size of national populations at mid-year.

Average annual rate of population change (%) Source: United Nations, Department of Economic and Social Affairs, Population Division (2011). *World Population Prospects: The 2010 Revision. DVD Edition - Extended Dataset in Excel and ASCII formats* (United Nations publication, ST/ESA/SER.A/306). Average annual rate of population change is the average exponential rate of growth of the population over a given period. It is based on a medium variant projection.

Male and female life expectancy at birth. Source*: United Nations, Department of Economic and Social Affairs, Population Division (2011). World Population Prospects: The 2010 Revision. DVD Edition - Extended Dataset in Excel and ASCII formats (United Nations publication, ST/ESA/SER.A/306).* These indicators are measures of mortality levels, respectively, and represent the average number of years of life expected by a hypothetical cohort of individuals who would be subject during all their lives to the mortality rates of a given period. Data are for the period 2010-2015 and are expressed as years.

Total fertility rate. Source: United Nations, Department of Economic and Social Affairs, Population Division (2011). *World Population Prospects: The 2010 Revision. DVD Edition - Extended Dataset in Excel and ASCII formats* (United Nations publication, ST/ESA/SER.A/306). The measure indicates the number of children a woman would have during her reproductive years if she bore children at the rate estimated for different age groups in the specified time period. Countries may reach the projected level at different points within the period. Estimates are for the period 2010-2015.

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