CHAPTER 1: What is Sexual and Reproductive Health?

The concept of reproductive health has evolved from a historic concern with population and development. For decades international organizations and national governments mobilized financial and political support for large-scale population control programmes that aimed to control fertility by encouraging widespread contraceptive use. This concern for population control led the United Nations to convene international conferences on population and development every 10 years since 1947. The last such conference, the 1994 International Conference on Population and Development (ICPD) in Cairo, marked a watershed in the international discourse on population and development.

The ICPD fundamentally redefined the dominant approach to population and development. The Programme of Action (PoA), which outlined a consensus reached by 179 countries, shifted focus from the delivery of contraceptive services to broader notions of reproductive health framed in terms of human rights, gender equality and women's empowerment. The PoA defined reproductive health as:

> *… a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, 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.*

In contrast to the traditional approach of providing contraceptives to married women, this definition of reproductive health aims to enable men and women to make healthy, voluntary and safe sexual and reproductive choices. Importantly, this applies to married and unmarried men and women, including adolescents and older people, thereby recognizing that issues of reproductive health are not restricted to people in their reproductive years. Indeed, this definition of reproductive health places the needs of men and women at the centre of debates. The PoA goes on to recognize reproductive health as the cornerstone of population and development programmes.

Reproductive rights

Implicitly, this definition of reproductive health refers to the rights of men and women to make informed decisions for themselves and to have access to safe and appropriate reproductive health services that respond to their needs. The ICPD PoA defines reproductive rights thus:

> *[Reproductive rights] rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and time of their children and to have the information and means to do so, and 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.*

Reproductive rights advance our understanding of reproductive health beyond a concern for the adverse outcomes of sexual behaviour and reproduction to a focus on the minimum entitlement to well-being for all men and women. These principles and the broad definition of reproductive health adopted in the PoA were reinforced and expanded at the Fourth World Conference on Women (FWCW) in Beijing in 1995. - e conference's Platform for Action clearly articulates the right of women and men to freely decide matters concerning their reproduction.

> *[R]eproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to*

decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and 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.

Sexual health, sexuality and sexual rights

The definition of reproductive health outlined in the ICPD PoA includes the ability of people to have safe and satisfying sexual relationships. This concern for sexual health arose in response to the HIV epidemic, among other health issues, and challenged the traditional linking of sexual activity with reproduction. Attention was also drawn to how the long-established approach neglected the emotional, mental and physical health aspects of sexual activity and reproduction. As a result, sexual health is being proposed as a necessary prerequisite for reproductive health, instead of an aspect of reproductive health. According to the following working definition, sexual health is:

…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

This definition of sexual health remains relevant throughout life and is not restricted to the reproductive years. It also gives explicit attention to sexuality and safer sex, while recognizing the need to address sexual behaviour, social stigma and discrimination. Sexual health encompasses people's beliefs, values and attitudes including their roles, identity and personality and their individual thoughts, feelings and behaviours within relationships.

A central concept in this understanding of sexual health is that of sexuality. Sexuality is a fundamental aspect of being human. And yet it remains taboo in many societies. While debate concerning how to define sexuality continues, WHO recently proposed the following working definition:

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.

This definition of sexuality encompasses biological sex, gender identities and roles and sexual orientation. As such, sexuality includes attention to people's cultural norms, practices and behaviours, while also dealing with anatomy, physiology and the biochemistry of the sexual response system. It draws attention to the multiple ways sexuality is experienced and expressed and the ways in which men and women of all ages and sexual orientations seek out, desire and/or refuse sexual activity. Importantly, this conceptualization of sexuality expands the traditional concern with the negative implications of sexual activity, such as disease and discrimination, to include positive aspects such as pleasure, fulfilment and affirmation. It also recognizes the possibility of multiple sexualities, thereby moving away from the belief that there only two genders (male and female) and that heterosexuality is the norm.

The process of translating the concepts of sexual health and sexuality into the language of human rights continues. To date, sexual rights have not been defined in international documents or treaties. The ICPD PoA noted the right of individuals to have a "satisfying

and safe sex life", yet it does not use the term "sexual rights". The Beijing Declaration and Platform for Action took one step further than the ICPD PoA. The Platform for Action stated that the human rights of women include the ability to:

… have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.

This passage defines "sexual rights" without using the specific term.

The concept of sexual rights remains contested. However, some common ground has recently been reached; sexual rights are understood to support the ability of people to decide whether to engage in reproductive or non-reproductive sexual activity and to enjoy sexual health regardless of their reproductive capacity. Indeed, the right of women and men to control their bodies and make decisions concerning their fertility is a central aspect of both sexual and reproductive health. According to the proposed working definition of sexual rights, all persons are entitled to:

- *the highest attainable standard of sexual health, including access to sexual and reproductive health care services;*
- *seek, receive and impart information related to sexuality;*
- *sexuality education;*
- *respect for bodily integrity; x choose their partner; x decide to be sexually active or not;*
- *consensual sexual relations;*
- *consensual marriage;*
- *decide whether or not, and when, to have children; and*
- *pursue a satisfying, safe and pleasurable sexual life.*

This definition of sexual rights applies to all individuals regardless of their age, gender or sexual orientation. Sexual rights recognize and, thereby, challenge discrimination rooted in gender inequality and sexual orientation and the advantages heterosexual men and women enjoy over those who are homosexual or transgendered. Sexual rights thus protect against the possible negative impacts of sexuality and sexual activity, such as morbidity, mortality, discrimination and violence, and promote the positive aspects of sexuality and sexual activity.

Measuring sexual and reproductive health

The broad definition of sexual and reproductive health adopted at the ICPD advances a holistic approach to sexual and reproductive health, underpinned by respect for human rights, gender equality and empowerment of sexual minorities, such as those who are lesbian, gay, bisexual or transgendered (LGBT).

While this approach enhances our understanding of sexual and reproductive health, it also complicates the process of estimating the burden of morbidity and mortality related to sexual and reproductive health at the international, national and community levels. As a result of broadened definitions, sexual and reproductive health have come to encompass not only physiological processes, such as pregnancy, but also communicable diseases, i.e. sexually transmitted infections (STIs), and noncommunicable diseases, such as breast or cervical cancers.

Moreover, the factors that can increase or decrease the risk of poor sexual and reproductive health in individuals and communities are intimately connected with cultural beliefs, traditions and a range of social and economic factors. It can thus be difficult to elucidate and objectively measure these and other determinants of sexual

and reproductive health. In particular, sexual and reproductive health issues are often underreported in countries where discussions of sexual activity and sexuality are taboo. Keeping these constraints in mind, the sections below

Table 1: Share of DALYs lost due to reproductive health-related causes, by region, 2001 (percent)

	World	Africa	Americas	Europe	Eastern Mediterranean	Southeast Asia	Western Pacific
STIs (excluding HIV/AIDS)	0.8	1.4	0.4	0.2	1.0	1.0	0.2
HIV/AIDS	6.0	18.8	1.9	0.6	1.3	3.2	0.8
Maternal conditions	2.1	3.2	1.3	0.5	3.0	2.4	1.1
Perinatal conditions	6.7	6.1	4.9	1.9	9.1	9.4	5.7
Other SRH conditions	2.7	1.7	3.5	3.7	2.5	2.8	3.0
Total (percent)	18.4	31.3	12.0	6.9	16.9	18.9	10.8
Total DALYs (thousands)	**270**	**112**	**17**	**10**	**23**	**79**	**28**

Source: Vlassoff *et al.* 2004. In: United Nations Millennium Project 2006.

consider some aspects of sexual and reproductive health.

The global burden of mortality and morbidity related to sexual and reproductive health

Depending on the definition used, reproductive ill-health was estimated to constitute between 5% and 20% of the global burden of disease in 1998. More recent calculations suggest that death and disability related to sexual and reproductive health account for 18.4% of the global burden of disease and 32.0% of the burden of disease among women aged 15–44 years of age. Calculations suggest that the distribution of morbidity and mortality related to sexual and reproductive health varies among conditions and regions. Table 1 presents the share of disability-adjusted life years (DALYs) lost due to reproductive health-related causes by region in 2001.

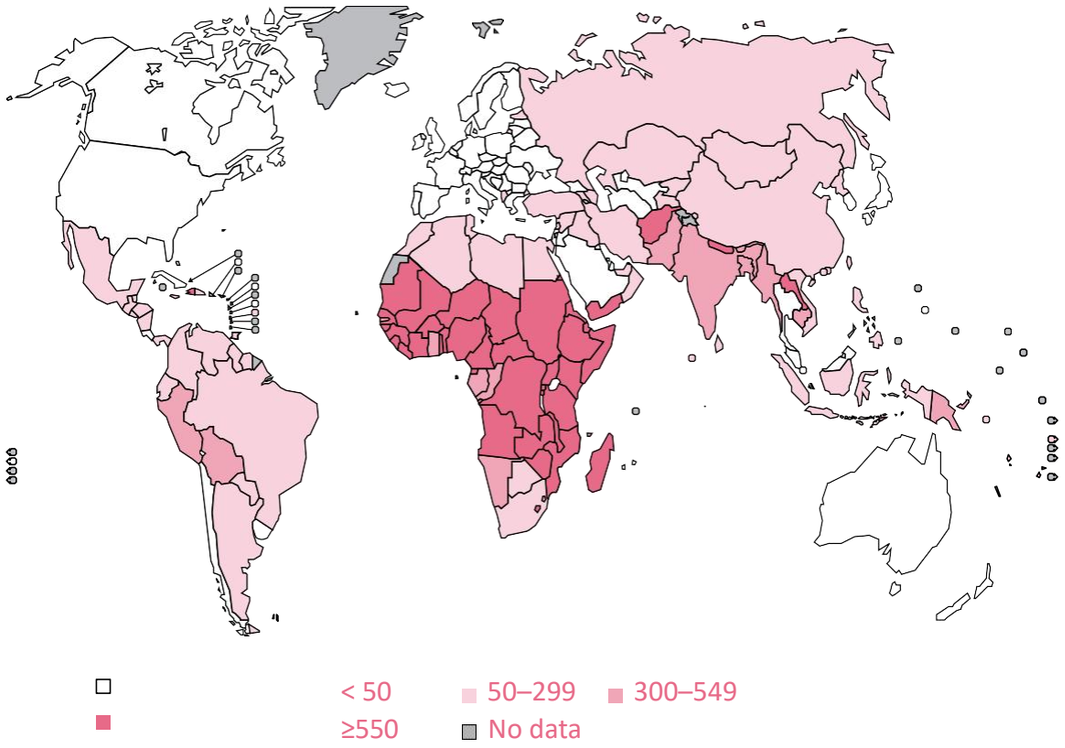
An estimated 50% of the global population is under the age of 25 years. Adolescents (10–19 years of age) and young people (ages 10–24 years) are particularly vulnerable to death and disability related to sexual and reproductive health. Recent analysis concludes that the adverse effects of STIs, including HIV, and early pregnancy threaten these age groups more than any other. Adolescents do not always plan sexual activity and may not have the knowledge and skills to protect themselves from STIs. This vulnerability is amplified by profound changing social norms in many developing countries that include a trend towards delays in marriage and childbearing, urbanization, weaker influence of families and culture and greater autonomy for women. In this changing environment, many adolescents continue to experience difficulties accessing information and appropriate health care services.

At the other end of the lifecycle, older people constitute an increasing proportion of the population in many developing countries. As populations age, the reproductive health needs of older people will come to the fore. In general, women are disproportionately represented among older people. In developing countries, these women tend to be widows and are often poor and illiterate. As a result, older women may be particularly vulnerable to sexual and reproductive ill-health.

Maternal mortality

Complications during pregnancy and childbirth are the leading cause of mortality and morbidity among women of reproductive age in developing countries. Each year, an estimated 210 million

Figure 1: Maternal mortality ratios by country, 2000



women experience life-threatening complications during pregnancy, which often result in serious disability and perhaps death. Based on 2000 data, at least 529 000 maternal deaths occur worldwide every year. About 90% of these deaths take place in developing countries.

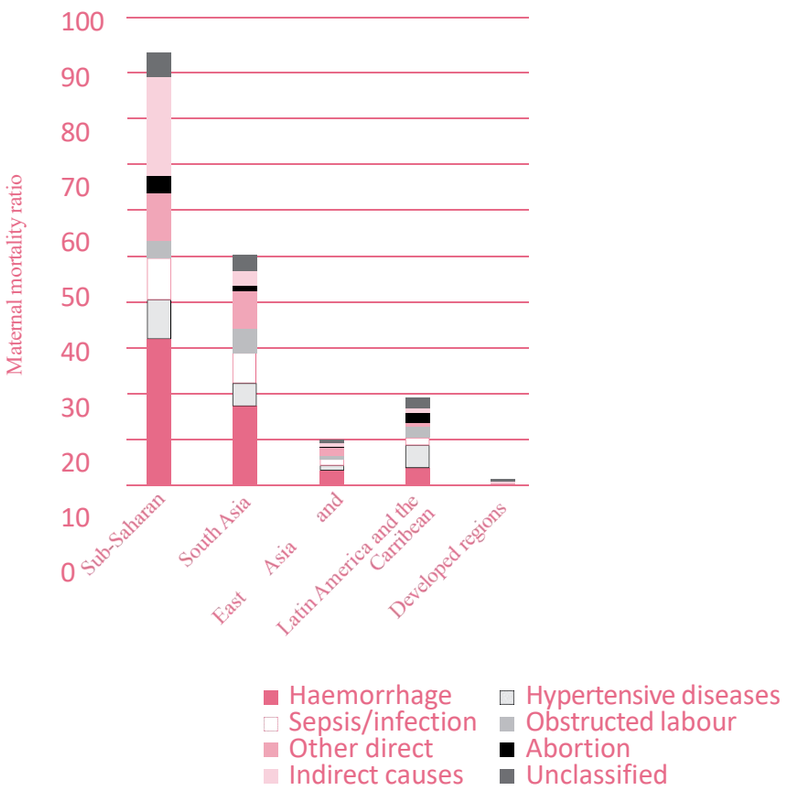
Globally, the maternal mortality ratio (MMR) is 400 per 100 000 live births. However, maternal mortality in developing countries is more than 100 times higher than that in industrialized countries, making it the health indicator with the greatest disparity between rich and poor nations. The lifetime risk of maternal deaths in Sub-Saharan Africa is 1 in 16, as compared with 1 in 43 in South Asia, and 1 in 2800 in industrialized countries. Figure 1 presents the worldwide distribution of MMR among countries.

Maternal mortality is also a sensitive indicator of women's status within societies. In many countries, gender inequality and the low status during pregnancy, which often result in serious disability and perhaps death. Based on 2000 data, at least 529 000 maternal deaths occur worldwide every year. About 90% of these deaths take place in developing countries. Globally, the maternal mortality ratio (MMR) is 400 per 100 000 live births. However, maternal mortality in developing countries is more than 100 times higher than that in industrialized countries, making it the health indicator with the greatest disparity between rich and poor nations. The lifetime risk of maternal deaths in Sub-Saharan Africa is 1 in 16, as compared with 1 in 43 in South Asia, and 1 in 2800 in industrialized countries. Figure 1 presents the worldwide distribution of MMR among countries. Maternal mortality is also a sensitive indicator of women's status within societies. In many countries, gender inequality and the low status of women cause high numbers of women to die in pregnancy and childbirth. Globally, few improvements in maternal mortality have been achieved over the last 15 years. The reasons are complex

and tend to vary across countries. In developing countries, much of the stagnation has been attributed to low coverage of health services during pregnancy and the tendency for women to deliver outside health facilities without skilled birth attendants. More broadly, gender inequality, including women's lack of decision-making power and unequal access to economic and political resources, impinges upon their health during pregnancy and childbirth.

Most maternal deaths occur between the third trimester and the first week after pregnancy. The risk of mortality can be particularly high during the first and second days after birth. Recent evidence shows that maternal deaths can be especially high following an abortion or stillbirth. In Bangladesh, for example, up to 50% of maternal deaths

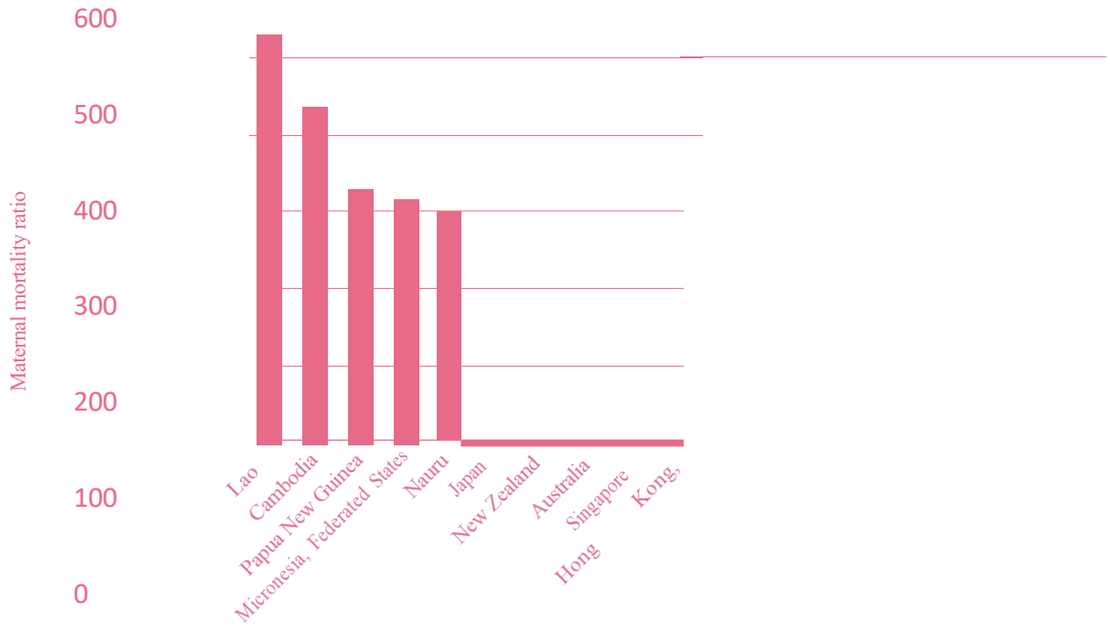
Figure 2: Maternal mortality ratios by medical cause and region, 2002



during the first week after pregnancy occurred in women whose pregnancy had ended in abortion or stillbirth. Unsafe abortions cause up to 17% of maternal deaths in Latin America and 19% in South-East Asia. About 26 million legal abortions are performed each year. Roughly 97% of the estimated 20 million unsafe abortions that occur annually take place in developing countries. An estimated 68 000 women die from complications related to unsafe abortions each year. Given the sensitive nature of induced abortions, these figures likely underestimate the true extent of the problem.

The causes of maternal death can be classified as "direct" and "indirect". Direct causes account for the majority of maternal mortality in developing countries. Direct causes include: haemorrhage, anaemia, infection or sepsis, obstructed labour and hypertensive disorders of pregnancy. Up to

Figure 3: Maternal mortality ratios for selected countries in the Region, 2002



Source: World Health Organization Regional Office for the Western Pacific 2005a.

166 000 maternal deaths are caused each year by severe bleeding. Figure 2 breaks down the direct causes of maternal mortality by region. The indirect causes of maternal deaths, such as HIV/ AIDS and malaria, differ between regions and countries.

An estimated 25 to 30 million deliveries are performed in the Western Pacific Region annually. Of these, more than 30 000 result in maternal death. Although improvements have been made in maternal health, the Region's MMR was estimated in 2001 to be 120 per 100 000 live births. This average masks stark differences between countries in the Region (Figure 3). The risk of death among pregnant women in the Lao People's Democratic Republic was 530 per 100 000 live births in 2002, compared to 7 per 100 000 live births in Japan. Data indicate that adolescents bear a significant burden of maternal mortality in the Region. In the Philippines, for

Box 1: Links between maternal and child health

The health and well-being of newborns, infants and children are closely linked to that of their mothers. While this relationship continues throughout the lifecycle, maternal health affects the well-being of children most drastically during the first four weeks of life (the neonatal period). Simply, mothers who are healthy and well nourished tend to have healthy babies. Effective health care during pregnancy and delivery also benefits newborns. Globally, maternal health complications contribute to the deaths of at least 1.5 million infants in the first week of life and 1.4 million stillborn babies.

In contrast to maternal deaths, child deaths have declined from a global average of 146 per 1000 live births in 1970 to 79 in 2003. The under-five mortality rate in the Western Pacific Region fell from 154 per 1000 live births in 1955-1959 to 48 in 1995-1999. Recent analysis suggests, however, that this decline in child mortality is slowing and approximately 3000 children under five years of age die every day in the Region.

Moreover, these substantial reductions in child mortality have not translated into similar improvements in neonatal survival. From 1998 to 2000, child mortality after one month of life (from two months to five years) decreased by one third, while mortality during the neonatal period declined by only one fourth. As a result, an increasing proportion of child deaths occur during the first four weeks of life. Neonatal deaths now account for about 40% of all deaths among children under five years of age. In the Western Pacific Region, this proportion rises to 50%.

These deaths account for only a fraction of the problems associated with neonatal health. The conditions that cause neonatal deaths and stillbirths often lead to severe disability that can last throughout a lifetime. For example, birth asphyxia can lead to cerebral palsy, learning difficulties and other disabilities. The extent of such morbidity is suggested by the fact that for every newborn baby who dies, another 20 suffer birth injury, infection, complications of preterm birth and other neonatal conditions.

Sources: World Health Organization 2005b; Filippi et al. 2006; Lawn et al. 2005; Ahmad, Lopez and Inoue 2000; World Health Organization Regional Office for the Western Pacific 2005b.

example, 20% of maternal deaths occur among teenage mothers.

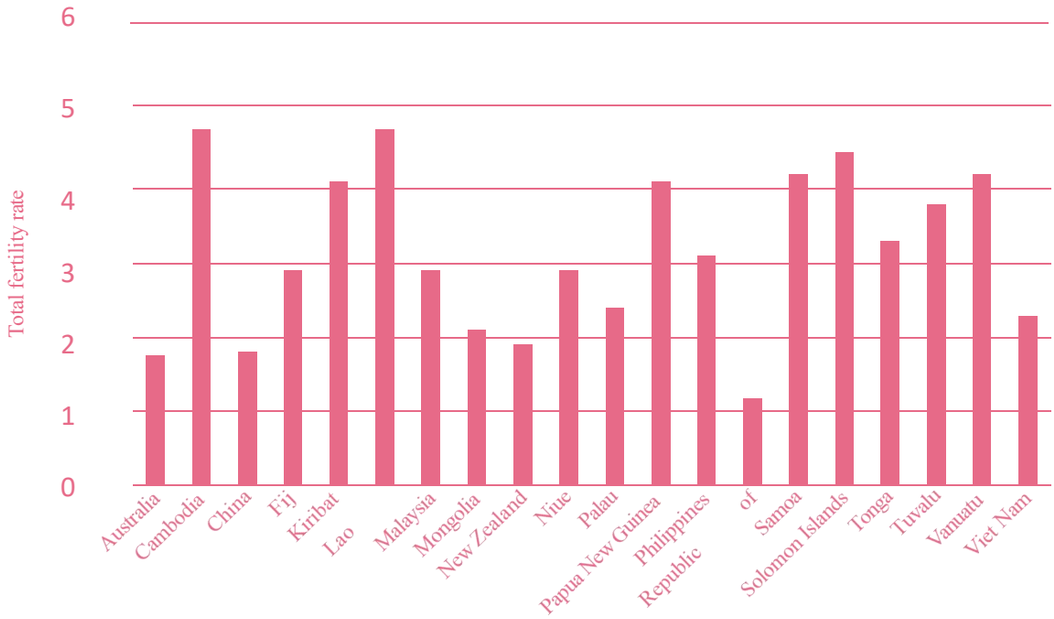
Apart from pregnancy-related deaths, illness and disease related to pregnancy and childbirth affect up to one quarter of adult women in developing countries. Maternal morbidity is estimated to be 30 times the number of maternal deaths, accounting for 2.1% of the global burden of disease and 13.0% of DALYs lost among women aged 15 to 44 years of age in 2001. Short-term morbidity from pregnancy and childbirth can include anaemia, reproductive tract infections (RTIs) and depression, while uterine prolapse, vesicovaginal fistulae, incontinence, dyspareunia, and infertility can affect women in the longer term. High rates of depression arising from childbirth have been reported throughout the world, with childbirth being one of the factors potentially responsible for the high rates of unipolar depression among young women.

Worldwide, teenagers give birth to one in 10 babies. In developing countries, this proportion rises to one in six. Adolescent girls are at particular risk of pregnancy- and childbirth-related morbidity and mortality. Girls under 15 years of age are more likely to have premature labour and four times more likely to die from pregnancy-related causes than are women older than 20 years of age. Box 1 discusses the links between maternal and child health.

Men's reproductive health

Traditionally, family planning and reproductive health services concentrated largely on women. While an awareness of the need to involve men

Figure 4: Total fertility rate for selected countries in the Region, 2002



in reproductive health initiatives is growing, there continues to be a general lack of information on the reproductive health needs of men in developing countries. Men can suffer from a range of reproductive health problems. Several cancers, such as prostate, colon and testicular, can affect the male reproductive system. An estimated 30% of infertility cases are due to problems in the male reproductive system, while an additional 20% of cases are caused by problems in the reproductive system of both the man and women. Sexual health issues include erectile dysfunction and premature ejaculation. In one study, men in Pune, India mentioned masturbation, the consequences of loss of semen, menstruation, pregnancy and AIDS as sexual issues that affected them. A study conducted in a men's clinic in Bangladesh found that patients complained most about: pain passing urine; psychosexual problems such as impotence, premature ejaculation and sexual dissatisfaction; and urethral discharge.

Family planning

A spectacular decline has occurred globally in the total fertility rate (TFR). TFR is defined as the total number of children a woman would have by the end of her reproductive life if she met the prevailing age-specific fertility rates from 15–49 years. While fertility rates have declined in most countries, women dwelling in developing countries tend to have more children than those living in developed countries. - is trend is apparent in the Western Pacific Region, where TFR ranges from 1.0 and 1.2 in Hong Kong (China) and Singapore, respectively, to 4.8 in Cambodia and the Lao People's Democratic Republic. Figure 4 presents TFR in 2002 for selected countries in the Region.

Contraception is an integral component of reproductive health because of its positive effect on the health of women. Contraception enables women to postpone or cease childbearing, which can protect them from the harmful health effects of frequently giving birth. In 2000, the use of effective contraception by women who did not want to become pregnant may have averted up to 90% of abortion-related and 20% of obstetricrelated morbidity and mortality. Moreover, the ability to regulate the timing and frequency of pregnancies is held to be a fundamental right of all individuals. Contraceptive prevalence rates (CPRs) in married women aged 15–49 years vary considerably throughout the world. Globally, the proportion of married women using contraceptives has increased from 10% in 1960 to 60% in 2000. During this period, the average number of children per woman declined from six to three. Concomitantly, the number of children men and women desire has similarly decreased.

Contraceptive prevalence has similarly increased throughout the Region. Contraceptive use among Cambodian women doubled from 6.9% in 1995 to 18.5% in 2000. Although

contraceptive use in the Lao People's Democratic Republic has risen rapidly since 1995, it remains at 32%. In 1998, 33% of all women and 46% of married women in Mongolia used contraceptives. Among Filipino women, 33.1% were using modern contraceptives in 2001, while in Papua New Guinea 20% of couples use modern contraceptives. In contrast, the contraceptive prevalence rate in China and Vietnam was 83% and 75%, respectively.

Although contraceptive prevalence is increasing, the unmet need for contraceptives remains high in some parts of the world. More than 120 million couples worldwide have an unmet need for family planning services. This situation contributes to the continued high maternal mortality and morbidity in many countries. An estimated 80 million women have unintended pregnancies, of which 45 million are terminated. Roughly 40% of these women are under 25 years of age. Many more women are unable to plan the timing of their first pregnancy and the space between subsequent births. Up to 201 million women who wish to limit or space their births are not using modern contraceptive methods. Of these, 137 million are using no method, while the remaining 64 million rely on traditional methods, which are less effective. Vasectomies, which are simple, safe and effective, are rare in many developing countries in the Region, except China. For example, this method of contraception was almost nonexistent in Cambodia prior to 2000.

The unmet need for contraceptives is very high among adolescents. Early marriage contributes to high fertility rates in adolescents (please see section on early marriage below). Estimates from 2006 suggest that between 17% and 47% of married women aged 15–19 years of age do not use contraceptives. Among married women aged 20–24 years, this proportion decreases to between 16% and 40%.

Sexually transmitted infections

Unsafe sexual activity has been identified as the second most important risk factor leading

Table 2: Leading risk factors of the burden of disease in poorest and developed countries

Poorest countries	Developed countries
1. Underweight	1. Tobacco
2. **Unsafe sex**	2. High blood pressure
3. Unsafe water, sanitation and hygiene	3. Alcohol
4. Indoor smoke from solid fuels	4. High cholesterol
5. Zinc deficiency	5. High body mass index
6. Iron deficiency	6. Low fruit and vegetable intake
7. Vitamin A deficiency	7. Physical inactivity
8. High blood pressure	8. Illicit drugs
9. Tobacco	9. **Unsafe sex**
10. High cholesterol	10. Iron deficiency

Source: Ezzati *et al.* 2002.

to mortality and morbidity in the poorest countries. In developed countries, unsafe sex is ranked ninth (Table 2). In 2001, sexually transmitted infections (STIs) (excluding HIV/AIDS) accounted for 0.9% of the global burden of disease, having declined from 1.3% in 1990. Estimates from 1990 suggest that STIs (excluding HIV/AIDS) account for 8.9% of the disease burden among women aged 15–45 years of age and 1.5% in men of the same age. When the burden of HIV/AIDS is added to these figures, STIs are a leading cause of death and disability in developing nations.

In 1999, WHO estimated that 340 million new cases of four curable STIs—gonorrhoea, syphilis, chlamydia, trichomonas—were acquired annually. There are at least 30 other bacterial, viral and parasitic STIs. Some cause low morbidity but are stressing, such as scabies and pubic lice, while others can be physically damaging, such as the human papillomavirus (HPV) and herpes simplex virus. Worldwide, roughly 20% of women

under the age of 24 years are positive for HPV. Other RTIs and various gynaecological problems plague women throughout the world. STIs often affect young people who are vulnerable to forced sex and often do not have the skills to protect themselves. At least 25% of gonorrhoea, syphilis, chlamydia, trichomonas cases occur in people under the age of 25 years. - e proportion of some STIs among young people rises to 50%.

Estimates of the burden of STIs in countries in the Region are scarce. A recent study concluded that the incidence of primary and secondary syphilis in China was 5.67 per 100 000 people in 2005. In Solomon Islands, clinical data show an increasing number of STI cases since 1992 (Figure 5). High levels of STIs were observed among women attending antenatal clinics and among seafarers in Tarawa, Kiribati in 2003. The prevalence of chlamydia and syphilis were estimated to be 9.3% and 2.7%, respectively.

STIs can lead to a myriad of reproductive health problems, including infertility and negative pregnancy outcomes. For example, data reported in 2006 suggest that, if left untreated, syphilis can result in stillbirth rates of 25% and perinatal mortality of up to 20%. Globally, maternal gonorrhoea causes up to 4000 new babies to go blind annually. Around 33.2 million people worldwide are infected with HIV and roughly 2.1 million people died

Figure 5: Number of STI cases in Solomon Islands, 1992–2000

Table 3: Global summary of the AIDS epidemic

	2001	2007
Number of adults (15+) and children living with HIV	29.0 million (26.9 million–32.4 million)	33.2 million (30.6 million–36.1 million)
Number of adults (15+) and children newly infected with HIV	3.2 million (2.1 million–4.4 million)	2.5 million (1.8 million–4.1 million)
HIV prevalence in adults (15–49)	0.8% (0.7%–0.9%)	0.8% (0.7%–0.9%)
Number of adult (15+) and child deaths due to AIDS	1.7 million (1.6 million–2.3 million)	2.1 million (1.9 million–2.4 million)

Source: Joint United Nations Programme on HIV/AIDS 2007.

of AIDS in 2007. Another 2.4 million people become infected with HIV annually. AIDS is now the leading cause of death and productive life years lost for adults aged 15–59 years worldwide. Table 3 presents a global summary of the AIDS epidemic in 2001 and 2007.

In many parts of the developing world, most new infections occur in young adults, with young women being especially vulnerable. In 2006, roughly 40% of all adults aged 15 years and over living with HIV/AIDS were young people (15– 24 years of age). In Sub-

Saharan Africa, three women are infected for every two men. Among those aged 15–44 years of age, the ratio of female to male infection increases to 3:1.

In the Western Pacific Region, generalized epidemics were previously reported in Cambodia and Papua New Guinea. However, in Cambodia the prevalence of HIV has decreased among some vulnerable groups, such as female sex workers. In China, Malaysia and Vietnam, HIV transmission occurs primarily among vulnerable groups, especially sex workers and their clients, men who have sex with men and injecting drug users. Figure 6 presents HIV prevalence rates among the general population in Cambodia from 1995 to 2006.

Gender-based violence

Gender-based violence affects people in countries worldwide and is an underlying determinant of many other reproductive health problems. Genderbased violence encompasses physical, sexual and psychological violence. Measuring the prevalence of gender-based violence is often challenging, as it continues to be viewed as a private matter in many countries. Globally, violence against women is most common in the private sphere and is usually

Figure 6: HIV prevalence among the general population in Cambodia, 1995-2006

carried out by an intimate male partner, family member or acquaintance. The lifetime prevalence of physical or sexual violence, or both, among women varies by country and ranges from 15% to 71% worldwide. Among women who were or who had ever been married, the prevalence of physical abuse by an intimate partner ranged 13% to 61% in 2002, and the prevalence of sexual violence was calculated to be between 6% and 59%. A high incidence of non-consensual sex, particularly among young women, has been reported globally. Some men, particularly those who are young, also suffer coerced sex or intimate partner violence. Homosexual men, or other men who do not conform to dominant notions of masculinity, can also experience gender-based violence. Violence, or the threat of violence, can affect all aspects of men and women's sexual and reproductive health. The World Bank estimated that domestic violence and rape accounted for 5%–16% of DALYs lost among women of reproductive age.