The Right to Choose:

Reproductive Rights and Reproductive Health
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We must be courageous in speaking out on the issues that concern us: we must not bend under the weight of spurious arguments invoking culture or traditional values. No value worth the name supports the oppression and enslavement of women. The function of culture and tradition is to provide a framework for human well-being. If they are used against us, we will reject them, and move on. We will not allow ourselves to be silenced.

- Dr. Nafis Sadik, UNFPA Executive Director, Beijing, 1995
Rights, Empowerment, and Development

Yet millions still suffer from disease, injustice, injury, stunted lives, and even death when this right is denied. Most of these people are women, and most of these women are in the developing world.

What are sexual and reproductive rights?

The current international understanding of sexual and reproductive rights includes the rights to:

- Reproductive and sexual health as a component of overall lifelong health.
- Reproductive decision-making, including choice in marriage, family formation, and determination of the number, timing, and spacing of one's children; and the right to the information and the means to exercise those choices.
- Equality and equity for women and men to enable individuals to make free and informed choices in all spheres of life, free from gender discrimination.
- This publication summarizes The State of World Population 1997, published by the United Nations Population Fund (UNFPA). UNFPA's third State of World Population report after the ICPD tracked the progress made and the problems encountered since that historic declaration in Cairo.

The effect of denying sexual and reproductive rights

The following statistical estimates show just some of the terrible effects of denying these human rights:

- 585,000 women-one every minute-die each year from causes related to pregnancy.
- About 200,000 maternal deaths each year result from lack or failure of contraceptive services.
- 120-150 million women who want to limit or space their pregnancies are still without the means to do so effectively.
- At least 75 million pregnancies each year (out of a total of 175 million) are unwanted; they result in 45 million abortions and over 30 million live births.
- 70,000 women die each year as a result of unsafe abortion: an unknown number suffer from infection and other health consequences.
- 1 million people die each year from reproductive tract infections, including sexually transmitted diseases (STDs) other than HIV/AIDS. There are an estimated 333 million new cases of STDs per year.
- Six out of ten women in many countries have a sexually transmitted disease. All face a higher risk of infertility, cervical cancer, or other serious health problems.
- 3.1 million people in 1996 were infected by the human immunodeficiency virus (HIV) which leads to AIDS.
- 120 million women have suffered female genital mutilation; another 2 million are at risk each year. The international community and individual governments have condemned the practice, yet it remains widespread in 28 countries.
Reproductive Health Access Up, Fertility and Population Growth Down

Meeting people's needs for reproductive health care and family planning has helped reduce fertility rates and slow population growth around the world. In a number of countries, the average number of children per woman declined significantly in the past decade, the current global average is 2.96. The unexpected pace of this decline led the United Nations to reduce its estimate of world population, which in mid-1997 stood at 5.85 billion. The population in 2050 is expected to be roughly 9.4 billion, nearly half a billion less than previously projected.

Nevertheless, fertility rates remain high in many countries, indicating considerable unmet need for family planning services. Population growth, though slower than ten years ago, is still at 81 million additional persons per year. What happens with these trends in the future will depend largely on the actions or inactions of the world's nations in the next few years.

Rape and other forms of sexual violence are increasing. Unfortunately, the stigma of rape has kept all but 3 per cent in South Africa and 16 per cent in the United States, for example, from being reported.

At least 60 million girls are "missing" from the population due to son-preference, via either sex-selective abortions or neglect.

2 million girls between 5 and 15 years old are put on the commercial sex market every year.

Nearly 600 million women are illiterate, compared with about 320 million men.

Refugees are only now being offered reproductive health care. Contraception for women could be offered for just $1 to $5 per woman; safe childbirth could be guaranteed for $5 to $10.

The total worldwide cost of better reproductive health care is roughly $17 billion per annum—less than one week of the world's expenditure on armaments.

Human rights, global needs

Achieving sexual and reproductive rights for all is an end in itself; it needs no further justification. But it also confers great benefits on the economic and social life of the community, and the future of the planet.

Global and national needs coincide with personal rights and interests in this case. Given the choice, most women and men have smaller families. Lowering the disease and mortality burden, lessening the ravages of hunger, and improving the education and opportunities of the people are just some of the benefits that accrue.

In fact, the most practical and effective way to improve a nation's prospects is to give the power of reproductive choice to its people. Each country and community needs to invest in the necessary social services. Most of all, they must invest in women and redress the injustices under which they labour enabling them to make choices on an equal basis with men.
Reproductive Health and Human Rights

In recent decades, most nations have come to recognize and accept the right of their citizens to reproductive health. Accordingly, they have signed treaties and accords, and endorsed the programmes of conferences on population and development.

The importance of this, of course, is that there is now an international standard that practice can be measured against—a standard that draws on the best principles of all societies, and can protect individuals from local injustices and discrimination. There are now several legal instruments recognized by the world community that support and demand the protection of the right to reproductive and sexual health.

The Legal Framework
The right to reproductive and sexual health is not really new. It is a necessary component of long-established and internationally recognized human rights: to life and survival, liberty and personal security, equal treatment, education, development, and the highest attainable standard of health. Nor is it a specifically “Western” idea. In every culture, the health and security of the individual are recognized as important to both the individual and the community.

In 1945, the United Nations Charter was drawn up in the aftermath of World War II. There, at the beginning, the nations declared that one purpose of their new assembly would be to “achieve international cooperation in ... promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion.” Just three years later, the Universal Declaration of Human Rights set a “common standard of achievement for all peoples and nations” for ensuring fundamental political, social, economic, and cultural rights and freedoms. Declaring that these rights were the foundation of freedom, justice, and peace in the world, the document also reaffirmed the UN Charter’s “faith in fundamental human rights, in the dignity and worth of the human person, and in the equal rights of men and women.”

Over the years, the process of refining and reinforcing these basic international agreements has continued. In the 1970s, the international community agreed to two additional treaty covenants: the International Covenant on Civil and Political Rights (the "Political Covenant"), and the International Covenant on Economic, Social, and Cultural Rights (the “Economic Rights Covenant”). That there were two agreements reflected a difference of emphasis between states more concerned with individual rights and states more concerned with group rights. But both covenants agreed on the right of women to be free of all forms of discrimination, and on family rights.

Specifically, the Economic Rights Covenant obligates states to take all steps necessary to reduce stillbirth and maternal mortality, and to assure medical services to all and medical attention in the event of sickness. The Political Covenant, in an optional protocol, enables individuals from participating states to make complaints about rights violations, and obliges states to respond if violations are found.

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These two Covenants have not been ratified by all countries, however, and many have done so only with substantial reservations.

In 1979, in an attempt to fight the worldwide social, cultural, and economic discrimination against women, the UN General Assembly adopted the Women's Convention (formally the Convention on the Elimination of All Forms of Discrimination Against Women). It declares that states must act to eliminate violations of women's rights whether by private persons, groups, or organizations. It compels nations to work to eradicate discrimination in all its forms—including disadvantages conferred by gender roles.

Articles in the Women's Convention relevant to reproductive health include the following issues: that states should endeavour to modify social and cultural patterns of conduct that stereotype either gender or put women in an inferior position; that states should ensure that women have equal rights in education and equal access to information; that states should eliminate discrimination against women in their access to health care; and that states should end discrimination against women in all matters relating to marriage and family relations.

The Convention on the Rights of the Child (1989), ratified by nearly all countries, has encoded a broad set of rights for children, and reaffirmed the right to family planning services (recognized by prior conventions and conferences). It compels states to confirm that they are making an effort to realize its goals, which include:

- Ensuring appropriate prenatal and post-natal health care for mothers.
- Abolishing traditional practices prejudicial to the health of children.
- Protecting children from sexual exploitation and abuse.
- Giving children access to information they need for their social, spiritual, and moral wellbeing, and physical and mental health.

**Monitoring compliance**

The nations did not simply sign the conventions and treaties and walk away—all signatories agreed to be monitored by the so-called treaty bodies, and report to them on a regular basis on the actions they have taken to live up to their promises to protect these rights. The treaty bodies also hear complaints from individuals whose rights have been violated.

Once reports have been submitted, the treaty organizations review them and make recommendations about actions the country or group needs to take to protect or expand a right. They also, with the consent of the signatory nations, define standards and interpret the scope of rights codified in the treaties. And they specify what countries should include in their periodic reports on treaty compliance.

One of the most important monitoring organizations for reproductive and sexual health and rights is the Committee on the Elimination of Discrimination Against Women (CEDAW), which monitors implementation of the Women's Convention.

The UN system includes various other human rights commissions, working groups, and reporting systems. Special rapporteurs, for example, examine specific issues globally or in individual countries for the Commission on Human Rights.

Once they enter into force, treaties are legally binding on all states that accept them. They are under constant review, and the interpretation of the obligations they embody is discussed by all the countries involved. (See the section on the Glen Cove meeting of treaty organizations, page 27.)
Consensus decisions of international conferences

Conference documents are not legally binding, but the human rights treaty bodies can take their recommendations into account in setting standards. These conference documents express the international conscience on matters of human rights, and are therefore powerful tools for change.

The 1993 World Conference on Human Rights (Vienna) declared human rights to be a universal norm, independent of the standards of individual states. It emphasized that the rights of women and girls are "an inalienable, integral, and indivisible part of human rights" requiring special attention. It urged that greater priority be given to "the eradication of all forms of discrimination on grounds of sex" and to the eradication of all forms of gender-based violence. The conference called for universal ratification of the Women's Convention by the year 2000, and for a special rapporteur to monitor the issue of violence against women.

In 1994, the International Conference on Population and Development convened in Cairo, Egypt. The ICPD Programme of Action stated that development and human (and, specifically, women's) rights are interdependent, and that reproductive rights are included in human rights that are already recognized in international law.

Speaking of women, the Programme of Action is quite specific (Chapter 2, Principle 4): "Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population- and development-related programmes.... The full and equal participation of women in civil, cultural, economic, political, and social life at the national, regional, and international levels, and the eradication of all forms of discrimination on grounds of sex, are priority objectives of the international community."

The Fourth World Conference on Women (Beijing, 1995) reaffirmed and underlined the Cairo consensus. Signatories agreed that women must be freed from all forms of discrimination, coercion, and violence, and be empowered to make free and responsible decisions about their sexuality and reproductive health.

ICPD on Reproductive Health and Rights

ICPD Programme of Action, Chapter 2, Principle 8: “Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a 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. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education, and means to do so.”

Components of Reproductive and Sexual Rights

The United Nations Population Fund, the World Health Organization (WHO), and the International Planned Parenthood Federation (IPPF) make the protection of reproductive and sexual rights a central focus of their work.

What are these rights, then, and what do they entail?

- The right to survival/right to life. abrogated by maternal mortality.
The right to liberty and security of the person: abrogated by female genital mutilation, compulsory sterilization, and the criminalization of contraception, among others.

The right to the highest attainable standard of health.
The right to family planning.
The right to marry and found a family.

The right to a private and family life: abrogated by state or community interference in the decision of whether or when to have children.

The right to the benefits of scientific progress: including quality contraception.
The right to receive and impart information, and to freedom of thought.
The right of women to education.
The right to non-discrimination on the basis of sex.

The right to non-discrimination on the basis of age: abrogated when young people are denied information and confidentiality about reproductive health services.

Reforming Laws and Policies
More and more states are now incorporating these rights into their laws and constitutions. Alongside legal reforms, many governments are also revising their population and development strategies to emphasize individual needs and rights. They recognize that population dynamics and distributions are closely connected to education, the empowerment of women, protection of the environment, and finally, prospects for sustainable development.

Words are one thing, however; actions are another. Not all policies are implemented, and not all laws are enforced. Legal protection may be available, for example, only (in practical terms) to the rich. So progress has been made, but much remains to be done.
Some of the doers are non-governmental organizations (NGOs): human rights groups, women's groups, health activists, local community groups, religious organizations, and public service groups. In addition to helping provide much-needed reproductive health information and services, many lobby governments to live up to their commitments made at Cairo and Beijing.

To make a difference in the lives of the people, the consensuses of Cairo and Beijing will need to be integrated into the treaty process and made law. Governments must also be urged to withdraw their reservations to the Women's Convention, and groups and individuals (not just states) will need to be allowed to report violations to CEDAW.

**Why Rights Matter**

Human rights rest on a moral basis that all can recognize, and as such, they need no defence. But guaranteeing these rights is also not only practical, but a matter of more urgency for all of us than ever before. These are some of the global trends that demand immediate action on these issues:

Urbanization—More and more people and cultures, with different attitudes and practices, are in contact and sometimes collision. Consensus-based human rights safeguards can be the mortar between these very different bricks, and promote social cohesion.

International and internal travel and migration—They are accelerating with modern transport and communication. Wars and internal conflicts are driving millions of refugees across countries and borders. A common understanding of the fundamental rights and protections of individuals is sorely needed in this turmoil.

Increasing complexity and decentralization of governments—The only way to protect the rights of the people across the board is to rely on uniform guidelines and standards.

Civil society's growing role—Non-governmental institutions are vital to sustainable development, and they function best in a climate of commonly understood rights. They can also advocate those rights and monitor their protection.

The collapse of civil administration—In wars and conflicts, the innocent must be protected from the predation of the powerful. They need impartial and strong advocates.

Transnational entities and multinational corporations—These entities are increasingly powerful, sometimes too much so for a host nation to regulate. But they could be held accountable to an international code of conduct.

Rapid social change—Firm agreement on human rights standards provides a basis for assessing both tradition and innovation.
Women’s sexual and reproductive roles have largely determined their social status, economic opportunities, and self-worth. Ironically, for most women, childbearing has been both over-valued and under-supported.

Changes have taken place in the last few decades. The percentage of couples using some form of modern contraceptive has skyrocketed, from 15 per cent in 1960 to nearly 60 per cent across the developing world, and 70 per cent elsewhere. And women’s ability, at long last, to control their fertility is changing power relations between the sexes.

But women still carry a much heavier-and largely avoidable-burden of poor health related to reproduction and sexuality.

Poor Women, Poor Health

Poor women who lack adequate food, basic health care, or modern contraception suffer grave consequences. A woman who is malnourished and in poor health runs much greater risks in sexual contacts and childbearing, and she usually is forced to suffer from illness and complications of pregnancy without proper treatment. Many such women die.

The major categories of illness and mortality of poor women relating to reproductive health are:

Malnutrition, anaemia: In many families, girls and women are last in line for food. Malnutrition contributes more than any other single factor to disease and injury worldwide. Anaemia, one consequence of malnutrition, is the third leading cause of disease among women in developing countries, accounting for even more of the disease burden than war.

Complications of pregnancy: More than 585,000 women die each year from causes related to pregnancy. For each death, at least 13 women suffer from other threats to their health. And nearly all maternal deaths are in developing countries: an African woman is 500 times more...
likely to die of these causes than her counterpart in one of the Scandinavian countries.

Obstructed labour, haemorrhage, and postpartum infection are the chief threats to the health of poor mothers. Obstructed labour is often due to the youth of the mother: the undeveloped pelvis is too small. Other mothers' growth is stunted by malnutrition. These women suffer hours of terrible pain in labour, and can haemorrhage or become infected. Some are permanently crippled.

**Sexually transmitted diseases:** There are an estimated 333 million new cases of STDs every year. Worldwide, the number of women afflicted by these is five times the number of men. Almost two thirds of infertility cases are caused by STDs. And fully 50 per cent of HIV infections are to young people aged 15-24. For girls and young women, intercourse is much likelier to lead to infection. The practices of "dry sex" and female genital mutilation place them at even greater risk of injury and infection.

STDs cause pregnancy-related complications, sepsis, spontaneous abortions, premature births, stillbirths, and congenital infections. Thirty-five per cent of post-partum illness is attributed to sexually transmitted diseases. The human papilloma virus is a cause of cervical cancer, the second most common cancer in the world.

**HIV/AIDS:** There are now 22.6 million people living with HIV/AIDS. So far, 6.4 million have died. According to UNAIDS estimates, there were over 3.1 million new HIV infections in 1996 alone-more than 8,500 a day. The majority of newly infected adults are just 15 to 24 years old.

Worldwide, 75 to 85 per cent of HIV infections in adults were transmitted through sex without condoms. Heterosexual intercourse accounts for more than 70 per cent of all adult HIV infections. Mother-to-child transmission accounts for more than 90 per cent of all infections in infants and children. Over 85 per cent of these children are in sub-Saharan Africa.

**Unsafe abortion:** About 70,000 women die each year from unsafe abortion, and a much larger number suffer from infection, injury, and trauma. Victims of unsafe abortions fill hospital wards. The ICPD called on all governments to reduce the impact of unsafe abortion by increasing access to family planning, providing services to manage the consequences of abortion, and assuring that legal abortions are performed safely. Better contraceptive services for all would greatly reduce abortions: in Bolivia, for example, only 7 per cent of women hospitalized for abortion complications had ever used contraception, yet 77 per cent said that they wanted to do so.

**Female genital mutilation:** Female genital mutilation (FGM) is a traditional practice with horrific effects on the health of girls and women. The International Conference on Population and Development and the Fourth World Conference on Women condemned FGM as a violation of human rights.

It is estimated that over 120 million living women have endured some form of genital mutilation, and at least 2 million girls per year are at risk of mutilation. Pain, injury, infections, loss of all sexual feeling, pain in intercourse and childbirth are just some of the complications of these cruel procedures.

The custom of female genital mutilation shows a desire to control and limit women's sexual experience and reinforce established gender roles. Such practices are often defended, not only by men but also by women who have undergone the procedure, as being central to their religion or cultural identity, and many resist and resent those who oppose the practice. But a WHO/UNICEF/UNFPA joint statement stresses that societies can "give up harmful practices
Without giving up meaningful aspects of their culture.

Efforts to eliminate female genital mutilation are gaining ground. In Uganda, a culturally sensitive initiative known as REACH (Reproductive, Educative, and Community Health) was launched in January 1996. REACH has actively sought to educate local leaders, policy makers, health professionals, parents, and adolescents on the need to do away with the practice. It stresses that a community's cultural values are different from cultural practices, and that the latter can change. The programme reports that the number of girls and women undergoing FGM in western Uganda declined by 36 per cent between 1994 and 1996.

Towards Successful Reproductive Health Services

Much progress has been made and should be acknowledged, yet much still needs to be done. Most countries have yet to make reproductive health an achievable goal for their citizens. But the track records of various health programmes in different countries in the last two decades have shown what works, and what does not. The successful programmes are both inspiration and example, showing the way ahead.

The life-cycle approach: Reproductive health is a lifelong concern for both women and men, with specific issues that change over the course of people's lives. Men need early socialization in sexual responsibility to promote healthy sexual and family-formation behaviour; women need protection from discrimination and positive moves towards equality. Both need reproductive health care suitable to their age and situation.

Too many women are regarded solely as wives and the bearers of children. Maternal and child health programmes traditionally have focused on the welfare of the children, addressing only a small fraction of the women's health needs. Adolescents, in particular, need information and services that will enable them to be responsible in exercising their sexual and reproductive rights. Parents should do no harm to children's reproductive and sexual health potential.

Integrated health programmes—treating the person in context. Improved access to primary health care, agreed upon at the Alma Ata "Health for All" Conference in 1978, has led to longer and healthier lives for many of the world's peoples. But matching resources and needs can be difficult. Population growth, stagnant budgets, structural adjustment programmes, and problems in the changeover from communism to capitalism have hit hard, causing declines in life expectancy in some regions.

The long-term economic viability (or sustainability) of health programmes will need a balanced mix of funding sources—the central
budget, local governments and communities, the private sector, NGOs, and consumers. Inefficiency and corruption in the public sector have been a problem. The private sector and NGOs in such cases are not always able to carry the load instead.

Successful health programmes also need to be (generally) under one roof, or “vertically integrated”, offering a wide range of services. Administrative integration means the end of segregating reproductive health as a poorly funded and even neglected sideline in the health establishment. Patients will receive better care, and referrals to other services can be made where necessary.

**Integrating reproductive health care.** Providing quality services is not going to be easy for countries with tight budgets. It will call for concentration of resources, integrated primary health care, staff training and career development—and the imaginative use of every possible means of service delivery. Nevertheless, many countries are prepared to make this investment in the future.

A key objective of integrated reproductive health care is to ensure that women know their options and exercise them, instead of suffering in silence, ignorance, and shame. In that sense, it goes beyond the clinic and into the wider society, and involves raising the status and educational level of women.

**Prenatal care, attended births:** At the ICPD, the international community called for maternal mortality to be reduced to half the 1990 level by the year 2000, and halved again by 2015—but extending the scope of maternal and child health services is proving to be much tougher than anyone expected. Reaching this goal will require emergency obstetrical care to be broadly available, and attended birth to be the norm.

The proportion of births that are attended by trained personnel varies widely—from near-universality in the industrialized nations, to 2 per cent in some regions of Africa. The widest variation is in Asia: from 6 per cent in Nepal to 97 per cent in Sri Lanka.

Training traditional birth attendants helps. But there still need to be trained doctors and nurses to handle medical emergencies, emergency blood supplies, and equipment.

**Quality of care:** Some facilities lack even such basics as clean water, electricity, and equipment; others struggle with insufficient or under-trained staff, no blood supplies, and shortages of drugs and other supplies.

**Facilities.** The crucial ingredients of a decent facility are the physical structure, equipment and supplies, and trained staff. Water, light, and cleanliness, including sterilizers, are vital, but lacking in an alarmingly high percentage of clinics.

**Training, supervision, and accountability.** In many clinics, supervisors rarely visit, and when they do, they seldom watch the clients interacting with the clinic staff. Quality of care suffers from this lack of supervision and monitoring. Service providers who run clinics need to listen to their patients as well, and try whenever possible to respond to their needs and listen to their recommendations. The gender of service providers is important, too: because of modesty taboos, it is often more practical to have trained female staff and female doctors available to examine clients.

**Response to reproductive health needs.** Privacy and time spent counselling each client are also important to the effectiveness of care. Offering broad-spectrum reproductive health care (rather than just handing out contraceptives) demands that the staff spend time with each client, explaining the risks and benefits of various
methods, asking about their family circumstances and reproductive goals, and asking questions that will unearth any other reproductive health problems the client may be unaware of or embarrassed about. Service providers must be candid about side-effects, and make sure that they are not prescribing inappropriate methods (IUDs to women suffering from infections, for example).

Poorly trained or biased staff, on the other hand, can evade questions or suppress information, or stress the problems with methods and procedures they personally disapprove of. Their beliefs can affect what they recommend, and to whom.

Follow-up. Follow-up should be more than just short visits to the clinic to renew contraceptive supplies. Older women and men may be interested in sterilization if they have completed their families. Some people need protection against STDs as well as pregnancy. Some who suffer from side-effects need information about alternatives, and treatment for any problems that arise.

Record-keeping is also critical to the health system as a whole to discover what the people’s needs are, how they are being met, and what should be improved.

Choice of family-planning methods: If people can find the right family planning method for their needs, they are much likelier to use it. A range of choice is necessary for a reproductive health programme to reach all the people who wish to take advantage of it.

Current contraceptive use worldwide is now approaching 60 per cent, up from an estimated 57 percent in 1991. Sub-Saharan Africa has the lowest rate of contraceptive use-only 13 per cent of all couples. Of these, just two thirds are using modern methods. In all other developing regions, more than 80 per cent of couples that practise contraception use modern methods.

Sterilization accounts for 40 per cent of global contraceptive use.

Unmet needs for reproductive health: The International Conference on Population and Development estimated that fully 350 million couples worldwide lack access to the full range of modern family planning methods. As many as 150 million married women who wish to cease bearing children or delay their next birth are not using any method of family planning.

Others in need of reproductive health services include those who need STD prevention and treatment, infertility services, safe childbirth, maternal and child care, and sexual health services. Unmarried adults or adolescents, married or not, are often given short shrift or excluded from services. Millions of others who are receiving services of some sort are poorly served, by lack of or incorrect information, limited choice of methods, and inadequate counselling, for example.

Another group of people who need reproductive health services is women at extra risk of illness or death in childbearing due to age, the number of children they have already borne, or pre-existing problems.

About 200,000 mothers die each year because of the lack, or failure, of contraceptive services. At least 75 million of the 175 million pregnancies each year—well over one third—are unwanted, resulting in 45 million abortions and 30 million live births.

Lifting the barriers: There are still many official and informal barriers to contraceptive access that need to be lifted, such as spousal authorization (usually applied only to women), age restrictions, and marital status. In addition, governments have historically imposed contraceptive import restrictions and censored certain kinds of information, especially in school sex education programmes.
Sexual and Reproductive Self-Determination

Adolescent Sexuality

Young people are particularly vulnerable, and at the same time ill-served by (or excluded from) most reproductive health programmes. Both girls and boys are usually poorly informed about how to prevent pregnancy and the transmission of diseases, including HIV/AIDS. Teenage mothers have a higher-than-average risk of dying in childbirth, and their children die. But the growing number of adolescents who are having babies or unsafe abortions is due also in part to poverty and poor education. Poor young women and girls the world over are particularly vulnerable to sexual abuse, violence, and prostitution.

Early sexual activity. The start of sexual activity, marriage, and motherhood are now more separate than ever before. Improvements in nutrition mean girls reach menarche at earlier ages. At the same time, the average age at marriage has gone up. Particularly in Asia and sub-Saharan Africa, however, many girls still marry young and begin childbearing early.

Premarital sex, though condemned in most societies (at least for girls), is on the rise in much of the world. In many industrialized countries, young people frequently commence to have sex in their mid- to late teens but do not marry until their twenties. Some of these countries have high rates of adolescent pregnancy and young unwed mothers. More sex education has reduced the number of unintended pregnancies in other industrialized countries.

In some areas, girls are initiated sexually even before they reach puberty. In Malawi, for example, over half of 300 teenage village girls in a survey said they had had sex before menarche. The percentage of prepubescent girls thus initiated varies greatly from place to place, however. Those who report being sexually active before age 15 range from less than 2 per cent in Burundi to more than one third in Liberia. In Great Britain and Northern Ireland, 18.7 per cent of women under age 20 and 27.6 per cent of men report first intercourse before age 16.

Most adolescents, though, are not engaging in premarital sexual relations. Those who do, including the sizeable number who are forced or coerced by older partners, are at greater risk of pregnancy and disease. They are usually too embarrassed to use contraception: taking such precautions is often felt to reflect premeditation rather than spontaneity.

Knowledge about sexuality and contraception: Adolescents everywhere complain of the unwillingness of adults to teach them about reproduction, sexuality, family planning, and reproductive health. Parents are uncomfortable talking about it, and the young people turn to their ill-informed peers-with predictable results.

The myth still persists that sex education leads to promiscuity. But the opposite is true: It has been repeatedly shown that sex education leads to responsible behaviour, higher levels of

Adolescents’ Right to Reproductive Health Services

Acknowledging parental rights to provide appropriate guidance in sexual and reproductive matters, the ICPD Programme of Action (paragraph 7.45) goes on to state: “... Countries must ensure that the programmes and attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need, including on sexually transmitted diseases and sexual abuse. In doing so, ... these services must safeguard the rights of adolescents to privacy, confidentiality, respect, and informed consent, respecting cultural values and religious beliefs.... [C]ountries should, where appropriate, remove legal, regulatory, and social barriers to reproductive health information and care for adolescents.”
Abstinence, later initiation of sexuality, higher use of contraception, and fewer sexual partners. These good effects are even greater when the parents can talk honestly with their children as well.

Such talks are unusual in most societies. In the United States, for instance, fewer than one in three girls and one in six boys discuss these concerns with either parent.

Family life education (FLE) has been part of the curriculum in many countries, but all too many have forbidden discussion of contraception or even reproductive physiology. Teachers' discomfort with these subjects, opposition from some traditionalists and religious groups, fear of parents' criticism, and difficulty in setting priorities can all cause problems.

FLE can help dispel myths and misinformation if it is allowed to cover all the subjects needed to fully inform young people about their sexuality. When the benefits of doing so are understood, parents and communities work with their youth to bring this about.

Rights of adolescents and parents: Most parents want to protect and guide their children, but none want to give them a free rein to do whatever they please. The rights of both parties must be acknowledged and balanced. The rights of the adolescent, however, have only recently been legally recognized, and have much further to go to reach full realization in practice.

Parents must also be realistic about the possibility that their children will engage in sexual activity. The only way to protect them from unwanted pregnancies, disease, and death will be to make available to them the information about sexual and reproductive health and the services they need to take care of themselves.

This does not mean that young people should not be encouraged to be responsible in their
behaviour, or that they will no longer be taught what is acceptable in their society. It does mean that they have the right to private and confidential services to protect them from health risks. Sexual abuse and exploitation of adolescents must also be severely proscribed.

The Convention on the Rights of the Child recognizes the primacy of children's interests in decisions by families, legal systems, and other state action.

**Voluntarism and Marriage**

Marriage customs are part of the fabric of any culture's life, and they differ from place to place. But it is necessary to examine these customs in the light of internationally agreed-upon standards of sexual and reproductive rights.

People should be free to marry or not to marry. There are customs that endanger the right of the parties to freely enter and participate in the marriage contract: child marriage, dowry and bride price arrangements, consanguineous marriage, women's inheritance rights, the timing and frequency of pregnancy, and polygyny.

**Changes in the age at marriage.** Overall, the age of first marriage, for both women and men, has been rising in many parts of the world, most rapidly in Asia and North Africa.

The proportion married by age 20 has remained comparatively stable in Latin America and the Caribbean over the past 20 years, declining only from 50 to 42 per cent. Western Europe and North America have also seen steady rises in the age at marriage, to the mid to late twenties. In all regions, less-educated women are likelier to marry young.

The age of the man, and the gap in ages between spouses, also reflect social expectations and affect marital and other social relationships. Larger age differences between husbands and wives reinforce stereotypes of wifely dependency and powerlessness. These age differences tend to be highest in West Africa (commonly six to nine years). South Africa's age gap is a good bit lower, at over two years.

Girls have traditionally been deemed ready to marry at the onset of menstruation, while men customarily are expected to wait until they can support a wife and family. Such rules reinforce male power and the predominance of women's domestic roles, as does women's comparative lack of education.

**Child marriage.** In a wide variety of societies in Asia, Latin America, and Africa, marriages are arranged by parents during their offspring's childhood or adolescence. In some but not all societies, the young couple have the opportunity to accept or reject the arrangement once they have met.

All nations have marriage laws. These may or may not be enforced, and some are superseded by custom or family decisions. They vary widely in any case. And parents can and do marry off their children in practice, as laws often do not protect young people (even when over the age of consent in some cases) from forced marriages.

**Early childbearing.** Young couples often face strong pressure from their families and communities to begin childbearing immediately. Marriages can be secured by a quick pregnancy or wrecked by lack of one. Teenage brides often feel pressure
to prove they can bear sons. Women aged 15-19 face four times the risk of death during pregnancy or childbirth than women 25-29 years old.

Polygyny. The custom of taking more than one wife used to be widespread in Africa, parts of the Muslim world and parts of Asia. Defenders of the practice claim that it benefits wives, who have co-wives to help with the chores and share the burdens of childbearing, and that it confers status upon senior wives.

Women in these unions, when asked, say they strongly disapprove of the custom, however. Competition, favouritism, and jealousy, they say, create serious problems. A study of the Kaguru people of Tanzania found that the majority of the women there rejected the practice of polygyny. Some respondents were fatalistic, saying they had little power to prevent their husbands from taking another wife. Other responses indicated that women threaten to, and sometimes do, divorce their husbands in such cases. Although the Kaguru women have a substantially heavier workload than the men, the study found no indication that women perceive polygyny as a way to reduce their workload by sharing it with co-wives.

**Son preference:** In Asia alone, at least 60 million girls who would otherwise be expected to be alive are "missing", due to sex-selective abortions, neglect; and in a small number of cases, infanticide. In countries where the couples expressly prefer sons, unusual patterns of child death and distorted sex ratios at birth reflect the low status accorded to girls. When these girls survive, they are often fed less (resulting in malnutrition) and their health neglected.

The lower number of children in such countries has the unfortunate and deadly result of less tolerance for girls, especially in families that have had no sons. Laws in India and China now ban sex-determination testing. In Taiwan (Province of China), a culturally sensitive public education campaign against the practice also tells parents about the risks and possible unreliability of some

**Pregnancy and Childbirth:**

**Intention and Reality**

People no longer feel it is up to fate or the gods to determine when and how many children they will have. They now know they can choose and plan their pregnancies.

**Husband-and-wife communication:** Spouses actually tend to agree about family size and family planning, when interviewed separately. Unfortunately, they seldom talk with each other about family planning or sexuality, so the desire to space or limit births may go unspoken and not be acted upon.
forms of testing, which has lowered the number of sex-selective abortions.

**The Principle of Non-Coercion**

The International Conference on Population and Development and the Fourth World Conference on Women both recognized the right to reproductive self-determination. Coercion in any form, they declared, is unacceptable. For countries, population growth targets have been found to be ineffective and may lead to coercive practices.

Incentives: Using incentives, financial or otherwise, to induce couples to limit their family size or accept contraception has been very controversial. Concerns about abuse led the ICPD to sharply circumscribe their use in its Programme of Action. Incentives, if offered, should be modest and proportional and not infringe on the right of informed choice. Twenty-nine countries used some combination of client incentives in their national family planning programmes in 1994.

Pronatalist pressures: Less attention has been paid to strong pressures, particularly on women, in many societies to have more children than they would choose. The effect of these pressures can amount to coercion.

**Violence against Women**

One expert calls violence against women "the most pervasive yet least recognized human rights abuse in the world", Accordingly, the Vienna Human Rights Conference and the Fourth World Conference on Women gave priority to this terrible problem.

Violence against women jeopardizes their lives, bodies, psychological integrity, and freedom. It generally serves by intention or effect to perpetuate male power and control.

Domestic violence: Most domestic violence everywhere is male violence directed against their women partners. This gender difference appears primarily to be due to the way boys and men are socialized. The search for biological factors in boys and men that might contribute to violence has not identified anything strong enough to account for the dramatic differences in behaviour.

Cross-cultural studies of wife abuse have found that nearly a fifth of peasant and small-scale societies are essentially free of family violence. The existence of such cultures proves that male violence against women is not the inevitable result of male biology or sexuality.

Furthermore, studies of very young boys and girls show only that boys have a lower tolerance for frustration, greater irritability and impulsiveness, and a tendency towards rough-and-tumble play. These tendencies are dwarfed by the importance of male socialization and peer pressure into gender roles.

The prevalence of domestic violence in a given society, therefore, is the result of tacit acceptance by that society. The way men view themselves as men, and the way they view women, will determine whether they use violence or coercion against women.

The problem is worldwide: In the United States, between 21 and 30 per cent of women are beaten by a partner at least once in their lives; half of these women are beaten more than three times a year. In Colombia, about 20 per cent of women have been beaten by a partner. In Papua New Guinea, 67 per cent of rural women and 56 per cent of urban women have been physically abused. In Norway, 25 per cent of gynaecological patients were found to have been physically or
sexually abused. In Kenya, 42 per cent of women said that they were regularly beaten by their husbands. And many women who are thus tormented commit suicide.

Rape: Eighty per cent of the women who are sexually assaulted already know their attackers-friends, acquaintances, intimates, or family members. Women who are assaulted and raped suffer myriad health consequences: severe injuries, unconsciousness, mental illness and trauma, STDs, and unwanted pregnancies. Their ability to love and accept love can be destroyed. Stigma leads some to commit suicide.

In all cultures, incredibly, the rape survivor is suspected of or treated like she colluded with the rapist. Since women are traumatized and stigmatized by the experience, only a small proportion of rapes are reported.

The majority of sexual assault victims are young. In Canada, a 1993 study found that more than half of the women surveyed had experienced some form of unwanted or intrusive sexual experience before reaching age 16; 51 per cent of these reported being the victims of rape or attempted rape. In Peru, a study found a staggering 90 per cent of young mothers aged 12 to 16 in a hospital to be victims of rape, often by a family member.

In June 1995, an interagency symposium drew up a field manual on meeting the needs of women caught up in conflicts, *Reproductive Health in Refugee Situations*. Participating in this were UNFPA, the Office of the United Nations High Commissioner for Refugees (UNHCR), WHO, the International Federation of Red Cross and Red Crescent Societies, and non-governmental organizations. In November 1996, UNFPA, UNHCR, and the Federation agreed to use the manual's recommendations to help Rwandese, Burundese, and Zairean refugees in Central Africa. The pilot project provided many of the estimated 220,000 displaced women of childbearing age with a much-needed package of reproductive health care services. The new services also included care and post-coital contraception for sexually violated women.

Tracking in girls and women: Tens of millions of children are already in the global sex market, and each year two million girls age 5 to 15 are introduced to the trade. In developing countries, commercial demand for young women brings children from poor families in the country into the cities, where the sex industry pimps them to the wealthy, including some tourists. Concerned political figures report the complicity of police and local authorities in some of this trafficking.

Women in positions of abject dependence on male authorities are also particularly subject to unwanted sexual coercion.

Violation of reproductive rights in emergency situations: Rape in time of war is still common. It has been extensively documented in the former Yugoslavia, Rwanda, Cambodia, Liberia, Peru, Somalia, and Uganda. It has been used systematically as an instrument of torture or ethnic domination. And women who have been raped must often endure a second torment-rejection by their friends and families for "consorting with the enemy".

Poverty fuels the sex trade in Latin America and Africa. Chinese women are kidnapped and sold into forced marriages in areas where few wives are available. The European Commission is concerned about a "slave trade" in Eastern European women-an estimated 500,000 of them have been forced into commercial sex.

Sex workers are much more in danger from STD/HIV infection than most women, and suffer more from reproductive tract infections. As many as 80 per cent are HIV-positive, and they and their clients are carriers and spreaders of the disease.
Reproductive Rights and Sustainable Development

Reproductive and sexual rights for the individual, whether man or woman, are foundation stones of prosperity and a better quality of life for all people. As such, they are absolutely essential to any hope of achieving sustainable development.

Gender Equality

International conferences and treaties have recognized that women must be helped to rise from poverty, exploitation, social inferiority and dependence, in the name of justice and for the sake of securing the human rights of half the human race. We now know that women's empowerment is also critical to succeeding in the development tasks that face many nations. Countries need the contributions of their women as much as they need those of their men.

Social, economic, and political rights are inseparable in practice.

The social empowerment of women clearly contributes to, and depends on, good reproductive health. That means women must be able to travel outside the home, must be able to own property and have cash savings, and must share in the household decision-making. All this benefits their families as well: where women have control over their own purchases, they invest more of their discretionary income in their children, their household, and their own health needs.

Exercise of their reproductive rights strengthens women's families as well, both in lessening time lost due to illness and the number of untimely deaths, and because planned children are wanted children, and having fewer children means more of the family's resources are available for each.

Family planning has been shown to lower the likelihood of broken marriages. A woman's control over her fertility is also frequently associated with having more choices in other areas of her life.

A woman's knowledge of government and participation in the political arena, including informal associations, are important for the exercise of her rights as well.

Role of men: Efforts to advance women's rights began with the recognition of the need to redress the systematic exclusion of women from opportunities open to men, and to end gender-based discrimination in the distribution of resources and rewards. But the roles assigned to men can be burdensome to men, too.

Men's commitment to their children is key to the quality of the family's life and the prospects of the next generation, yet they have not taken up their share in family life, even when their wives share in work outside the home.

To promote male involvement in the family, concerned leaders, governments, and NGOs must begin by confronting cultural barriers. The media can help by painting a positive picture of relationships between fathers and children.

Men's support for women during pregnancy and involvement in childbirth have not been promoted, effectively. Yet programmes in Jamaica, Cameroon, and other countries showed that men do respond very well to efforts to involve them in the period after childbirth.

However, men are frequently unaware of and insensitive to women's reproductive and sexual health needs. Male socialization has perpetuated myths about female and male sexuality, expectations about sexuality and masculinity, and acceptance of domestic violence. A large minority of men still consider sexual and reproductive health matters to be "women's concerns" beneath their notice.

Men's support, though, is going to be crucial for women's empowerment. Women cannot do it alone. Men must come to recognize that-
women's empowerment is not a threat but rather a way to improve their families and societies.

Promoting Education

Too little attention has been paid to the education of girls in much of the world. Globally, nearly 600 million women are illiterate today, compared with about 320 million men. In some parts of the world, as many as three out of four women are illiterate.

The education of girls is a key factor in improving family health, reducing infant mortality, and changing reproductive behaviour. In almost every setting, regardless of region, culture, or level of development, well-educated women have a greater say in their lives, including their reproductive lives, and bear fewer children than do uneducated women.

But threshold levels must be reached before the good effects of education can be seen: for women, more than five or six years of schooling. The International Conference on Population and Development's Programme of Action called for universal access to primary education before 2015, and urged countries to take steps to keep girls and adolescents in school.

Men, as decision-makers and authorities, need to make sure that girls are able to go to school, stay in school, and are taught the skills they need to succeed in the workplace and the world at large on equal terms. Men must also teach boys new ways to think about their roles and about women in this rapidly changing world.

Attacking Poverty

There is a circular relationship between poverty and reproductive health: attacking poverty improves reproductive health, and realizing sexual and reproductive rights will help end poverty.

The poor endure many disadvantages in their quest for healthy lives: poor children suffer from malnutrition; poor mothers tend to have more children; poor couples are often unaware of contraception or unable to afford it; more children in the family means less for each of them—poor families are less able to afford to support their children's education; and daughters are often kept at home to help rear their brothers and sisters.

Poor people now are more aware than their parents' generation were that education is one important key to a better life. New social norms lend community support to family planning and the choice of having a small family.

Research around the world shows that programmes attacking poverty have the greatest effect when they give poor people, especially poor women, greater control over all aspects of their lives. In Bangladesh, the Grameen Bank has provided small loans to women's groups for business activities. They found that all women in the communities they served, even nonparticipants, had more power of decision than women in other communities, and were likelier to use contraception as a consequence.

In societies that have socially isolated their women, self-employment programmes have had quite an impact simply by involving women in informal social interaction with other women. News of family planning methods spreads, and social norms about fertility and contraception change.

Since 1982, UNFPA has supported more than 20 projects combining reproductive health services and information with "micro-credit" activities. Improving livelihoods enhances women's self-esteem, their confidence, their participation in political and family life, their decision-making power, and their position in the family. They benefit, their families benefit, and their communities prosper.
Challenges and Needs

Human rights that include reproductive and sexual rights must be established, to prepare the ground for providing the information, education, and health services people need.

And greater attention has to be paid to establishing the legal rights and equality of women. Internationally, human rights goals must be given their proper importance in assistance programmes.

Poverty prevents both women and men from exercising their reproductive and sexual rights. The actions advocated in this report will have a powerful impact on poverty, but specific action is needed to increase women's access to credit and economic resources.

We must close the gap in education between boys and girls. In addition, men and boys should be educated and encouraged to treat women as equal partners in family, community, and national life. Sexual violence will not end while inequality exists between men and women.

Health services need to be reformed and expanded to meet the reproductive and sexual health needs of their clients. All the institutions of civil society must be involved in this reformation. Sexual and reproductive health can no longer be last on the list for funding if it is to reach all those who need it.

Enabling Rights

Population and development strategies will need to be revised to fulfill the new international consensus. The UN Inter-Agency Task Force on Basic Social Services for All is working on a set of indicators of progress in areas addressed by the recent global conferences. So are multilateral and bilateral assistance agencies.

Women's equality and equity need to be realized, and the Convention on the Elimination of All Forms of Discrimination Against Women must be adopted without reservations. Human rights activists, UNFPA, UNICEF, WHO, the UN Division for the Advancement of Women, and the human rights treaty bodies are beginning to draw up their own set of indicators to monitor progress in protecting human rights, particularly women's rights. Violations must be documented and redressed. Rights protections must be enforced.

Legal reforms, internationally and nationally, are needed to support women's rights, the rights to sexual and reproductive health, and quality health care. Programmes must be held accountable for their performance and any transgressions of their clients' rights.

People must be mobilized and educated to monitor human rights issues in their communities. Organizations focused on human rights, women's empowerment, and health and reproductive rights need to continue to forge alliances to promote their shared concerns.

International assistance programmes need to ensure that the programmes they support advance human rights.

Towards Better Sexual and Reproductive Health

The ICPD Programme of Action calls for the elimination of barriers to information and services for reproductive health by 2015.

Providing high-quality services is a goal that will demand improved staff training and supervision, and regular monitoring of their interactions with their clients. Improving the scope and the quality of care will also mean additional investments in both physical plant (water,
electricity, supplies) and personnel. Managers should make every effort to provide good, comprehensive services to their clients in each of their clinics.

Some groups—the poor, women, rural dwellers, adolescents, indigenous peoples, the disabled, migrants, and refugees—are often under-served by, or left out of, programmes. Special efforts will need to be made to reach these groups.

Partnerships with civil society will be fundamental to success in designing and carrying out these programmes. Programmes can also benefit from qualitative research on the dynamics of social change. NGOs have become particularly important in designing, researching, and testing new methods of service delivery, and have been a force urging the expansion of national programmes.

Finally, guidelines and standards of conduct for health systems need to incorporate a reproductive rights perspective. The World Health Organization is developing standards of reproductive and sexual health care. On the front lines, staff members need training in the protection of clients' rights.
Implementing the ICPD Programme of Action

Since the Cairo and Beijing conferences’ historic accords, countries have moved to put their recommendations into action. Numerous population and development policies have been revised. There have been legal reforms to better protect women's rights and promote gender equality. Health services have been improved and reorganized.

In many other developing countries, though, lack of funds and trained personnel has hampered efforts to improve family planning and reproductive health programmes.

Population policies: Countries that had population policies in place have reformed them to better meet the ICPD criteria. Other countries that had no formal policies have adopted them, or are in the process of doing so. In some countries, reproductive health and family planning issues that were too sensitive to discuss publicly are now part of the political discourse.

Reproductive health and family planning: After the ICPD, many countries organized workshops and seminars for planners and health workers on the new reproductive health approach and how to put it into action. Many have also made institutional changes. Even more widespread are various measures to expand access to reproductive health services, improve their quality, and widen their focus. Family planning is increasingly being integrated with other reproductive health concerns.

A number of developing countries have begun to train health care providers in counselling and communication, strengthen their health infrastructure, and develop medical protocols.

Other efforts have focused on reducing maternal mortality, passing new laws, improving the quality and expanding the scope of services, and creating new programmes where needed.

Adolescents: Since 1994, many governments have taken new initiatives to meet adolescents' reproductive and sexual health needs, often in education about reproductive health and family planning in an effort to reduce the number of teenage pregnancies. Several are also focusing on education and services for disease prevention.

Non-governmental organizations: NGOs have a central role to play in advocacy and service delivery. Governments are working with them more and more. NGOs have a track record of higher standards of service and greater flexibility in reaching the marginal members of society. Consequently, governments have asked their help in providing services, testing new approaches, and training government staff.

NGOs' missions are varied and often creative, including programmes that use gender-sensitive approaches to reproductive-health problems, give testing for breast and cervical cancer, provide shelter to battered women, teach young people to support themselves, and train adolescent peer counsellors.
**Human rights:** Some of the most important results of the ICPD are the strengthening of national laws and policies promoting human rights, particularly the rights to reproductive and sexual health, gender equality, and freedom from sexual violence. Several countries have established institutions to safeguard the rights of women.

Both the ICPD and especially the Beijing women's conference raised global awareness of the need to enact and enforce legislation protecting women against sexual and domestic violence. Many countries have taken steps to do so.

**Women's participation:** Women must be empowered to participate fully in the political and development processes, the ICPD programme affirmed. The political gender gap is evident in nearly all countries, but some notable advances have been made, by executive mandate and by elections.

**Role and responsibility of men:** The signers of the ICPD Programme of Action agreed that it is important for men to take more responsibility for their sexual and reproductive behaviour and family life. Everyone is more aware than ever of the need to involve men in reproductive health programmes. Several NGOs are also conducting research to determine what men's reproductive health needs are, and to better understand their sexual, marital, parenting, and family decision-making roles.

**Global and regional initiatives:** Since the Cairo conference, governments and NGOs have held many fruitful regional meetings to assess the status and needs of reproductive health services and determine how to follow up on the ICPD recommendations. The organization Partners in Population and Development (headquartered Dhaka, Bangladesh) is promoting the exchange of experience and expertise among developing countries. UNFPA has organized two post-ICPD meetings of an international NGO Advisory Committee, established to advise the Fund on policies, programmes, and strategies.

**Parliamentary initiatives:** As a follow-up to the ICPD, parliamentarians from both developed and developing countries have organized various activities to promote population issues: calling on governments to mobilize resources, addressing key themes of the Cairo and Beijing conferences, and focusing on population and development-related concerns.

**Inter-agency collaboration:** After the ICPD, the United Nations established an inter-agency task force (now the Task Force on Basic Social Services for All) to strengthen country-level collaboration. It developed a set of guidelines for the UN Resident Coordinator System to facilitate cooperation among governments, NGOs, UN agencies, and other development partners.

UNFPA has been working with other UN agencies and international experts to draw up a reliable set of indicators to measure progress towards the goals of these conferences. Besides conventional statistics, the new indicators will measure unmet demand, access, service coverage, quality of care, and whether the laws and administrative apparatus needed are in place.

**Resource mobilization:** The ICPD was the only international conference in this decade to agree on specific money amounts needed to carry out its recommendations—some $17 billion annually by the year 2000, and $21.7 billion by 2015. They estimated that about two thirds of this cost would be borne by the countries involved, and one third by the international donor community.

Annual government expenditures, however, are still well below half the $17 billion the ICPD estimated will be needed by 2000. Developing countries have shown that they are prepared to do their part—but it remains to be seen if richer nations will have the vision to do the same.
Women's right to health, including reproductive and sexual health, is central to the struggle for gender equality and women's empowerment. In December 1996, all the bodies of the United Nations system responsible for monitoring human rights treaties gathered in Glen Cove on Long Island, New York, to consider ways to promote and protect this right.

The meeting was called by UNFPA, the United Nations Division for the Advancement of Women (DAW) and the Office of the United Nations High Commissioner for Human Rights.

They were joined by representatives of non-governmental organizations (NGOs) and several UN agencies. It was the first time that experts from all six treaty bodies, UN organizations and NGOs had ever met to discuss the interpretation of rights related to a particular theme.

Participants:

The treaty bodies were: the Human Rights Committee; the Committee on Economic, Social, and Cultural Rights; the Committee on the Elimination of Racial Discrimination; the Committee on Torture; the Committee on the Elimination of Discrimination against Women (CEDAW); and the Committee on the Rights of the Child. United Nations agencies were: the UN Division for the Advancement of Women (DAW), the International Labour Organization (ILO), UNICEF, the United Nations Development Fund for Women (UNIFEM), the United Nations Development Programme (UNDP), UNESCO, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO). A number of NGOs also took part.

More than 50 people attended.
UN agencies and other bodies were called upon to:

Train their staff in the human rights dimensions of their policies and programmes;

Help governments and NGOs obtain training, information, and resources to understand and use human rights dimensions in formulating, implementing and monitoring their own policies and programmes;

- Follow up on the comments and suggestions of the treaty bodies on the states' reports and work with the states to implement them.

The roundtable recognized NGOs as a valuable source of information on the implementation or abuse of rights, and recommended that they be allowed to participate in treaty monitoring and conference implementation. It urged UN agencies and donors to consider providing NGOs with resources for programmes on human rights education, improving legal literacy, and educating their staff about the treaty monitoring process. NGOs were urged to communicate the meeting's recommendations to constituents, colleagues, and other NGOs.

Other recommendations proposed specific forms of collaboration among treaty bodies, UN agencies, and NGOs.

The meeting recommended that country reports to the treaty bodies by national commissions should be more widely publicized and that treaty bodies should ask for amplification as desired.

**UNFPA Follows Up**

UNFPA is collaborating with CEDAW DAW and the Office of the UN High Commissioner for Human Rights to promote reproductive and sexual rights, through training programmes and technical assistance to developing countries, and support for advocacy and research.

With WHO and UNICEF, UNFPA is increasing its support for the eradication of harmful traditional practices, including female genital mutilation, as human rights violations. Activities are being integrated into programmes in reproductive health, population and development, and are being addressed by advocacy at all levels.

In April 1997, at the initiative of UNFPA, an informal working group of gender and human rights focal points was established, including DAW, ILO, the Office of the UN High Commissioner for Human Rights, the Office of the UN High Commissioner for Refugees, UNDP, UNESCO, UNICEF and UNIFEM.

The group now meets monthly to exchange information and work together on, for example:

- Strengthening national-level advocacy and legislation for enforceable reproductive rights;

Promoting reproductive health, including family planning and sexual health, as a human right;

© Eliminating female genital mutilation;

Advocating for the needs and aspirations of young women;

Fighting commercial sexual exploitation;

- Strengthening governments' and NGOs' capacity to promote gender equity and equality and women's empowerment;

Integrating reproductive health and economic empowerment;

- Promoting male involvement in reproductive health;

Mainstreaming gender issues into policies and programmes;

Integrating reproductive rights and human rights into a prototype gender-training manual.