

# Integrating Poverty and Gender into Health Programmes

*A Sourcebook for Health Professionals*



## Module on Sexual and Reproductive Health



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## ABBREVIATIONS

ADB	Asian Development Bank
AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
CMH	Commission on Macroeconomics and Health
CPR	Contraceptive prevalence rate
CRC	Convention on the Rights of the Child
DALY	Disability-adjusted life year
DHS	Demographic and Health Survey
FWCW	Fourth World Conference on Women
GBV	Gender-based violence
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
ICPD	International Conference on Population and Development
IMF	International Monetary Fund
IMR	Infant mortality rate
ITN	Insecticide-treated net
LBW	Low birth weight
LGBT	Lesbian, gay, bisexual and transgendered
MDG	Millennium Development Goal
MMR	Maternal mortality rate
NGO	Nongovernmental organization
NMR	Neonatal mortality rate
OECD	Organisation for Economic Co-operation and Development
PHC	Primary health care
PND	Post-natal depression
PoA	Programme of Action
PRSP	Poverty Reduction Strategy Paper
PTSD	Post-traumatic stress disorder
RHI	Reproductive health initiative
RTI	Reproductive tract infection
SEWA	Self-Employed Women's Association
STI	Sexually transmitted infection
TFR	Total fertility rate
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
VIA	Visual inspection with acetic acid
WHA	World Health Assembly
WHO	World Health Organization
YLD	Years lived with disability

Note: In this publication, \$ means US dollar.

## PREFACE

Over the past two or three decades, our understanding of poverty has broadened from a narrow focus on income and consumption to a multidimensional notion of education, health, social and political participation, personal security and freedom, and environmental quality.<sup>1</sup> Thus, it encompasses not just low income, but lack of access to services, resources and skills; vulnerability; insecurity; and voicelessness and powerlessness. Multidimensional poverty is a determinant of health risks, health seeking behaviour, health care access and health outcomes.

As analysis of health outcomes becomes more refined, it is increasingly apparent that the impressive gains in health experienced over recent decades are unevenly distributed. Aggregate indicators, whether at the global, regional or national level, often tend to mask striking variations in health outcomes between men and women, rich and poor, both across and within countries.

An estimated 70% of the world's poor are women.<sup>2</sup> Similarly, in the Western Pacific Region, poverty often wears a woman's face. Indicators of human poverty, including health indicators, often reflect severe gender-based disparities. In this way, gender inequality is a significant determinant of health outcomes in the Region, with women and girls often at a severe societal disadvantage.

Although poverty and gender significantly influence health and socioeconomic development, health professionals are not always adequately prepared to address such issues in their work. This publication aims to improve the awareness, knowledge and skills of health professionals in the Region on poverty and gender concerns.

The set of modules that comprise this Sourcebook are intended for use in pre-service and in-service training of health professionals. This publication is also expected to be of use to health policy-makers and programme managers as a reference document, or in conjunction with in-service training.

All modules in the series are linked, but each one can be used on a stand-alone basis if required. There are two foundational modules that respectively set out the conceptual framework for the analysis of poverty and gender issues in health. Each of the other modules is intended for use in conjunction with these two foundational modules. The Sourcebook also contains a module on curricular integration to support health professional educational institutions in integrating poverty and gender concerns into existing curricula.

All modules in the Sourcebook are designed for use through participatory learning methods that involve the learner, taking advantage of his or her experience and knowledge. Each module contains facilitators' notes and suggested exercises to assist in this process.

It is hoped that the Sourcebook will prove useful in bringing greater attention to poverty and gender concerns in the design, implementation and monitoring and evaluation of health policies, programmes and interventions.

# Introduction



## Introduction

Sexual and reproductive health is now widely understood to be a holistic concept that encompasses physical, mental and social well-being in all matters relating to sexuality and reproduction. This approach aims to enable men and women to make healthy, voluntary and safe sexual and reproductive choices. As such, it is framed by a commitment to human rights and gender equality.

Nevertheless, the burden of sexual and reproductive health remains considerable. Estimates suggest that sexual and reproductive conditions 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, although there is significant variation among regions.<sup>3</sup> In many areas, young adults may be particularly vulnerable to sexual and reproductive ill-health, while in other areas, ageing populations draw attention to how sexual and reproductive health concerns continue throughout the life cycle.

As evidence on the burden of sexual and reproductive ill-health mounts, it is becoming increasingly clear that poverty and gender inequality are important determinants of sexual and reproductive health. In the Western Pacific Region, the burden of sexual and reproductive ill-health, such as maternal mortality, HIV/AIDS and unplanned pregnancies, is higher in developing countries than in developed ones. Similarly, within countries, poor households and communities appear to experience greater mortality and morbidity related to sexual and reproductive conditions than those who are better off. Conversely, research shows that sexual and reproductive ill-health can lead to increased poverty and vulnerability.

Gender inequality has also been shown to determine the opportunity for good sexual and reproductive health among men and women of all ages. Most simply, men and women have different reproductive health systems. These biological differences interact with social norms that ascribe different roles, behaviours and expectations to men and women. These norms stratify the opportunities

for good sexual and reproductive health that men and women enjoy, such as their exposure to the risk factors of sexual and reproductive ill-health and their access to appropriate quality health care.

The growing commitment to addressing sexual and reproductive health requires that health professionals at the community, provincial, national and international level have the knowledge, skills and tools to more effectively respond to the health needs of poor and marginalized people. Similar commitment to addressing gender inequality and the empowerment of women demands that health professionals respond to the different health needs of men and women. The need for such knowledge and skills among health professionals is even more necessary given the pledge to ensure universal access to reproductive health services in the Region. However, many health professionals in the Region are not adequately prepared to address these issues.

This module is designed to improve the awareness, knowledge and skills of health professionals on sexual and reproductive health. The module is divided into six sections:

- **Section 1** provides an overview of key concepts in sexual and reproductive health and reviews the global and regional burden of mortality and morbidity related to sexual and reproductive health.
- **Section 2** examines WHAT the links are between poverty, gender and sexual and reproductive health.
- **Section 3** discusses WHY it is important for health professionals to address poverty and gender concerns in sexual and reproductive health, from efficiency, equity and human rights perspectives.
- **Section 4** discusses HOW health professionals can address poverty and gender concerns in sexual and reproductive health policies, plans and programmes.
- **Section 5** provides notes for facilitators.
- **Section 6** is a collection of tools, resources and references to support health professionals in their work in this field.

# 1. What is Sexual and Reproductive Health?



## 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.<sup>4</sup> 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.<sup>5</sup>

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.<sup>6</sup> The PoA defined reproductive health as:<sup>7</sup>

*... 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.<sup>8</sup> The PoA goes on to recognize reproductive health as the cornerstone of population and development programmes.<sup>9</sup>

### 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.<sup>10</sup>*

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.<sup>11</sup> 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. The 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.<sup>12</sup>*

## 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.<sup>13</sup> Attention was also drawn to how the long-established approach neglected the emotional, mental and physical health aspects of sexual activity and reproduction.<sup>14</sup> 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.<sup>15</sup>*

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.<sup>16</sup> 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.<sup>17</sup> 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.<sup>18</sup>*

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.<sup>19</sup> 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.<sup>20</sup> 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.<sup>21</sup>

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.<sup>22</sup> 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.*<sup>23</sup>

This passage defines “sexual rights” without using the specific term.<sup>24</sup>

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.<sup>25</sup> According to the proposed working definition of sexual rights, all persons are entitled to:<sup>26</sup>

- *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;*
- *choose their partner;*
- *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.*<sup>27</sup>

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.<sup>28</sup>

### 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.<sup>29</sup>

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.<sup>30</sup> 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
<b>Total (percent)</b>	<b>18.4</b>	<b>31.3</b>	<b>12.0</b>	<b>6.9</b>	<b>16.9</b>	<b>18.9</b>	<b>10.8</b>
<b>Total DALYs (thousands)</b>	<b>270</b>	<b>112</b>	<b>17</b>	<b>10</b>	<b>23</b>	<b>79</b>	<b>28</b>

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.<sup>31</sup> 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.<sup>32</sup> 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.<sup>33</sup> 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.<sup>34</sup> Adolescents do

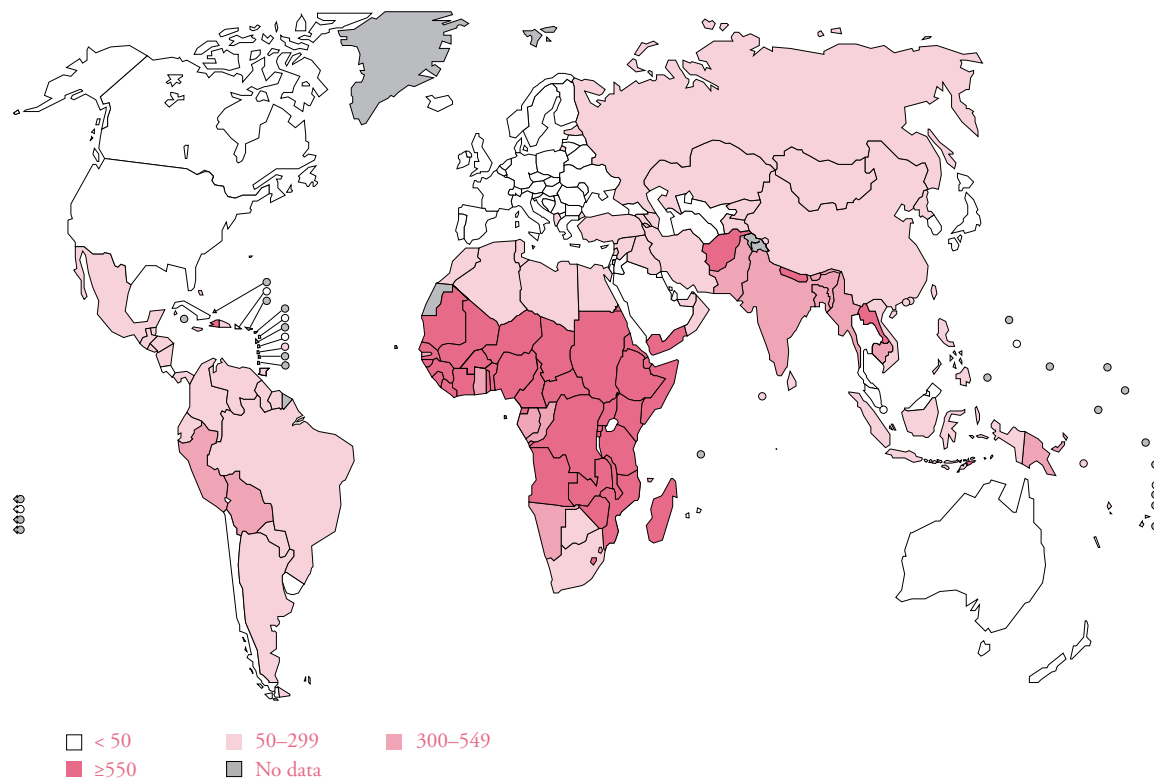
not always plan sexual activity and may not have the knowledge and skills to protect themselves from STIs. This vulnerability is amplified by profound changing social norms in many developing countries that include a trend towards delays in marriage and childbearing, urbanization, weaker influence of 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.<sup>35</sup> Each year, an estimated 210 million

Figure 1: Maternal mortality ratios by country, 2000



Source: World Health Organization 2005b.

women experience life-threatening complications during pregnancy, which often result in serious disability and perhaps death.<sup>36</sup> Based on 2000 data, at least 529 000 maternal deaths occur worldwide every year.<sup>37</sup> About 90% of these deaths take place in developing countries.

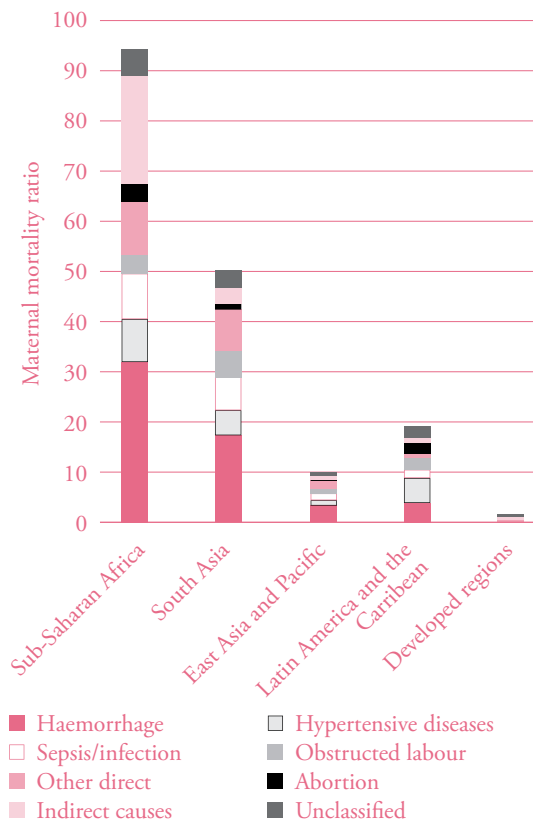
Globally, the maternal mortality ratio (MMR) is 400 per 100 000 live births. However, maternal mortality in developing countries is more than 100 times higher than that in industrialized countries, making it the health indicator with the greatest disparity between rich and poor nations. The lifetime 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.<sup>38</sup> 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.<sup>39</sup> 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.<sup>40</sup> 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.<sup>41</sup>

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.<sup>42</sup> 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**

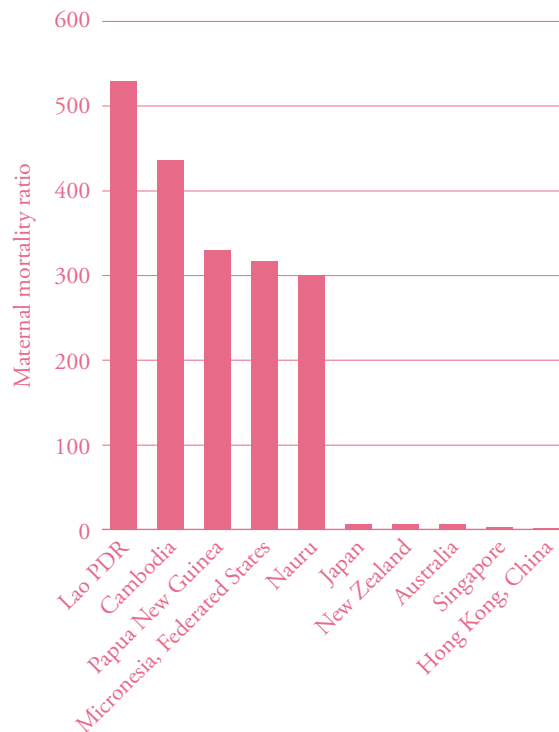


Source: Ronsmans *et al.* 2006.

during the first week after pregnancy occurred in women whose pregnancy had ended in abortion or stillbirth.<sup>43</sup> Unsafe abortions<sup>44</sup> 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.<sup>45</sup> 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.<sup>46</sup> 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.<sup>47</sup>

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.<sup>48</sup> Although improvements have been made in maternal health, the Region's MMR was estimated in 2001 to be 120 per 100 000 live births.<sup>49</sup> 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.<sup>50</sup> 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.<sup>51</sup>

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.<sup>52</sup>

Apart from pregnancy-related deaths, illness and disease related to pregnancy and childbirth affect up to one quarter of adult women in developing countries.<sup>53</sup> 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.<sup>54</sup> 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.<sup>55</sup> High rates of depression arising from childbirth have been reported throughout the world, with childbirth being one of the factors potentially responsible

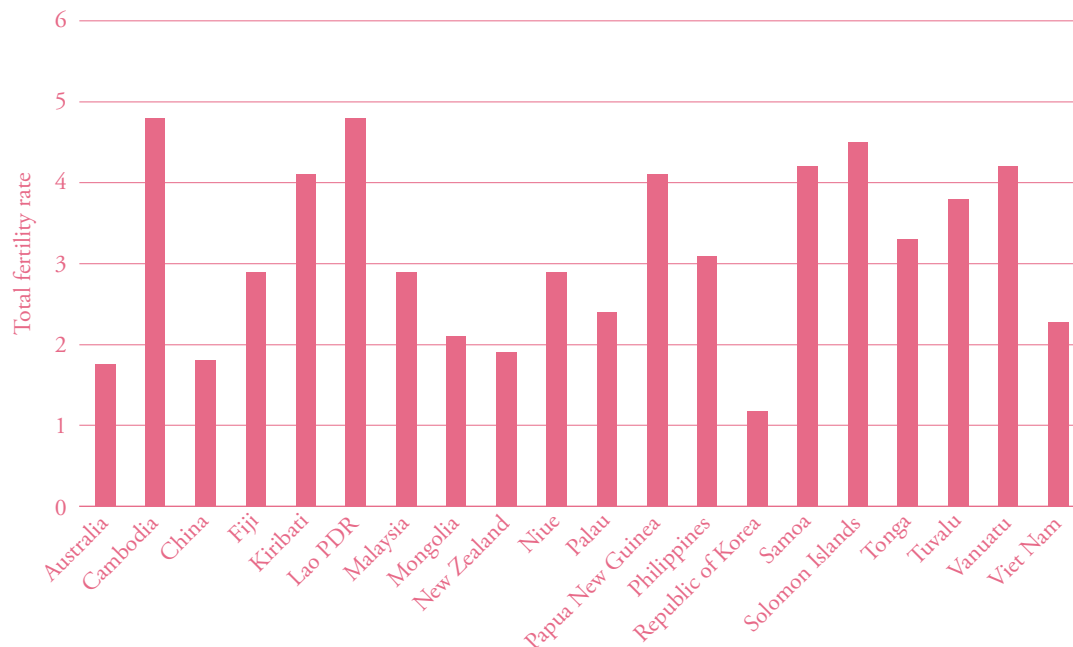
for the high rates of unipolar depression among young women.<sup>56</sup>

Worldwide, teenagers give birth to one in 10 babies. In developing countries, this proportion rises to one in six.<sup>57</sup> 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.<sup>58</sup> 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**

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

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.<sup>59</sup> 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.<sup>60</sup> 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.<sup>61</sup>

### **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.<sup>62</sup> While fertility rates have declined in most countries, women dwelling in developing countries tend to have more children than those living in developed countries. This 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.<sup>63</sup> 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 obstetric-related morbidity and mortality.<sup>64</sup> 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.<sup>65</sup> 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.<sup>66</sup> 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.<sup>67</sup> In contrast, the contraceptive prevalence rate in China and Viet Nam 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.<sup>68</sup> 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.<sup>69</sup> 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.<sup>70</sup> 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.<sup>71</sup>

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%.<sup>72</sup>

### ***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. <b>Unsafe sex</b>	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. <b>Unsafe sex</b>
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).<sup>73</sup> 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.<sup>74</sup> 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.<sup>75</sup> 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.<sup>76</sup> 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. The proportion of some STIs among young people rises to 50%.<sup>77</sup>

Estimates of the burden of STIs in countries in the Region are scarce.<sup>78</sup> A recent study concluded that the incidence of primary and secondary syphilis in China was 5.67 per 100 000 people in 2005.<sup>79</sup> 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.<sup>80</sup>

STIs can lead to a myriad of reproductive health problems, including infertility and negative pregnancy outcomes.<sup>81</sup> 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**



Source: Government of Solomon Islands and United Nations Development Programme 2002.

Table 3: Global summary of the AIDS epidemic

	2001	2007
<b>Number of adults (15+) and children living with HIV</b>	29.0 million (26.9 million–32.4 million)	33.2 million (30.6 million–36.1 million)
<b>Number of adults (15+) and children newly infected with HIV</b>	3.2 million (2.1 million–4.4 million)	2.5 million (1.8 million–4.1 million)
<b>HIV prevalence in adults (15–49)</b>	0.8% (0.7%–0.9%)	0.8% (0.7%–0.9%)
<b>Number of adult (15+) and child deaths due to AIDS</b>	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.<sup>82</sup> 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.<sup>83</sup> 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).<sup>84</sup> 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.<sup>85</sup>

In the Western Pacific Region, generalized epidemics<sup>86</sup> 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 Viet Nam, 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. Gender-based 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



Source: Joint United Nations Programme on HIV/AIDS and World Health Organization 2007.

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%.<sup>87</sup> A high incidence of non-consensual sex, particularly among young women, has been

reported globally.<sup>88</sup> 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.<sup>89</sup>

## 2. What are the links between poverty, gender, and sexual and reproductive health?



## 2. What are the links between poverty, gender, and sexual and reproductive health?

Sexual and reproductive health is a holistic concept that encompasses a collection of diseases as well as healthy physiological functioning. Social factors, such as gender relations, sexual identities and social inequalities, play a primary role in determining an individual's ability to achieve good sexual and reproductive health. Gender-based violence is also recognized as a determinant of poor outcomes with respect to other reproductive health indicators, such as maternal mortality and RTIs.

Poverty and gender inequality exercise considerable influence and constitute important determinants of men's and women's sexual and reproductive health at all ages. They also shape the access of men and women to appropriate reproductive health care. That is, poor people are less likely than those who are better-off to purchase or access promotive, preventive or curative reproductive health services. The cumulative adverse effects of living in poverty and experiencing unequal gender relations are reflected in inequalities in the burden of poor sexual and reproductive health and differences in how men and women experience sexual and reproductive health.

In the following sections, the relationship between poverty and sexual and reproductive health is considered, followed by a discussion of the influence of gender inequality on the sexual and reproductive health of men and women. In each case, the effects of poverty and gender inequality on the reproductive health of adolescents and older people are highlighted.

### The influence of poverty on reproductive health

#### *Poverty is a determinant of sexual and reproductive health*

##### Household income

Household income is a powerful determinant of sexual and reproductive health outcomes both between and within countries. Women residing in poor households are more likely to experience

early childbearing, short birth spacing and high parity births.<sup>90</sup> As much as 70% of the variance in infant mortality witnessed across and within countries can be attributed to differences in income.<sup>91</sup>

Within countries, low household income is also associated with malnutrition and low educational attainment, factors that also increase the risk of adverse sexual and reproductive health outcomes. Evidence shows that women residing in poor households are more likely than those from better

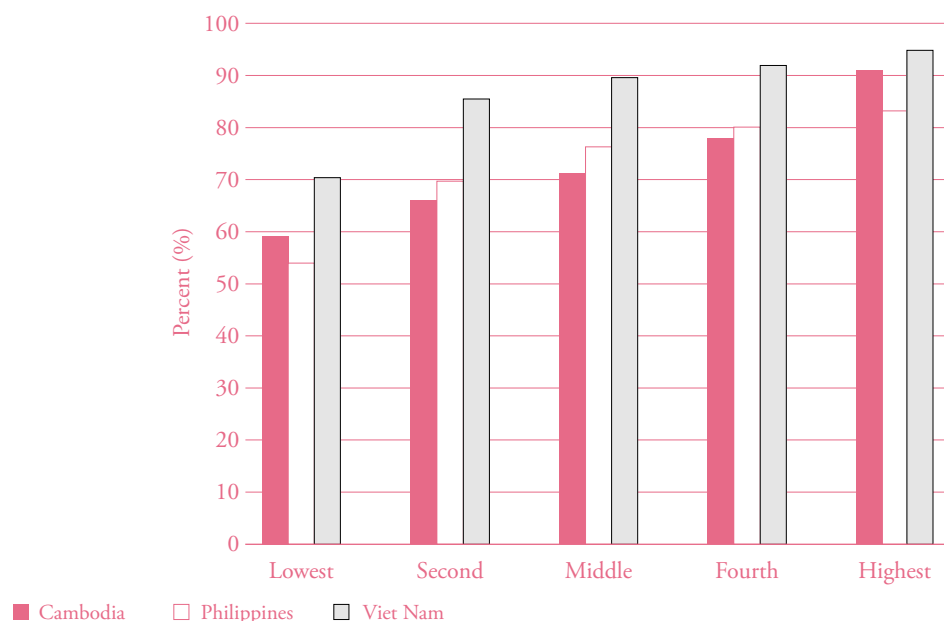
#### Box 2: Defining poverty

In this module, poverty is defined to encompass not only low income but also other forms of deprivation, including limited economic opportunities; diminished education and health outcomes; reduced access to services, resources and skills; and voicelessness and powerlessness to influence decisions that affect one's life.<sup>92</sup> This definition of poverty moves beyond the narrow association of poverty with low income and consumption, which tends to inadequately capture the experience of poverty in the Region. For example, among communities in the Pacific, poverty, as measured by income or consumption, may be deemed to be low or nonexistent. However, households in the Pacific may be vulnerable to natural disasters; located in isolated or remote places; lack economic choices or opportunities to earn income; have limited access to education, health and financial services; and suffer from social exclusion.<sup>93</sup>

Poverty often overlaps with and reinforces other types of social exclusion that are based on age, ethnicity, geographical location and gender. Because of this, communities, households, and even members within the same household tend to have different experiences of poverty. The poverty experienced in rural communities often differs from that of urban poor communities, such as slum dwellers. Women within poor households tend to be particularly disadvantaged, as women lag behind men in almost every social and economic indicator of well-being.

Sources: Lightfoot and Ryan 2001; Lampietti and Stalker 2000.

**Figure 7: Proportion of women aged 15–49 years who know at least one way to avoid sexual transmission of HIV/AIDS, by income quintile, in Cambodia (2000), the Philippines (2003) and Viet Nam (2002)**



Source: Gwatkin *et al.* 2007a, 2007b and 2007c.

off households to experience early child bearing, short birth spacing and high parity births. Adult nutrition and health-seeking have also been found to improve with income level.<sup>94</sup>

A clear correlation between household income and the likelihood of HIV infection has been observed in a number of countries. Analysis of data from Cambodia and Viet Nam found that household income was associated with reduced risk factors for HIV, such as increased awareness about modern contraceptives and about the benefits of using condoms.<sup>95</sup> A study carried out in Thailand found that people from the poorest households were the most likely to be infected with HIV.<sup>96</sup> Similarly, in Cambodia, the Philippines and Viet Nam, women's awareness of HIV prevention appears to improve as household income rises (Figure 7).

Across countries in the Region, household incomes tend to be lower in rural areas than in urban areas. As a result, rural residence may be considered as a dimension of poverty or social exclusion. In the Lao People's Democratic Republic, knowledge of contraceptives was found to be higher among

urban youth aged 15 to 24 years than youth in rural areas (79% vs. 45%). Similarly, youth in urban areas were more likely than their rural counterparts (69% vs. 40%) to have heard of STIs.

### Restricted economic opportunities

Poverty may increase the likelihood of women and men engaging in income-generating activities that can be harmful to their sexual and reproductive health. Although women enter sex work for a variety of reasons, female sex workers often come from households that are poor or otherwise deprived. For example, a study carried out in Siem Reap, Cambodia found that 51.4% of female sex workers had never attended school.<sup>97</sup> Similarly, transgendered individuals who face social marginalization and extreme exclusion from the labour market may be left with few options other than sex work to survive. Sex workers who live in poverty are vulnerable to inadequate working conditions that can increase the risk of physical and reproductive health problems, unwanted and complicated pregnancies, STIs and a range of other negative health outcomes.



In many parts of the world, men and women leave their homes to find work. Migration might occur from rural to urban areas within a country (internal), or to destinations outside the country of origin (external). Studies from countries across the Region show that the risk of poor reproductive health is often greater for mobile populations than for non-mobile populations. Most notably, migrant populations are more vulnerable to HIV infection than the general population in many countries. This vulnerability is attributed, in part, to the absence of family and social norms and to constrained access to reproductive health services.<sup>98</sup> Work-related migration can create an imbalance in the ratio of men and women in sending or receiving areas. In some cases, these disproportions can lead to the sharing of sex partners.<sup>99</sup> For example, a study in Sichuan province, China reported that migrant workers constituted the majority of male clients of female sex workers. On average, migrant workers were found to have bought sex 11 times during the previous six months and the majority (64%) had not used a condom the last time they paid for sex.<sup>100</sup>

### Limited access to education

Worldwide, a larger share of men (80%) than women (64%) is literate. While boys and girls in more developed countries are both enrolled in primary and secondary school, women in less developed countries complete fewer years of education than men and are more likely to be illiterate.<sup>101</sup> Table 4 presents the literacy rates for men and women in selected countries in the Region.

Although the literacy rates of women are generally lower than men, evidence shows that women who can read and write are better equipped to protect their health and their family's health. Girls who have at least seven years of schooling are less likely than those with little or no education to become pregnant during adolescence and are more likely to postpone marriage.<sup>102</sup> In Mongolia, a higher pregnancy rate was observed among girls with only primary schooling compared to those who had completed grade 10.<sup>103</sup> In the Lao People's

Democratic Republic, youth aged 15–24 years with some education were nearly three times as knowledgeable as those with no education (60% vs. 21%) about contraceptive methods. Similarly, as many as 52% of youth with some education and only 21% of those with no education had heard of STIs.<sup>104</sup> In the Philippines, youth who were attending school knew more about reproductive health than out-of-school youth.<sup>105</sup> Moreover, Filipino youth with lower education reported a higher incidence of sex work than those with higher levels of education.<sup>106</sup> Studies report that poor, uneducated men and women have higher rates of STI including HIV.<sup>107</sup> Similarly, a study conducted in Long An, Viet Nam in 2002 revealed a lower prevalence of HIV among injecting drug users with high school or undergraduate education.<sup>108</sup>

Educating women is a long-term strategy for advancing their reproductive health. Educated women generally have a better understanding of health care practices and nutrition. Women with higher levels of education are more likely than those with lower education to seek care during pregnancy and childbirth, to pay attention to nutrition and to increase spacing between births.<sup>109</sup>

**Table 4: Adult literacy rates for selected countries in the Region, 2000–2004\***

Country	Adult literacy rate (%)	
	Male	Female
Cambodia	85	64
China	95	87
Fiji	94	91
Lao People's Democratic Republic	77	61
Malaysia	92	85
Mongolia	98	98
Papua New Guinea	63	51
Philippines	93	93
Singapore	97	89
Tonga	99	99
Viet Nam	94	87

\*Data refer to the most recent year available during the period indicated in column heading  
Source: United Nations Children's Fund 2006.

Data collected in Peninsular Malaysia from 1950 to 1998 revealed that educational attainment positively influenced a woman's decision to obtain prenatal care and to deliver in a clinic or hospital.<sup>110</sup> Research from the past 20 years shows that educated women tend to have smaller and healthier families. In contrast, women with no schooling have about twice as many children as do women with 10 or more years of education.<sup>111</sup> For all of these reasons, educated women are less likely than uneducated women to die in childbirth. Indeed, the World Bank estimates that, for every 1000 women, an extra year of education could prevent two maternal deaths.<sup>112</sup>

### Undernutrition

Hunger and undernutrition are closely associated with poverty. Undernutrition includes protein-energy undernutrition and deficiencies in micronutrients such as iron, vitamin A, iodine and zinc.<sup>113</sup> In Cambodia, the rate of undernutrition (BMI <18.5 kg/m<sup>2</sup>) was found to be higher among women from the poorest income quintile (24%) than among women from the richest (17%) in 2000.<sup>114</sup> Women in rural areas of Mongolia were found to be more likely than their urban counterparts to give birth to underweight children because of relatively difficult living and working conditions.<sup>115</sup>

Evidence on nutritional inequalities between men and women, and boys and girls, tends to come from countries in South Asia. Nevertheless, a few studies have investigated possible gender-based inequalities in nutrition between men and women, and boys and girls, in the Western Pacific Region. One study in the Philippines reported differences between the diet of boys and girls, i.e. boys had a higher intake of protein-rich foods than girls, who were given more vegetables.<sup>116</sup> A second study from the Philippines found that the intrahousehold allocation of calories favoured boys over girls.<sup>117</sup>

Undernutrition adversely affects the health of a woman during pregnancy and childbirth, as well as the child. These adverse effects can also

be transmitted to the next generation. Children of under- or malnourished mothers often suffer malnutrition *in utero*, leading to low birth weight (LBW).<sup>118</sup> Furthermore, an underweight girl will grow into a stunted woman, who is more likely to have LBW babies. As discussed above, LBW babies face a higher risk of disease and a greater probability of dying in the neonatal period or in infancy than their healthier counterparts.<sup>119</sup>

### *Poverty-related inequalities in access to reproductive health care*

Preventive and curative health care have been shown to effectively improve the well-being of poor households.<sup>120</sup> This positive association applies to sexual and reproductive health as well. For example, inequalities between developed and developing countries in the likelihood of a woman dying in childbirth are at least partly explained by the higher coverage of good quality maternal health services in developed countries. Maternal mortality from obstructed labour rarely occurs in developed countries because of the widespread availability of services providing low-cost interventions to prevent and treat postpartum haemorrhage, infection and hypertensive disorders.<sup>121</sup> In addition, preliminary estimates suggest that as many as 71% of maternal deaths could be averted in developing countries by improving the coverage of key maternal interventions: essential obstetric care, access to safe abortion, active rather than expectant management in third stage of labour, and use of magnesium sulphate and other anticonvulsants for women with pre-eclampsia.<sup>122</sup> Similarly, increasing the coverage of existing evidence-based interventions for neonatal survival could reduce neonatal deaths by an estimated 35%–55%.<sup>123</sup>

Poor individuals and households who urgently need sexual and reproductive health services often have insufficient access to appropriate preventive and curative care. While the coverage of maternal health care in developing countries has risen over the last decade, an estimated 33% of women still receive no care during pregnancy.<sup>124</sup> An estimated 60% of women deliver outside a health facility,



and 40% of deliveries are not attended by a trained health staff.<sup>125</sup>

In countries in the Region with the highest risk of maternal death, the coverage of appropriate maternal health services may be even lower. Analysis of data from Cambodia and the Lao People's Democratic Republic suggests that as many as 90% of deliveries occur at home without a skilled birth attendant.<sup>126</sup> Roughly 58% of women in Papua New Guinea attended antenatal clinics during pregnancy.<sup>127</sup> In the Philippines, 70% of women have the recommended four antenatal check-ups.<sup>128</sup>

The continued unmet need for family planning in many countries in the Region points to the incomplete coverage of family planning programmes. Unmet need for family planning among women who are married or in union was estimated to range from 40.0% in the Lao People's Democratic Republic to 18.8% in the Philippines in 2005.<sup>129</sup> The unmet need for contraceptives correlates strongly with household income in developing countries.<sup>130</sup> Estimates suggest that unmet need in the poorest fifth of the population in Asia and Latin America might be twice as high as that of the wealthiest fifth.<sup>131</sup> A similar trend is observed among countries in the Region (Table 5).

While these data illustrate the general incomplete coverage of many reproductive health services in the Region, they say little about the distribution of these services within countries

**Table 5: Total fertility rates (actual and wanted) by income quintile in the Philippines, 2003**

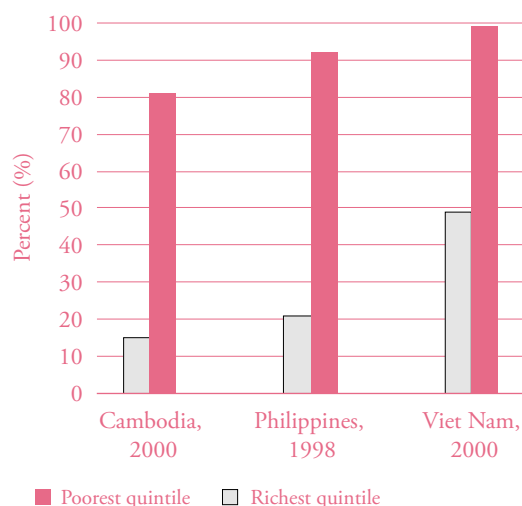
Wealth index quintile	Wanted	Actual
Lowest	3.8	5.9
Second	3.1	4.6
Middle	2.6	3.5
Fourth	2.2	2.8
Highest	1.7	2.0
<b>Total</b>	<b>2.5</b>	<b>3.5</b>

Source: National Demographic Health Survey 2003. In: Health Action Information Network 2005.

and between communities. Further analysis of data from more than 50 developing countries reveals that reproductive health services tend to disproportionately benefit better-off communities within countries, even though poor individuals and households are more vulnerable than the non-poor to reproductive ill-health.

Among women in the poorest income quintile, for example, births are five times less likely to be attended by trained health personnel than births to women from the highest income quintile.<sup>132</sup> The proportion of women from households in the poorest income quintile in the Philippines and Viet Nam who received at least one antenatal care consultation with an adequately trained person was 71.5% and 78.5%, respectively, in comparison with over 97% of women from households in the richest income quintile in both countries. The inequalities in deliveries attended by trained personnel are even starker: only 21.2% of births to women from the poorest income quintile in the Philippines were assisted by a doctor, nurse or trained midwife, while over 91.0% of women from the richest income quintile received such assistance. Figure 8 compares the proportion of deliveries assisted by a trained health worker for women in the poorest and richest income quintiles

**Figure 8: Percentage of women receiving delivery assistance from a doctor, nurse or midwife in Cambodia, the Philippines and Viet Nam**



Source: Gwatkin, 2000. In: Carr 2004.

in Cambodia, the Philippines and Viet Nam. Over 90% of women from the poorest quintile in the Philippines gave birth at home, while a mere 20% of those from the richest quintile chose home births.<sup>133</sup> Women from households in the richest quintile in Viet Nam are more than 150% more likely than women from the poorest quintile to have deliveries in health facilities.<sup>134</sup>

### Barriers to access to services

Access to reproductive health services can be constrained by geographical, economic, knowledge- and awareness-related, or sociocultural barriers. This section describes the barriers that delay or prevent poor men and women from accessing appropriate services. It then discusses inequalities in the quality of reproductive health services received by the poor—the quality of care is often worse in health facilities serving poor communities.

### Geographical barriers

The availability of appropriate reproductive health services can depend on the allocation of financial resources for health. In developing countries, the poorest 20% of the population typically receives less than 20% of the benefits from public health spending (Table 6).<sup>135</sup> Government resources for health often disproportionately benefit wealthier households and communities; public resources tend to be allocated to hospital-based curative services in urban areas, leaving primary health services and other health initiatives targeting poor communities or households under-funded.

This skewed distribution of health resources tends to disadvantage poor populations and often

results in substandard health services in the areas where they live. In Vanuatu, for example, almost 75% of the health budget in 1996 was allocated to urban rather than rural services. As a result, only 20% of the population benefited from public spending on health services.<sup>136</sup> In Cambodia, 13% of government staff are located in rural areas, where 85% of the Cambodian population lives.<sup>137</sup> In Mongolia, the geographical distribution of health staff may be partly why people from rural households visit health facilities only half as often as those from urban households.<sup>138</sup> In 2002, the ratio of physicians to population ranged from 1:206 in Ulaanbaatar to 1:794 in Zavhan.<sup>139</sup> Similarly, health staff in the Philippines are largely concentrated in urban areas.<sup>140</sup>

Inequalities in the distribution of health resources are also evidenced by the distances that some people must travel to access health services. For example, the proportion of households with access to primary health services in the Lao People's Democratic Republic ranges from 82% in the southern parts of the country to 67% in the northern areas. In the Northern Region, 13% of households live more than eight hours away from a hospital, which is more than twice the distance for those living in the other two regions.<sup>141</sup> Remote islands in the Pacific, such as Torba and Tafea in Vanuatu, can suffer particular transportation constraints.<sup>142</sup> Travel time to the nearest aid post (nursing station clinic) in Papua New Guinea ranges from 67 minutes in Papua/South Coast to 28 minutes in the New Guinea Islands.<sup>143</sup> The incomplete coverage of services in rural, remote and marginalized areas can delay a poor household's access to health services and increase the overall costs of seeking health care.

The distribution of reproductive health services correspondingly reflects the low and incomplete coverage of health services in many poor and marginalized areas of the Region. In Mongolia, reproductive health information, education and communication (IEC) materials and infrastructure are concentrated in Ulaanbaatar.<sup>144</sup> A study in Cambodia found that HIV/AIDS prevention efforts were largely focused on urban populations,

**Table 6: Share of public health spending received by households in the poorest and richest income quintiles**

Country	Poorest quintile	Richest quintile
Malaysia, 1989	29%	11%
Viet Nam, 1992	12%	29%

Source: Hsiao and Liu. In: Evans *et al.* 2001.

thereby missing the 85% of the population living in rural areas.<sup>145</sup> Research carried out in the Lao People's Democratic Republic in 1999 found that contraceptives were not reaching rural communities. Indeed, transportation was cited as a key challenge in obtaining contraceptives.<sup>146</sup> Maternal deaths from infection, hypertension and uterine rupture are rarely reported in urban areas of Viet Nam. In contrast, these are the most common causes of maternal death in rural areas.<sup>147</sup>

Urban–rural inequalities in the coverage of antenatal care and skilled attendance at delivery appear to be prevalent in countries in the Region. A survey carried out in 2000 in Cambodia found that only 33.8% of rural women with a recent birth had one or more antenatal care (ANC) visits to medically trained personnel as compared with 62.3% of urban women. The proportion of urban births assisted by a trained health worker was almost double (57.2%) that in rural areas (28.0%).<sup>148</sup> Similarly, in 2003, women in urban areas of the Philippines were more likely than those in rural areas (91.2% vs. 83.9%) to have had at least one ANC visit to a trained health worker. The discrepancy in births assisted by a trained health worker were even more striking, however, ranging from 79.0% among urban women to 40.8% among rural women.<sup>149</sup> In the same way, many women in rural parts of China have been found to deliver at home with no skilled health worker in attendance.<sup>150</sup> Antenatal care coverage in Solomon Islands ranges from 78% in Honiara to 47% in the remote province of Rennell Bellona.<sup>151</sup>

### **Economic barriers**

The total cost of seeking care can be disaggregated into direct costs (such as fees charged for health services), indirect costs (such as the cost of transportation and food) and opportunity costs (such as time away from work). Many people in the Region, particularly those who are poor, have to pay for their own health care at the time of illness and greatest need.<sup>152</sup> For example, in the Lao People's Democratic Republic, out-of-pocket

payments financed more than 50% of household health care costs, which consisted mainly of drugs.<sup>153</sup>

Yet the costs of seeking health care are often more than poor households can bear. In Tianjian, China, for example, 64.8% of women and 55.6% of men reported that financial difficulties prevented them from accessing hospital services when referred by a doctor.<sup>154</sup> A case study in three poor rural counties in China found that financial difficulties prevented 41% of sick peasants from seeking treatment.<sup>155</sup> With regards to sexual and reproductive health specifically, studies from Bangladesh and India found that the cost of delivery in government facilities could be two to eight times the monthly income of the poorest 25% of the population. In Rajasthan, India, treatment for one RTI episode in a government health centre costs more than the average monthly household income, while the cost of an abortion is two to three times the monthly income. In one rural area of China, the cost of health care deterred 74% of women with complications related to pregnancy or delivery from seeking care in 1994–1995.<sup>156</sup>

Payments for health care services, such as user fees, have been found to adversely affect the ability of poor men and women to access services, including those for reproductive health.<sup>157</sup> A study in Kenya observed that the introduction of user fees, which were equivalent to half a day's income for poor individuals, resulted in fewer men and women seeking care for STIs, and the reduction in access was significantly greater for women than men.<sup>158</sup> A study in Nigeria showed that government attempts to improve health services by charging user fees led to a precipitate decline in the uptake of maternity services, accompanied by increasing numbers of deaths.<sup>159</sup> In a study in the rural areas of Yunnan province in China, local women were unwilling to pay the 15 yuan charged by village birth attendants for home delivery and medication in 1999. At the time of the study, the cost of a normal delivery at a hospital was 200 yuan. In 2002, the cost of a normal delivery had increased to 30 yuan at village level, 250 yuan at

township level and 600–800 yuan at county level institutions.<sup>160</sup>

Even when services are provided free of charge, the indirect costs of transportation, drugs, and food and lodging for accompanying family members can increase the financial burden of seeking reproductive health care. A number of studies have observed that, when admitted to a health facility for delivery, women must purchase bleach to sterilize materials, bed sheets, gauze, gloves, sanitary pads and other supplies.<sup>161</sup> A case study in a northern district of Viet Nam reported that the cost of transportation alone was equivalent to one third of monthly expenditure in the locality.<sup>162</sup> A 1999 study from the Lao People's Democratic Republic estimated the cost of transportation in case of emergencies to be 2000–3000 kip<sup>163</sup> for less than 8 km and 60 000 for a trip longer than 70 km in 1999.<sup>164</sup> The high cost of transportation for long trips can limit the access of men and women living in rural areas to adequate health services, depriving them of basic care.<sup>165</sup> It can also stop women from seeking emergency obstetric care, which tends to be more available in district or provincial health facilities located in larger communities.

In addition, the economic costs associated with seeking health care can be amplified for women who typically have lower access to and control over household and community resources, including means of transportation. In such cases, many women must rely on their husbands, other family members or community leaders to decide whether or not their health emergency warrants the use of household or community resources.

In some countries, reproductive health services are included in benefit packages under health insurance schemes. However, vulnerable groups who need these services the most are often unable to participate in such schemes. For example, all Mongolian children under the age of 16 or up to the age of 18 while in school are covered by the health insurance scheme. The notable exception is street children and young migrants, who might not have the documentation required to access

services.<sup>166</sup> In the Philippines and Viet Nam, as in other countries, the poor are underrepresented in insurance schemes because few are employed in the formal sector.<sup>167</sup> They are also less likely to have sufficient income to pay the fees associated with membership.

### **Lack of knowledge and awareness**

Access to reliable information can enable women and men to recognize the signs and symptoms of reproductive health problems, such as STIs. On the other hand, limited health-related information and awareness have been found to reduce demand for preventive and curative health services. A study conducted in the Lao People's Democratic Republic found a generally low understanding of danger signs during pregnancy, particularly among ethnic minorities. In addition, limited understanding of the risk of malaria for pregnant women resulted in few pregnant women being given anti-malarial medications.<sup>168</sup> Knowledge of sexual and reproductive health was found to be low among female sex workers in Cambodia regardless of their age.<sup>169</sup> A study carried out in 2002 in an urban slum in New Delhi reported that only 12.5% of respondents knew that a Pap test could diagnose cervical cancer. Further analysis showed that education was significantly and positively associated with correct knowledge and health-seeking.<sup>170</sup>

Health information may not reach poor and marginalized households and communities for a variety of reasons. Most simply, IEC materials may not be available in health facilities serving poor communities. A study in Viet Nam reported that abortion clinics did not have patient-friendly materials to help women to make an informed choice about the method used.<sup>171</sup> A similar lack of IEC materials for patients was observed among health clinics in the Lao People's Democratic Republic. In particular, no IEC materials were available in ethnic minority languages.<sup>172</sup>

Poor men and women, who may have little education, are less likely to be able to read

printed information materials and labels on drug packaging. Marginalized populations, such as ethnic minorities, may not be able to benefit from IEC materials and outreach activities if they do not speak the main language in the area.

Other forms of media may be similarly inaccessible to individuals residing in poor households that may not have radios or televisions. For example, a study in Indonesia observed that poor women were less likely than their better-off counterparts to be exposed to family planning messages through broadcast media. Among the poorest women, 20% recalled having seen or heard a family planning message in the previous six months, as compared to 56% of the wealthiest. Fewer radios and televisions among the poor households partially explained the disparity.<sup>173</sup>

Communities in remote or rural areas may not benefit from outreach activities. In contrast to the generally high level of awareness about contraceptives in the Lao People's Democratic Republic, for example, one study found that rural and remote communities not reached by the national programme knew little about contraceptives.<sup>174</sup>

### **Sociocultural barriers**

Access to health services can be a particular problem for women and men from indigenous or ethnic minority groups. Throughout the world, health care for ethnic minorities has proved to be challenging. Reasons for this challenge include:

- poverty and isolation of many ethnic minority populations
- differences between the dominant and ethnic minority populations with respect to:
  - ♦ cultural norms and values that differ from the dominant culture
  - ♦ health care practices that differ from the dominant culture
  - ♦ health-seeking behaviours
  - ♦ beliefs and values about life, death and destiny
  - ♦ religious beliefs and practices

### **Quality of care**

Many health facilities that serve poor communities are poorly resourced and thus tend to lack adequate medicines, equipment and supplies. These same communities often suffer from substandard infrastructure such as roads, transportation, electricity, water, sanitation, communication and links with other levels of care.<sup>175</sup> In Solomon Islands, for example, roughly 70% of the population lives within one-hour walking distance of a health facility. However, a study found that many of these facilities lacked staff and essential drugs and equipment.<sup>176</sup> A review of health facilities in the Lao People's Democratic Republic in 1999 reported that few had the supplies and equipment needed to provide adequate pregnancy-related care. In many facilities, privacy for patients was questionable and referral systems were generally inadequate: many health facilities lacked telephones or transmitters to contact district or provincial hospitals in the case of emergency.<sup>177</sup> In other cases, preventive efforts to reduce the risk factors for reproductive health problems have not been integrated into general health care services. For example, preventive efforts for cervical cancer appear to be lacking and effective methods of screening and treating cervical cancer have not yet become routinely available in primary health care.<sup>178</sup>

It is often difficult to recruit, educate and retain health workers in rural and remote areas. As a result, reproductive health services in poor areas are often provided by partially trained or untrained birth attendants and community or family members using traditional therapies and delivery methods. These methods often put the woman and baby at considerable risk.

Health staff in rural and remote areas may also lack the skills to assess and manage complex conditions or to know when a woman's condition requires referral to a higher-level health facility. Some women in peri-urban and rural areas prefer to give birth at home for this reason, even when institutional care is available. A study in the Lao People's Democratic Republic observed



that women cited low quality of care in health facilities and the absence of drugs and equipment as reasons for preferring home deliveries.<sup>179</sup> A study in four poor counties in Yunnan found that 29%–55% of township-level reproductive health service providers and 71%–91% of village-level providers lacked the competencies to diagnose and treat common RTIs.<sup>180</sup> Clinics providing treatment for STIs in Papua New Guinea are generally concentrated in the larger cities, such as the provincial capitals. Rural health staff were generally found to lack the training necessary to provide appropriate treatment and care for STIs, and the required drugs were not always available.<sup>181</sup>

Drug sellers in the Region often provide treatment for STIs. However, the quality of their services may be uneven. For example, evidence from Viet Nam suggests that drug sellers rarely dispense treatment for STIs in accordance with national guidelines or provide an adequate daily dose of drugs.<sup>182</sup>

In seeking health care, the poor are interested not only in the technical competence of health staff, but also in their interpersonal skills. This may be especially the case for women. The importance of interpersonal relations between clients and health service providers is evidenced by a study from Bangladesh. The study was carried out from January 1998 to July 2000 in two urban and two rural areas of Bangladesh to assess the impact of fees for services offered by nongovernmental organizations. The study concluded that poor respondents were willing to travel farther and pay more for better quality services, where the interpersonal dimension—treating clients with respect and kindness—was a critical dimension of

quality.<sup>183</sup> Yet health staff may not receive training on interpersonal communication, as was found to be the case in the Lao People's Democratic Republic, for example.<sup>184</sup> Similarly, counselling by health staff for reproductive health conditions appears to be rare in Viet Nam.<sup>185</sup>

Poor women are particularly unlikely to seek care from providers they view as disrespectful and insensitive to their needs.<sup>186</sup> Studies from Mongolia and Viet Nam report that, even though induced abortions are offered by the public health system, women, especially those who are young, prefer to seek care at private hospitals because of the confidentiality and privacy afforded. In some cases, however, private providers may have few skills and little training.<sup>187</sup>

### *Inequalities in reproductive health outcomes*

The relatively high burden of reproductive ill-health among poor individuals, combined with their generally lower access to preventive and curative reproductive health services, results in significantly worse reproductive health outcomes, including morbidity and mortality, as compared with the non-poor.

The risk of death in childhood was estimated to be 10 times higher for the poorest 20% of the global population than for the richest 20%.<sup>188</sup> Within countries in the Region, infants and children from poor households and communities suffer disproportionately from disease and death. An inverse association between infant mortality and maternal education has been observed in Cambodia, the Philippines and Viet Nam.<sup>189</sup> In 2003, the IMR in rural areas of Papua New Guinea was 2.5 times higher than in urban areas.<sup>190</sup>

**Table 7: Infant mortality rates in provinces with a high concentration of ethnic minorities compared to the national average in the Lao People's Democratic Republic and Viet Nam**

Country	National IMR	IMR in provinces
Lao People's Democratic Republic	100 per 1000 (1995)	132 per 1000 (Luang Prabang, 1999)
Viet Nam	36 per 1000 (1996)	52 per 1000 (Northern Highlands) 55 per 1000 (Central Highlands, 1996)

Source: Asian Development Bank 2001.

Rates of infant and child survival tend to be lower among marginalized communities in the Region, such as ethnic minorities (Table 7).

As noted above, data on the prevalence of STIs in the Region are scarce, particularly data on the distribution of STIs within countries.<sup>191</sup> Rates of RTIs among rural women in Yunnan province, China, might be as high as 50%.<sup>192</sup> Evidence suggests that genital discharge was higher among poor rather than non-poor women in the Philippines in 2003.<sup>193</sup>

Inequalities in the total fertility rate within countries correlate with various indicators of social exclusion. In the Lao People's Democratic Republic, the TFR ranges from 5.4 in rural areas to 2.8 in urban areas.<sup>194</sup> Similarly, the TFR has been found to be significantly higher among uneducated women as compared with those who are educated.<sup>195</sup> The TFR of Mongolian women living in remote western *aimags* is 3.85, which is higher than the national average of 3.00 and significantly higher than the TFR for women living in Ulaanbaatar (2.17).<sup>196</sup>

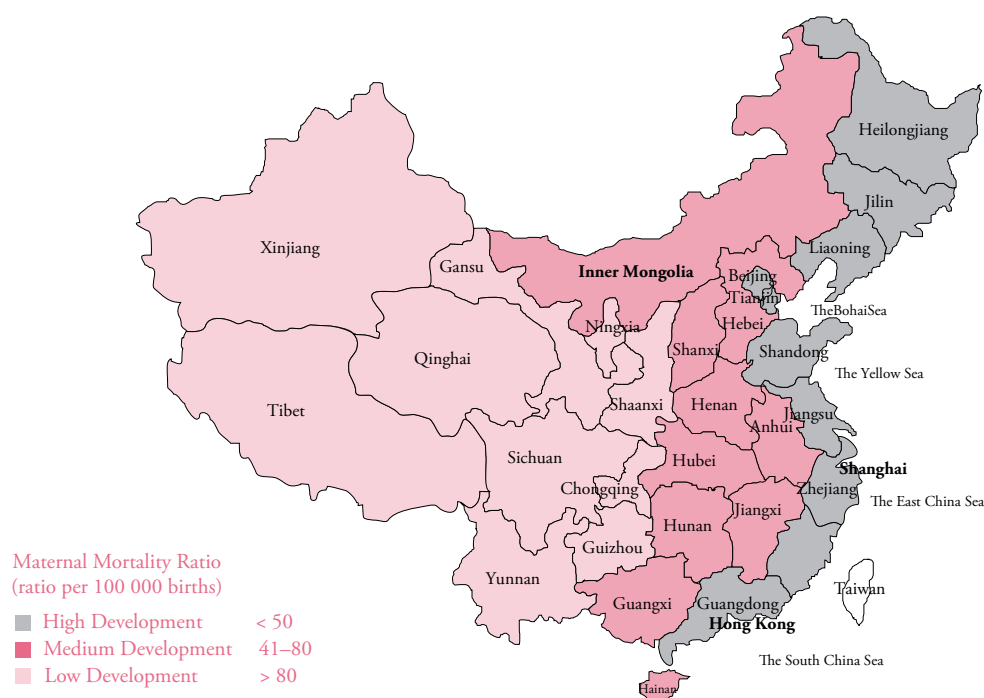
In more than 50 developing countries, the rates of undernutrition among women from the poorest income quintile are almost twice the rates among women from the richest income quintile.<sup>197</sup> For example, the incidence of anaemia is 71% among women living in rural Mongolia, compared to 45% among women residing in urban areas.<sup>198</sup> Anaemia is similarly more prevalent among rural than urban women in Cambodia (59.1% vs. 51.2%). Furthermore, women with no education in Cambodia were found to be more likely to be anaemic (62.1%) than their better-educated counterparts (57.8%).<sup>199</sup> Directly or indirectly, anaemia contributes to a significant proportion of maternal deaths in the developing world. Severe anaemia can lead to cardiac failure in pregnancy and childbirth with lesser grades of severity accounting for haemorrhage, infection and decreased maternal well-being. Anaemia may also contribute to perinatal morbidity and mortality by increasing the likelihood of intrauterine growth retardation and pre-term delivery.

Across developing countries in the Region, the likelihood of a woman dying in childbirth is higher in rural than in urban communities. In Mongolia, the maternal mortality rate in rural areas is 145 per 100 000 live births as compared with 79 in urban areas. Women from herding communities appear to be particularly disadvantaged. Although these women constitute 29.0% of all pregnant women in Mongolia, they account for 49.3% of maternal deaths.<sup>200</sup> The risk of maternal death in the Lao People's Democratic Republic is the highest in the Region, estimated to be 530 per 100 000 live births. Some estimates suggest that the MMR in rural areas might be as high as 900 per 100 000.<sup>201</sup>

Areas and communities in the Region that are poor and marginalized appear to experience higher rates of maternal mortality than those that are better-off. For example, the MMR in western areas of China is as high as 200 per 100 000 live births, which is four times higher than the average in urban areas and twice as high as that in rural areas (Figure 9).<sup>202</sup> The floating (migrant) population in China appears to be particularly vulnerable to maternal deaths.<sup>203</sup> The risk of maternal death in Viet Nam has been found to be 3.25 times higher for illiterate women than for literate women.<sup>204</sup>

Women from ethnic minorities appear to be particularly vulnerable to death in childbirth. In Viet Nam, the risk of maternal death was calculated to be 3.92 times higher for women from ethnic minorities than for Kinh women. A second calculation found that the MMR in the highland areas of Viet Nam, where ethnic minorities are concentrated, was nearly 10 times that in the lowland areas.<sup>205</sup> Maternal deaths occur more frequently in the Autonomous Region of Muslim Mindanao (ARRM) of the Philippines (320 per 100 000) than among the general population (96 per 100 000). Similarly, estimates from China suggest that the MMR in Tibet province (466 per 100 000 live births) is much higher than the national average (43 per 100 000).<sup>206</sup>

Figure 9: Maternal deaths per 100 000 live births in China, 2003



Source: United Nations Country Team China, 2004. In: World Health Organization Regional Office for the Western Pacific 2005e.

### *The influence of reproductive health on poverty*

Evidence suggests that the social and developmental consequences of poor reproductive health outcomes can be far-reaching and can weaken poverty reduction efforts at the household and national level.

Household impoverishment as a result of poor reproductive health can arise from the economic costs of seeking health care, as discussed above. Reproductive health-related morbidity can lead to decreased productivity and time away from work, thereby reducing household income. The death of an income-earning adult can have severe consequences for household survival. In addition, the opportunity costs of caring for an ill household member may also impose a substantial burden for poor households. Household members (usually girls and women) may have to forgo income-generating activities or leave school to provide the necessary care. In Sri Lanka, for example, the annual lifetime earnings lost because of an AIDS death were estimated to be 11 times the annual cost of treatment. In Nepal, these costs

were equivalent to more than four times the per capita annual income.<sup>207</sup> The negative impact of poor reproductive health can be especially severe or prolonged if households are forced to sell productive assets, such as land or livestock.

Limited access to contraceptives can undermine a household's efforts to escape from poverty. Early pregnancy has been found to reduce women's educational attainment.<sup>208</sup> A study in northeastern Brazil found that young women who continued their pregnancy were more likely to drop out of school than were those who sought an abortion.<sup>209</sup> Evidence also suggests that early pregnancy can negatively affect women's economic opportunities. For example, a study in Mexico observed that early childbearing led to lower monthly earnings for mothers and lower child nutritional status for women who were poor, but not for women who were not poor.<sup>210</sup> However, the negative effects of early pregnancy on women may be transitory and can be overcome with time.<sup>211</sup>

Early marriage is of great concern for the well-being of women and their children. A recent



report uncovered the negative consequences of early marriage for women. The study argued that women who married young had less education and fewer schooling opportunities, had less household and economic power than older married women, and had limited access to modern media and social networks. In addition, young married women were found to be at greater risk of gender-based violence and of poor health, including exposure to HIV and the negative health effects associated with early childbearing.<sup>212</sup>

Available evidence shows that children who are unwanted at conception and birth can be disadvantaged with regards to the allocation of household resources, such as nutrition and education. For example, an analysis of data from 11 countries and one Indian state concluded that unwanted children were 10%–50% more likely to be ill than wanted children.<sup>213</sup> Large families must allocate household resources among more children, which can result in fewer investments

in the health and education of each child. For example, a child's school enrolment is negatively associated with the number of siblings with whom the child lives.<sup>214</sup>

The death of a mother can have staggering repercussions for her surviving children. In Nepal, for example, infants of mothers who died during childbirth were six times more likely to die in the first week of life, 12 times more likely between eight and 28 days, and 52 times more likely between four and 24 weeks.<sup>215</sup> A mother's death can negatively affect the health of her other children as well. A study from the Kagera region of Tanzania reported that children in households where an adult woman had died in the previous six months spent half as much time in school than did those from households with no female adult deaths. The same pattern was not observed in households where an adult male had died.<sup>216</sup> Analysis of data from Indonesia shows that the loss of a mother decreases the likelihood of school

### Box 3: Economic growth, poverty reduction and reproductive health

Arguments for investing in family planning and reproductive health have historically concentrated on the relationship between population dynamics (population growth, the age structure, and rural–urban migration) and economic growth. While these theories remain controversial, attention is increasingly being devoted to elucidate the mechanisms through which reproductive health can spur economic growth and poverty reduction.

Recent analysis suggests that demographic changes contribute an estimated 25%–40% to macroeconomic growth, which is roughly split between decreased mortality and decreased fertility. Decreased mortality is associated with improved productivity while lower fertility leads to improved investments in human capital (health and education).

More nuanced arguments show that, as fertility declines, a window of opportunity opens when youth dependency in a society declines before the dependency associated with ageing increases. Research has shown that, when combined with good economic policies, the resulting swell in the working age population can create a 'demographic bonus' or 'dividend' that leads to economic growth. The most solid evidence for this theory comes from East Asia, where the demographic bonus is estimated to have contributed up to one-third of economic growth between 1965 and 1990. Further analysis suggests that this bonus could reduce poverty in developing countries by about 14% between 2000 and 2015.

Conversely, societies with a high dependency ratio need to devote a greater proportion of output to consumption than investments in education, nutrition or health. Such lower rates of investment can undermine the potential for economic growth and poverty reduction.

Sources: Birdsall 2001. In: United Nations Millennium Project 2006; Bloom and Canning 2004. In: United Nations Population Fund 2005; Mason and Lee 2004. In: United Nations Population Fund 2005.

enrolment, and increases the probability of child death and undernutrition.<sup>217</sup>

Aggregating these costs to the national level, the negative effect of poor reproductive health on economic growth and development may be substantial. For example, ill-health among women has been estimated to reduce the productivity of the female labour force by as much as 20%.<sup>218</sup> Moreover, healthier and better-educated women have smaller families, invest more in each child's health and education and enjoy greater earning opportunities than women who are less educated. This suggests that improved reproductive health has strong intergenerational effects.

### **The influence of gender on reproductive health**

Analysis reveals that men and women's experience of sexual and reproductive health tends to differ. These differences are now understood to arise not only from biological characteristics (male and female sex), but also from the socially constructed category of gender.

#### ***Biological differences in sexual and reproductive health***

Biological differences between men and women include anatomical and physiological differences and variations in genetic susceptibilities and immune systems.<sup>219</sup> Women experience reproductive health issues related to pregnancy, childbearing and menopause. The biological

characteristics of young women, namely immature reproductive and immune systems and incomplete body growth, contribute to an increased risk of negative outcomes from pregnancy and delivery.<sup>220</sup> While women must deal with health issues such as RTIs and cervical and breast cancer, men must contend with cancer of the prostate and haemophilia, for example.

During the neonatal period, newborn girls have a biological survival advantage over newborn boys.<sup>221</sup> Evidence also shows, however, that older women are more vulnerable than men to anaemia, osteoporosis and STIs, among other health issues, due to physiological factors. The transmission of HIV from men to women appears to be 24 times more efficient than transmission from women to men.<sup>222</sup> Women have a larger surface area of mucosa exposed to their partner's sexual secretions during intercourse. Semen also contains a higher concentration of HIV than vaginal secretions. Moreover, semen can stay in the vagina for hours after intercourse. In addition, STIs are more frequently asymptomatic in women than in men.

Pregnancy also influences the biological vulnerability of women to poor sexual and reproductive health outcomes. Pregnant women tend to be more vulnerable than non-pregnant women or men to malarial infection, in areas of stable and unstable malaria transmission.<sup>223</sup> In Papua New Guinea, for example, the prevalence and incidence of malaria are highest in young children and pregnant women.<sup>224</sup> A study from Uganda observed that the risk of infection with

#### **Box 4: Defining gender**

Gender refers to the differences and inequalities in the situations and needs of men and women that are based on societal understanding of being male or female, not on biological differences. Gender dynamics are understood as the different roles, expectations, identities, needs, opportunities and obstacles that society assigns to women and men based on sex. While sex is biologically determined, gender is socially ascribed. Girls and boys, women and men, may have the same rights, potential and capacities, but discrimination against girls and women based on sociocultural norms often relegates them to lower status and value. This bias often places them at a considerable disadvantage in terms of access to resources and goods, decision-making power, choices and opportunities across all spheres of life. It determines how individuals and societies perceive what it means to be male or female and influences how roles, attitudes, behaviours and relationships are enacted.

HIV was much higher for pregnant and lactating women than for non-pregnant or non-lactating women. The incidence of HIV was reported to have increased from 1.1 per 100 person years to 2.3 in pregnant women. The study concluded that biological changes in pregnant and lactating women accounted for a large proportion of this increased risk.<sup>225</sup>

### ***Gender-based differences in sexual and reproductive health***

Gender inequality within societies can influence the sexual and reproductive health of men and women, starting with the differential exposure of men and women to various determinants of sexual and reproductive health, and continuing on to differences in health-seeking and utilization of good quality health services. The discussion that follows analyses how gender inequality influences the sexual and reproductive health of men and women.

### ***Gender is a determinant of sexual and reproductive health***

#### **Gender norms**

Social norms give primacy to heterosexual relationships, which are primarily defined in terms of male dominance and desire.<sup>226</sup> These gender norms and others often translate into different ideas about appropriate behaviour for men and women with regards to sexuality and reproduction. According to dominant gender norms in many societies, men are expected to be macho, while women are to be sexually passive. In the Philippines, as in many countries in the Region, there is greater tolerance, and even expectation, of premarital sex for men, while women are expected to remain virgins until marriage.<sup>227</sup> Moreover, while men are encouraged to engage in sexual activity and to have multiple partners, women are expected to control and put limits on male sexual behaviour.<sup>228</sup> Societal norms in Cambodia dictate that women should be shy, submissive and unassertive. In contrast, men are understood to have irrepressible sexual needs and,

therefore, are accepted to have multiple partners or to visit sex workers.<sup>229</sup>

In many settings, women have no legal or customary right to refuse sex with their husbands.<sup>230</sup> In Cambodia, for example, a study documented the widely held belief that husbands have a right to the bodies of their wives.<sup>231</sup> In other countries, the laws regarding marriage and divorce have different implications for men and women. For example, Philippine law defines extramarital affairs differently for men than for women.<sup>232</sup> Under such circumstances, women find it difficult to assert their preference for safer sex, for their partner's fidelity or for no sex at all. Double standards on sexuality deny women the ability to refuse sex or negotiate condom use and at the same time encourage men to have multiple sex partners, thereby putting both at increased risk of STIs. Such sexual norms and practices put men and women at great risk for infection and poor reproductive health outcomes.

Gender norms spill over into other aspects of women's lives. In the Lao People's Democratic Republic, for example, pregnancy is not expected to interfere with a woman's workload and women must often resume work shortly after delivery.<sup>233</sup> Many women feel pressured to have many, closely spaced children to fulfil their reproductive roles in society.

Gender norms also tend to marginalize transgendered individuals and people whose sexual identities do not conform to social ideals. In many societies, heterosexuality is considered the norm and gender roles demand that individuals only express desire for the opposite sex.<sup>234</sup> In many areas, individuals who are lesbian, gay, bisexual and transgendered face discriminatory attitudes and, at times, violence. For example, a study from Cambodia found that transgendered individuals experience discrimination and abuse.<sup>235</sup> In India, established communities of transgendered people, known as *Hijras*, are often stigmatized and harassed.<sup>236</sup> In some areas, discrimination is rooted in the law, while in others, progressive laws protecting against discrimination on the basis of

sexual orientation may not be implemented. For example, although Fiji was one of the first countries to enshrine protection against discrimination on the basis of sexual orientation in its 1997 Constitution, implementation of this law has been weak in practice.<sup>237</sup>

Social movements for LGBT rights from around the world are increasingly drawing attention to gender and sexual orientation as an important source of bias and discrimination. These movements challenge common understandings of gender to move beyond the male/female dichotomy and to explore the possibility of “gender plurality.”<sup>238</sup>

### **Masculinity and male dominance**

Gender norms in many societies prescribe male dominant behaviour, with the expectation that men be risk-takers and the initiators of sex. For example, wearing a condom can be considered “unmanly”, so men may be unwilling to do so as well as being ill-informed about the health risks of such actions. Admitting to gaps in their knowledge can also be difficult, due to social expectations that men “know everything”.

In many countries in the Region, men are more likely than women to have several sexual partners. In other cases, some men find it difficult to conform to the male stereotype of masculinity and may feel compromised by their inability to match up to expectations. For example, homosexual men may be the subject of harassment, discrimination or physical abuse because their sexual orientation differs from the norm. In addition, men may have sex with men without recognizing the need to practice safe sex.

Gender stereotypes can also lead men to take up certain occupations or behaviours that affect their health. For example, men often hold jobs that require seasonal migration or frequent travel, removing them from their home environment. Such circumstances result in the increased likelihood of casual sex with multiple partners, including with commercial sex workers.<sup>239</sup>

Importantly, men’s behaviour and attitudes not only affect their own health but also the health of their partners.

### **Women’s lack of power and autonomy**

The low status of women relative to that of men in many societies limits their ability to control their own lives, including their fertility and access to health services. In many communities, gender roles assign men primary authority over sexual and reproductive health decisions. Thus, women may lack the ability to make independent decisions about using contraceptives or seeking reproductive health services.<sup>240</sup> For example, a study from the Lao People’s Democratic Republic found that when couples use contraceptives, men often make the decision regarding the method to be used. Similarly, husbands and other family members, particularly in-laws, appear to make decisions concerning whether or not a woman can seek health care.<sup>241</sup> A study in Indonesia found that one in seven women surveyed did not use contraceptives because their husband did not approve.<sup>242</sup> Similarly, a study from Diandong county in rural China found that 45%–55% of women respondents required their husbands’ permission to go to the market, clinic or natal village.<sup>243</sup>

### **Gendered communication patterns**

In many instances, communication between partners is limited. It is often taboo for couples to discuss issues related to sexual and reproductive health. Also, many men have erroneous information about sexual and reproductive health because their sources of information are generally their peers, who may be as uninformed as they are.<sup>244</sup> However, men often share many of the same concerns as women about family planning, childbirth, child spacing and number of children, whether contraception is safe, and how to select and use an effective contraceptive.<sup>245</sup> In addition, gender role expectations may also make men feel constrained in expressing their feelings and intimate experiences associated with sexuality. Cultural norms also often make it difficult for men to express devotion to their partners

or to participate in child raising or household management, lest they risk ridicule from friends and neighbours.

Such gendered communication patterns can particularly affect young men and women's access to information on sexual and reproductive health. Often, parents, teachers and health service providers are unwilling or embarrassed to discuss such issues with young people. For example, a recent study from Mongolia reported parents and the health system devote little attention to the reproductive health of young people. Consequently, only 25% of adolescents had basic knowledge of reproductive health and 50% had some knowledge of STIs.<sup>246</sup> According to a 2002 study, most sexually active Filipino youth were not aware of safe sex practices.<sup>247</sup>

Adult discomfort with young people's sexuality is common and often rooted in notions of appropriate behaviour for young men and women. Some adults mistakenly believe that providing young people with information on sexual and reproductive health will lead to promiscuity. In addition, many traditional families believe that a young girl should enter marriage innocent about issues related to reproductive and sexual health. As a result, young people in countries in the Region, particularly women, may be unable to access accurate information on sexual and reproductive health. As young people tend to be denied explicit information about sexuality and reproduction, they are often ill prepared for sexual relations or unable to protect themselves from unintended pregnancy and STIs.

### **Son preference**

In some communities, the higher social value ascribed to men has resulted in practices that prefer sons over daughters. As noted earlier, evidence suggests that the distribution of food among children within households might benefit male children at the expense of female children in some places in the Region. In some cases, the birth of girls may not be registered or girls may not be counted in censuses. In other cases, sex-selective

abortions may be performed. In more extreme forms, practices that prefer sons over daughters can result in the death of daughters over time, resulting in a skewed sex ratio or a disproportionate share of men within populations. In countries where sons are favoured over daughters, the natural ratio of 105 boys born to every 100 girls tends to be exceeded. Son preference is evident in China, the Republic of Korea and Viet Nam, where the sex ratios at birth in 2005 were 112:100, 108:100 and 108:100, respectively.<sup>248</sup>

### **Early marriage, sexual activity and childbearing**

Worldwide, most men and women become sexually active in their late teen years, although there is substantial variation between regions. For most women, sexual activity has been closely associated with marriage. Early marriage can lead to childbearing before physical development is complete and to frequent pregnancies thereafter. As discussed above, adolescent pregnancies can be particularly damaging to women's health. The association between marriage and first sexual intercourse among men is more variable.<sup>249</sup>

The practice of women marrying and bearing children at a young age is slowly changing in the Region with economic development and rural–urban migration. Variations within countries, however, are increasingly noticeable. For example, rural women in the Philippines marry at a younger age than do those from urban areas. In Viet Nam, adolescent marriage and childbearing are generally more common among rural and ethnic minority communities than among urban communities.<sup>250</sup> A 2002 review in Mongolia found that 11.5% of adolescents in provincial centres gave birth as compared with 4.4% in Ulaanbaatar. The highest rate of adolescent births was found in rural areas of the south (26.3%).<sup>251</sup> Adolescents in rural areas of the Lao People's Democratic Republic were found to be twice as likely as their urban counterparts (21% vs. 9%) to have started childbearing.

Education is generally inversely associated with the initiation of childbearing, as was found to be the

case among Laotian adolescents, for example.<sup>252</sup> In Cambodia, women with high school education or higher marry a year later than their less educated counterparts on average.<sup>253</sup> Adolescent births were also found to be more common among women with low educational attainment in the Philippines. Among women with low educational outcomes, 40% had given birth before the age of 20 as compared with 20% among women who were better educated.<sup>254</sup>

As young people in the Region are waiting longer to marry and have children, they are becoming increasingly sexually active outside of marriage. That is, the average time between the first sexual encounter and marriage is widening for both men and women. For example, dating has become common among young people in urban areas of

Malaysia.<sup>255</sup> Premarital sex was found to be more common among women in urban than in rural areas of the Philippines (23.1% vs. 10.7%).<sup>256</sup> A study in the Lao People's Democratic Republic found that early sexual activity was more common among women who were less educated, less literate, and from the northern region or rural areas.<sup>257</sup> Whatever their reasons, such changing sexual norms—and the increasing delay between sexual initiation and marriage—can have important implications for the sexual and reproductive health of young people in the Region.

### Gender-based violence

Gender-based violence encompasses physical, sexual and psychological violence.<sup>258</sup> Although both men and women experience violence, women

**Table 8: Locus and manifestations of gender-based violence**

Locus and agent		
Family	Community	State
<b>Physical aggression</b> <ul style="list-style-type: none"> <li>• murder (dowry or other)</li> <li>• battery</li> <li>• genital mutilation</li> <li>• foeticide</li> <li>• deprivation of food</li> <li>• deprivation of medical care</li> <li>• reproductive coercion and/or control</li> </ul>	<b>Social reference group</b> <ul style="list-style-type: none"> <li>• violence directed towards women within or outside the group (e.g. cultural, religious)</li> </ul>	<b>Political violence</b> (policies, laws, etc.) <ul style="list-style-type: none"> <li>• illegitimate detention</li> <li>• forced sterilization</li> <li>• tolerating gender violence by non-state agents</li> </ul>
<b>Sexual abuse</b> <ul style="list-style-type: none"> <li>• rape</li> <li>• incest</li> </ul>	<b>Physical abuse</b> <ul style="list-style-type: none"> <li>• battery</li> <li>• physical chastisement</li> <li>• reproductive coercion and/or control</li> <li>• witch burning</li> <li>• <i>sati</i> (widow burning)</li> </ul>	<b>Custodial violence</b> (military, police, etc.) <ul style="list-style-type: none"> <li>• rape</li> <li>• torture</li> </ul>
<b>Emotional abuse</b> <ul style="list-style-type: none"> <li>• confinement</li> <li>• forced marriage</li> <li>• threats of reprisal</li> </ul>	<b>Sexual assault</b> <ul style="list-style-type: none"> <li>• rape</li> </ul>	
	<b>Workplace sexual aggression</b> <ul style="list-style-type: none"> <li>• harassment</li> <li>• intimidation</li> </ul>	
	<b>Commercialized violence</b> <ul style="list-style-type: none"> <li>• trafficking</li> <li>• forced prostitution</li> </ul>	
	<b>Media</b> <ul style="list-style-type: none"> <li>• pornography</li> <li>• commercialization of women's bodies</li> </ul>	

Source: Schuler 1992.



constitute a higher share of victims of gender-based violence throughout the lifespan, from pre-birth to old age. Acts of violence against women (and girls) are manifestations of the power dynamics in the family, society and state, which seek to control women and ensure their subjugation to patriarchy.<sup>259</sup> Table 8 provides an overview of the power dynamics of family, society and state that underpin gender-based violence.

The roots of gender-based violence are complex and multiple, ranging from culture to patriarchal systems. Just as victims of gender-based violence are usually women, the perpetrators of such violence tend to be men. Male violence stems from the patriarchal model of masculinity that enables and justifies such behaviour. Men who tend to be violent believe that violence, like sexuality, is a biological and uncontrollable “instinct”, and thus an integral part of their masculinity. These men, who are often raised in a violent atmosphere, tend to learn how to be violent from their fathers.

Women who experience violence or the threat of violence are often unable to meet their reproductive health needs.<sup>260</sup> Coerced sex can lead to unwanted pregnancies, STIs (including HIV/AIDS) and gynaecological problems. In addition, physical abuse during pregnancy is associated with miscarriage, stillbirth and low birth weight babies. Abuse at an early age is also associated with risky behaviours later in life, including substance abuse, sexual risk-taking and smoking. Violence can also lead to mental health problems, such as depression, anxiety, post-traumatic stress disorder and suicide.<sup>261</sup>

### ***Gender-based inequalities in access to health services***

A number of studies from the Region have observed that access to services may not be equitably distributed between men and women or boys and girls. For example, a study from 2000 in Cambodia found that an estimated 36.1% of boys suffering from fever were seen by a health service provider, while only 32.0% of girls were seen. Evidence from the Philippines shows that in

2002 girls were slightly more likely than boys to be taken to a health service provider when they were sick with fever, while boys were more likely than girls to receive medical attention when suffering from acute respiratory tract infection (ARI).<sup>262</sup> In 2002, the proportion of Vietnamese children with ARI seen by a health service provider was 76.0% among boys and 64.8% among girls.<sup>263</sup> A study from Papua New Guinea found that mothers took their sons to health centres more often and travelled further with them than with their daughters.<sup>264</sup>

A study from three rural counties in Yunnan province, China in 1994–1996 found that most women suffering from RTIs did not seek health care.<sup>265</sup> A second study from Yunnan province

#### **Box 5: Female genital mutilation**

Female genital mutilation (FGM) refers to the removal of part or all of the genitalia. FGM is prevalent in Africa, in some parts of the Middle East and Asia, and also among immigrant populations in many other parts of the world.

Many parents view FGM as an essential rite for their daughters to find a husband. Some in-laws insist on FGM for their sons' spouses as a sign of chastity and purity. In many cases, older family members, such as grandmothers and mothers-in-law, and circumcision providers, influence the decision to have a girl mutilated.

Type I FGM involves the removal of the clitoral hood, with or without the rest of the clitoris. Type II involves the removal of the clitoris and part or all of the labia minora. Type III is also called infibulation, where part or all of the external genitalia is removed and the vaginal opening stitched together until only a small opening is left.

While Type III is the most serious, all forms of FGM can lead to internal bleeding, painful sexual intercourse, urinary tract infections, blocked menses and difficult deliveries that can end in the death of the mother and child and depression.

Source: World Health Organization 2007.



reported that while as many as 71.7% of women surveyed suffered from RTI symptoms, as few as 25.38% had sought care.<sup>266</sup> Similarly, unmarried women in the Lao People's Democratic Republic appear not to seek care for RTIs. Among the men and women in the Lao People's Democratic Republic who did seek care for STIs, men tended to visit drug sellers, while women sought care at a later stage of infection and therefore suffered more serious complications.<sup>267</sup> In India, a study found that only 8% of rural women had ever sought care for gynaecological illnesses, although 92% had one or more reproductive health problems, including some relatively serious conditions such as reproductive tract infections, pelvic inflammatory disease, genital prolapse and urinary tract infections.<sup>268</sup>

### Barriers to access to services

Such differences in the access of men and women to sexual and reproductive health services may arise for a number of reasons. Some of the barriers to access that were discussed above—geographical, economic and sociocultural—often constrain women from seeking health care to an even greater extent than men.

### Geographical barriers

In some areas, women may enjoy less mobility than men. Women may have difficulty accessing transportation either because they do not have their own source of transportation or because their generally lower access to and control over household resources or cash income prevents them from using public transportation. These constraints can be further reinforced through normative expectations that women remain in the private sphere or near the household or village while men move freely over long distances in public space. In some areas, women must obtain permission from their husbands or fathers to seek health care, while in others they must be accompanied, often by a male family member, when travelling beyond their community. This increases the cost of seeking care, both in terms of lost household labour and transportation costs.

A study of demand for prenatal care among pregnant women in Cebu, Philippines observed that women living in rural areas faced significantly longer travel times to facilities than did those living in urban areas. Travel costs in rural areas were reported to be almost double those in urban areas.<sup>269</sup> When faced with such constrained mobility, women may seek diagnosis and treatment from nearby but less qualified providers, traditional healers or village pharmacies, or may self-medicate rather than travelling farther to access better quality primary health care.<sup>270</sup>

### Economic barriers

Compared to men, women's generally lower access to and control over economic resources, including income, productive assets and health insurance, might constrain their access to preventive and curative health services. A case study in Tianjian, China found that women were less likely than men (41.9% vs. 46.3%) to be covered by the Government Insurance Scheme or the Labour Insurance Scheme in 1998.<sup>271</sup> Additional estimates suggest that up to 70% of women in China are not covered by any health insurance.<sup>272</sup> In the case of sexual and reproductive health, stereotypical notions about men and women's roles might restrict men's financial access to services. For example, in Mongolia, reproductive health services are covered by health insurance only for women.<sup>273</sup>

The association between household income and health has been found to be further influenced by the degree to which women can influence how their household income is spent. Studies suggest that use of health care services, as measured by antenatal visits, is less common among women who have relatively lower control over household resources.<sup>274</sup> A study in the Philippines observed that as the value of women's time (as measured by an estimated wage rate) increases, so does the intrahousehold allocation of calories to women and children, resulting in improved nutritional status for women and their children.<sup>275</sup>

Many women work in the informal sector or at home during their reproductive years. Because

of inequalities in income and wealth in earlier life, older women are more likely to have fewer material resources, and are less likely than men to receive assistance from their relatives and friends during their old age.<sup>276</sup> In general, women outlive men. However, widow's pensions, old age security payments and medical insurance coverage are often meagre or non-existent for older women. In addition, in circumstances where older women have the benefit of a husband's pension, this may be severely reduced or discontinued upon the death of the husband.

### **Sociocultural barriers**

The lower priority typically given to women's health in households and communities, relative to that of men, can delay health care seeking by women and girls. In some areas, women continue to rely on traditional birthing practices. This is partly due to prevailing norms and values within society and partly due to women's low status in the family.

In many parts of the developing world, access to appropriate perinatal care is limited. Women often prefer traditional birth attendants to hospital care, since they may feel isolated and alienated from their cultural norms and values in hospital settings. For example, in the Lao People's Democratic Republic, women from the Lao Theung community (an ethnic minority group) normally deliver alone in a forest or field behind her house because the blood of childbirth is understood to be "dirty". More recently, women have begun to give birth in small huts or underneath the house. In some areas of the Lao People's Democratic Republic, intrauterine devices are not a popular form of contraceptive because of traditional notions of the uterus as a moving organ.<sup>277</sup> In rural areas of Yunnan province, China, RTIs among women are seen to be normal and therefore are not considered to require medical attention.<sup>278</sup>

The social norms of communities may influence people's decisions on their health. Low condom use in Malaysia and the Lao People's Democratic Republic, for example, has been ascribed to the

commonly held belief that condoms are used during extramarital affairs and with sex workers and not in the context of marriage.<sup>279</sup> In many communities in the Region, adults deny the possibility of young people, particularly young women, engaging in sexual relations. As a result, young people may be discouraged from discussing or asking questions about sexual matters.<sup>280</sup> Stigma can also deter men and women from being tested for HIV and other STIs. Evidence suggests that stigma and discrimination restrict the access of men who have sex with men to information and health services.<sup>281</sup>

### ***Gender bias in health service provision***

Health systems and services also suffer from gender bias. For example, health service providers may demonstrate disrespectful or dismissive attitudes towards women patients, as compared to men. In addition, some physicians may view women's bodies and their reproductive processes as potential medical problems. This medicalization of normal reproductive health and childbirth has been noted as a problem in many industrialized countries with a loss of control by women over decisions concerning their bodies, health and reproduction, as well as lack of psychosocial support for women.<sup>282</sup>

In many of the parts of the world, women prefer to seek care for reproductive health issues from women health care professionals. Where women health workers are not available, treatment by a man may be deemed to dishonour a woman and her family, deterring women from seeking care. Evidence from China demonstrates the importance of having women staff available for reproductive health services. One study in rural Yunnan province found that male rural doctors appeared to be reluctant to provide care for women's reproductive health. In turn, rural women were embarrassed to seek care for RTIs from male doctors.<sup>283</sup> A second study observed that women in China were unwilling to speak with male health service providers about physical and contraceptive problems and that follow-up by male providers after women's sterilization was rare because of the

perceived impropriety of a man visiting another man's wife.<sup>284</sup>

For sexually active young people, particularly unmarried women, obtaining reproductive health services is even more difficult than gaining accurate, culturally relevant and age-specific information. Few clinics are designed, prepared or even willing to provide services to young people. Many young people are left with an unmet need for contraception and other reproductive health services. For example, many health service providers in the Lao People's Democratic Republic and Viet Nam disapprove of premarital sex and, therefore, may provide poorer quality services to young men and women. A study of formal and informal health service providers in Vientiane in 2000–2001 found that 18% of providers surveyed would inform parents if their unmarried children sought reproductive health services.<sup>285</sup> A second study in the Lao People's Democratic Republic reported that youth aged 15 to 24 years prefer to seek treatment for STIs at pharmacies because of the perceived greater confidentiality and greater ease of obtaining the required drugs.<sup>286</sup> A study in Viet Nam found that health providers are not adequately trained to counsel young people on sexual and reproductive health issues.<sup>287</sup> Similarly, a recent survey in Cambodia found that female sex workers—many of whom were between the ages of 16 and 26 years—preferred to seek care from private health providers. They described public facilities as lacking in confidentiality, privacy and anonymity. In addition to providing more privacy, the staff at private facilities were perceived to treat them with more dignity and respect.<sup>288</sup>

In many countries, the reproductive health needs of men have been neglected. Historically, most family planning and reproductive health programmes have focused exclusively on (married) women. For example, a study found that family planning programmes in Solomon Islands targeted only women.<sup>289</sup> Male gender stereotypes may also discourage men from accessing health care services. Barriers to men's inclusion in reproductive health services include:

- lack of information about men's perspectives that could be used to help design appropriate

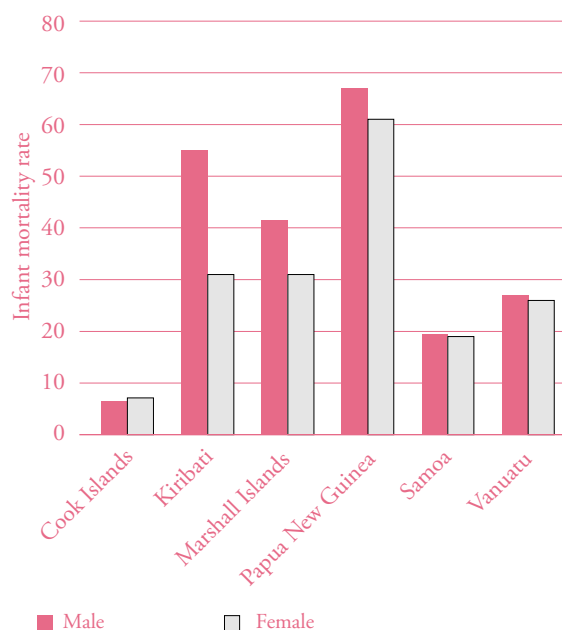
programmes;

- men's discomfort at reproductive health clinics (many feel out of place or unwelcome because they have been excluded from services for so long);
- men's hesitation in seeking medical care;
- limited availability of contraceptive methods for men;
- negative attitudes of policy-makers and service providers towards men (e.g. men can be viewed as irresponsible, not interested in playing a positive role or not appropriate clientele for reproductive health services);
- unfavourable policies, such as prohibitions on condom advertising; and
- logistical constraints such as lack of trained male staff, male-friendly clinics, convenient hours, or separate waiting and service areas for men.<sup>290</sup>

### Access to termination of pregnancy

Roughly 61% of the world's population reside in countries where induced abortion is permitted for

**Figure 10: Infant mortality rate (per 1000 live births) by sex for selected countries in the Region, 2002**



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

a range of reasons, while 26% live in countries where abortion is prohibited or allowed only to save a woman's life.<sup>291</sup> In countries in the Region where abortion is legal, evidence suggests that some clinics provide poor quality services, with very little pre- and post-abortion counselling.<sup>292</sup> The lack of privacy in public facilities can lead women, particularly those who are young, to seek care from private providers. In areas where government regulation of the private sector remains weak, the skills of private providers and standards of care do not necessarily comply with mandated guidelines and protocols.<sup>293</sup> As a result, women seeking care in private facilities may suffer abortion-related complications, including long-term disability and death. To be accessible, abortion services need to be affordable, respectful and offered in the communities where women live.

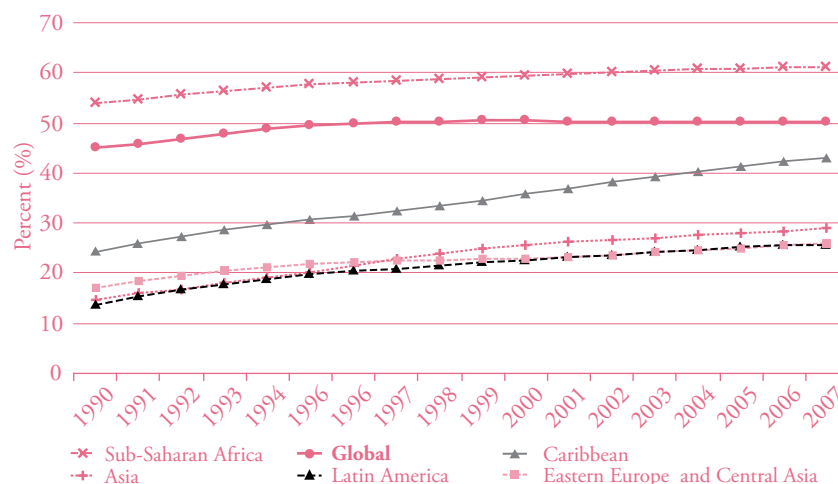
### ***Gender-based differentials in sexual and reproductive health outcomes***

While sex-disaggregated data on health outcomes in countries in the Region are limited, there is some evidence of how sex and gender interact to produce differential sexual and reproductive health outcomes among men and women and boys and girls. For example, data collected in 2002 suggest that infant mortality is higher among boys than

girls in the Region (see Figure 10). In contrast, the risk of dying is estimated to be 33% higher among girls than boys in China.<sup>294</sup>

Women's biological characteristics, combined with gender inequality, increase their vulnerability to infection with STIs. Globally, the burden of STIs among women is five times higher than among men.<sup>295</sup> Globally, 15.4 million women were living with HIV/AIDS in 2007.<sup>296</sup> The prevalence of HIV in men and women differs across countries in the Region. This is because the nature of the HIV epidemic, as well as gender norms, varies across countries. According to projections, the number of newly infected men and women in Cambodia was more or less equal in 2007. Thereafter, it is projected to be higher in the male population.<sup>297</sup> In the Philippines, where the status of HIV was previously described as "low and slow", but where local experts now consider the possibility of a "hidden and growing" trend in HIV, almost twice as many men as women were reported to be living with HIV by the end of 2007.<sup>298</sup> Similarly, in Viet Nam men accounted for 85.2% of total reported HIV cases, as of 2007.<sup>299</sup> Since its early days, the HIV epidemic in Malaysia has been predominantly male, with intravenous drug use as the main mode of transmission. However, by 2006, women and girls comprised almost 20% of newly-infected persons, compared to only

**Figure 11: Percentage of adults (15+) living with HIV who are women, 1990–2007**



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

about five percent 10 years ago, with heterosexual intercourse being the main mode of transmission for women.<sup>300</sup> In Papua New Guinea, where the epidemic is now generalized, of the total number of people diagnosed with HIV by the end of 2006, 46% were men and 48% women (six percent of infections occurred among those whose sex was not reported). Besides, the number of infected young women is rising the fastest.<sup>301</sup> Worldwide, women constitute an increasing proportion of adults (aged 15 and above) living with HIV (Figure 11).

Assessing the prevalence of gender-based violence in the Western Pacific Region is hampered by the varying definitions of gender-based violence, the silence that continues to shroud issues of domestic violence, and the normalization of violence in some areas. The prevalence rates for domestic physical violence against women ranges between 5.8% and 65% and for sexual abuse between 4% and 50% in countries and areas in the Region. It is likely that these figures underestimate the true extent of the problem.<sup>302</sup> In the Philippines, 10% of women who have had premarital sex did so against their will.<sup>303</sup> One study found that gang rape is a major concern in Cambodia, Papua New Guinea and the Solomon Islands.<sup>304</sup> A survey of male school students in Phnom Penh, Cambodia, concluded that 34% of respondents knew someone who had participated in *bauk* (gang rape).<sup>305</sup> Analysis of a national survey concluded that 4% of women in the Philippines have had non-consensual sex.<sup>306</sup>

Men, particularly young men and boys, may also be vulnerable to sexual abuse. A study in Cambodia concluded that sexual abuse is quite common among male street children. Of the study population, 41% homeless boys aged 15-19 years reported being raped and 18% reported experiencing incest.<sup>307</sup> An estimated 1% of men in the Philippines have experienced non-consensual sex.<sup>308</sup>

Studies in developing countries have found that women carry a heavy burden of gynaecological problems throughout their reproductive years and into later life. This burden is partly due to the limited medical care they received during pregnancy, labour and delivery.<sup>309</sup> Women's reproductive health problems in later life include cervical cancer, uterine prolapse, fistulas, bladder problems and breast cancer. In addition, during menopause, women experience a decline in their reproductive hormone levels. As men age, erectile dysfunction can become common as a result in changes in penile blood flow. At the same time, the incidence of prostate cancer tends to increase with age. These conditions can lead to urinary, erectile or libido problems.<sup>310</sup>

### ***Gendered consequences of poor sexual and reproductive health***

The social and economic consequences of poor sexual and reproductive health tend to be different for men and women. For example, the social repercussions of infertility, including that arising from abortion-related complications or maternal morbidity, tend to be more severe for women than for men. Infertile women may be discriminated against within their households, and divorced or separated from their families. In some societies, survivors of severe forms of gender-based violence such as rape tend to be blamed and scorned as "fallen women" who have lost their honour and, at times, their virginity. A study from Cambodia found that survivors of rape were perceived as bringing shame to their family and are often forced into prostitution or to marry the perpetrator.<sup>311</sup> Similar trends have been reported in the Philippines.<sup>312</sup> Women are often stigmatized as being reservoirs of STIs and other diseases.

The social and developmental consequences of reproductive health decisions can also be far-reaching. For example, an unintended pregnancy can severely compromise a young girl's health, education and job preparation.



### 3. Why is it important for health professionals to address poverty and gender concerns in sexual and reproductive health?



### 3. Why is it important for health professionals to address poverty and gender concerns in sexual and reproductive health?

#### Efficiency

Important gains in sexual and reproductive health have been made in the Region. In some areas, however, gains in maternal health have been slow and the contraceptive needs of many couples have not been met. Many countries in the Region are also contending with progressing HIV/AIDS epidemics and a growing burden of STIs, particularly among young people. Innovative strategies are required to address poverty and gender-related concerns in sexual and reproductive health care. Tailoring efforts in this way can better ensure that the sexual and reproductive needs of poor and marginalized men and women are met throughout their lifecycle.

As discussed above, poor and marginalized populations often bear a higher burden of reproductive and sexual ill-health than affluent groups. Unfortunately, investments in sexual and reproductive health care have not equally benefited the poor. Similarly, prevailing gender norms in the Region can constrict the ability of men and women, especially young men and women, to make decisions that protect and promote their sexual and reproductive health. Young people tend to be excluded from accessing services for and information on sexual and reproductive health; men have often been neglected by preventive and curative sexual and reproductive health programmes.

Nevertheless, healthy, voluntary and safe sexual and reproductive health has been recognized as being critical to human well-being.<sup>313</sup> Sexual and reproductive health has been identified as integral to efforts to reduce maternal mortality, improve child health and reduce the burden of HIV and STIs, among other health conditions. Universal access to reproductive health is understood to be a prerequisite for meeting many of the Millennium Development Goals (MDGs). As such, innovative strategies are required to address poverty and gender-related concerns in sexual and reproductive health care.

Prevailing gender norms likewise influence efforts to improve sexual and reproductive health among many communities in the Region. In particular, gender-related barriers can limit women's access to effective health care and professional advice during pregnancy, delivery and in the postnatal period. By tailoring programmes to address these barriers, many of the health-related risks of pregnancy and childbirth can be avoided. That is, targeting poor men and women with appropriate sexual and reproductive health care can reduce maternal and other sexual and reproductive health-related morbidity and mortality, thereby reducing the overall financial burden of reproductive health care. Incorporating a gender-sensitive response can likewise ensure that men and women benefit equitably from such efforts. Together these approaches can enhance the overall efficiency of sexual and reproductive health programmes.

The efficiency gains from better targeting poor men and women of all ages with preventive and curative sexual and reproductive health care are even more significant when considering the central role improved sexual and reproductive health can play in poverty reduction strategies. Improving the sexual and reproductive health of poor men and women can advance their overall health and well-being. Strategies that better meet the needs of poor men and women, including financial constraints, can protect poor households from the impoverishing effects of ill-health. Enhanced sexual and reproductive health among men and women can also lead to better health for their children. Such gains, when aggregated at the national level, can contribute towards improved

#### Box 6: Defining equity in health

Equity in health may be defined as the “absence of systematic disparities in health (or major social determinants) between groups with different levels of underlying social advantage or disadvantage, such as different positions in the social hierarchy.”

Source: Braveman and Gruskin 2003.



economic growth and poverty reduction in the longer-term.

## Equity

Inequities refer to inequalities that are seen as unfair, unjust and avoidable (Box 6).<sup>314</sup> In terms of access to sexual and reproductive health, inequities exist between men and women, between the rich and poor, and between industrialized and

developing countries. Because of gender-based equities, women may face additional disadvantages compared to men from the same social class, race, caste or ethnicity.

Pursuing equity in sexual and reproductive health is a commitment to increasing the opportunities for positive sexual and reproductive health outcomes among groups within societies that have suffered discrimination and marginalization.<sup>315</sup>

### Box 7: Government obligations to respect, protect and fulfil human rights: examples of reproductive rights

- **The right to life:** Includes the obligation of the state in relation to maternal mortality.
- **Rights to bodily integrity and security of the person:** Includes security from sexual violence and assault at the hands of partners and/or others. Also includes protection against population programmes that compel sterilization and abortion or those that physically prohibit women from receiving family planning services.
- **The right to privacy:** Includes some protections in relation to sexuality. The treaty body that monitors governmental compliance with the *International Covenant on Civil and Political Rights* has stated that “it is undisputed that sexuality is covered by the concept of privacy” and that “moral issues are not exclusively a matter of national concern in that they are subject to review for consistency with international human rights instruments.”
- **The right to the benefits of scientific progress:** This right now includes a woman’s right to control her own reproduction through access to microbicides, female controlled methods of contraception, research into a greater range of male contraceptives and access to safe abortion.
- **The right to seek, receive and impart information:** Includes a woman’s ability to make fully informed choices in reproductive decision-making, including her ability to protect herself against sexual exploitation, abuse or infection.
- **The right to education:** Literacy is critical to reproductive health and education about sexuality as an element of human personality is equally important.
- **The right to health:** Increasingly understood to mean that governments must create conditions that assure, for all, the enjoyment of the highest attainable standard of health. This interpretation would also draw attention to the almost complete lack of attention and resources devoted to the early detection of cervical cancer by a number of governments or state-controlled reproductive health programmes that exist for some populations groups but exclude certain marginalized communities from their consideration and outreach.
- **The right to equality in marriage and divorce:** Understood to refer to the equal ability of women and men to voluntarily enter into marriage and divorce. This right is being recognized by people involved in reproductive health because of its relevance to women’s ability to control and make decisions about their lives.
- **Non-discrimination:** Traditionally understood to mean that all people should be treated equally and given equal opportunity, including assurance of equal protection under the law. All treatment must be based on objective and reasonable criteria, therefore, applying different approaches to girls and boys in reproductive and sexual health policy and programme development must be based on a valid recognition of gender related differentials. The influence of prescribed gender roles and cultural norms when determining these differentials should be minimized.

Adapted from World Health Organization 2001d.

Although experience shows that some variation in health status is unavoidable—due to biological differences between men and women, for example—inequalities in sexual and reproductive health between the poor and non-poor and between men and women are increasingly understood to at least partially mirror social disadvantage, such as that based on income, ethnicity or geographical location.

Access to reproductive health services for all people in need, regardless of their socioeconomic status, is a matter of social justice, fairness and equity. Equity involves the distribution of well-being among social groups so that vulnerable, poor and marginalized people can access sexual and reproductive health care services and programmes. Therefore, achieving the goal of social justice requires addressing the inequities between men and women, the rich and poor, and disparities in reproductive health outcomes between the developing and industrialized nations of the world.

### Human rights

Human rights refer to an agreed-upon set of principles and norms that are contained in treaties, conventions, declarations, resolutions and guidelines at the international and regional level. The right to the highest attainable standard of physical and mental health, or the right to health, is rooted in the Universal Declaration of Human Rights. International laws make governments accountable for their actions in planning and implementing public health policies and programmes.<sup>316</sup>

Active, free and meaningful participation of individuals, affected communities and other key stakeholders is a key component of a rights-based approach.

While the right to health encompasses sexual and reproductive health, the right to the highest attainable standard of sexual and reproductive health was advanced at the ICPD and FWCW. These gatherings acknowledged the right of men

and women to have information on sexual and reproductive health, to have access to appropriate health services and to decide when to engage in sexual relations and have children, among other rights. Box 7 contains examples of rights that can be used to protect and promote gender equality in reproductive and sexual health. The right to sexual and reproductive health articulated by the ICPD and the FWCW have been widely endorsed by national governments, nongovernmental organizations and multinational agencies.

The Convention of the Rights of the Child (CRC) is another important framework for

#### Box 8: Yogyakarta Principles on the Application of International Law in Relation to Issues of Sexual Orientation and Gender Identity

Individuals experience human rights violations because of their actual or perceived sexual orientation or gender identity. Such documented human rights violations have included: extra-judicial killings; torture; sexual assault and rape; detentions; repression of free speech and assembly; denial of employment and education opportunities; and discrimination in work, health, education, housing, access to justice and immigration.

A group of international law experts recently advanced the struggle to apply international human rights law to sexual orientation and gender identity. The group launched the “Yogyakarta Principles on the Application of International Law in Relation to Issues of Sexual Orientation and Gender Identity” in Yogyakarta, Indonesia in November 2006. The Principles affirm 29 key human rights and outline the basic legal standards for governments and other actors to protect and promote the rights of people who are discriminated on the basis of sexual and gender orientation. The Principles provide recommendations for ending discrimination and abuse for governments, the United Nations human rights system, human rights institutions, nongovernmental organizations and others.

Source: The Yogyakarta Principles: Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity 2007.

addressing reproductive health, especially among adolescents and young people. The Convention states that children are entitled to the enjoyment of the highest attainable standard of health and to facilities for prevention, treatment of illness and rehabilitation of health. Nearly every country in the world has ratified the Convention.

The 2004 report of the United Nations Special Rapporteur on the Right to Health to the United Nations Human Rights Committee paid particular attention to sexual and reproductive rights.<sup>317</sup> The report underscored the fact that discrimination on the basis of sexual orientation is impermissible under international human rights law. The United Nations Human Rights Committee has ruled that discrimination on the basis of sexual orientation violates the rights to privacy and non-discrimination.<sup>318</sup> International initiatives have recently applied international human rights law to sexual orientation and gender identity (Box 8).<sup>319</sup>

Non-discrimination is a key concept within the right to health. It forbids “any discrimination in access to health care and the underlying determinants, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health”.<sup>320</sup> Yet, as discussed above, many poor and marginalized men and women, boys and girls, do not have adequate access to appropriate sexual and reproductive health care.

The concept of non-discrimination in conjunction with other human rights, such as the rights to information and privacy, should guide the interaction of individuals with the health system. Further, the notion of inclusiveness encompasses the right to health services and the right to the underlying determinants of health, such as education and food. Moreover, since the ICPD,

the international community has consistently reaffirmed the right of young people to age-appropriate reproductive health information and services that safeguard their rights to privacy, confidentiality, respect and informed consent. The international community has also reaffirmed that the rights and responsibilities of parents to provide guidance in such matters should not prevent young people from having access to the information and services they require for effective reproductive health.<sup>321</sup>

Member States are responsible for the progressive realization of human rights, including sexual and reproductive rights. Therefore, governments must put in place policies and plans that will make sexual and reproductive health care available and accessible, and will lead to the efficient realization of other human rights (Box 9). Governments must also regulate the actions of non-state actors to ensure the right to health is realized.

#### Box 9: A rights-based approach to sexual and reproductive health

Active, free and meaningful participation of individuals is a key component of a rights-based approach. Four criteria may be used to evaluate the right to health, in general, and the right to sexual and reproductive health, specifically:

- 1. Availability:** Sexual and reproductive health care is well-functioning and adequately available.
- 2. Accessibility:** Sexual and reproductive health care is accessible to all, encompassing four dimensions: non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility.
- 3. Acceptability:** Sexual and reproductive health care is respectful, culturally appropriate, gender-sensitive and honour the confidentiality of all patients.
- 4. Quality:** Sexual and reproductive health care is scientifically and medically appropriate and of good quality.

Source: World Health Organization 2002b.

#### 4. How can health professionals address poverty and gender in sexual and reproductive health programmes?



## 4. How can health professionals address poverty and gender in sexual and reproductive health programmes?

The burden of sexual and reproductive ill-health appears to be concentrated in developing countries in the Region. Within these countries, poor communities seem to suffer a disproportionate burden. For example, women from poor households are more likely than their better-off counterparts to die during pregnancy and childbirth. In addition, men and women experience sexual and reproductive health differently, with women of all ages appearing to be particularly affected by sexual and reproductive ill-health.

Despite this, the technical solutions necessary to improve the sexual and reproductive health of the poor exist: effective methods of contraception have been known for decades and simple technologies to make pregnancy safer are available; the ability to enhance safe-sex practices has been documented; and many STIs are treatable.<sup>322</sup> Overall, we have the information and means to expand the coverage of quality sexual and reproductive health services.<sup>323</sup> What is needed are ways to ensure that these solutions reach those who are most in need.

The sections below discuss strategies to tackle the burden of sexual and reproductive health among the poor in the Region and suggest approaches to respond to the different sexual and reproductive health needs of men and women.

### Policy level

#### *International policies*

At the international level, human rights have become a central framework for conceptualizing sexual and reproductive health. As recognized at the ICPD, men and women have the right to make voluntary, informed decisions concerning their sexual and reproductive health. The ability to make such decisions, however, depends on the realization of a range of entitlements, such as the right to appropriate reproductive health services and to adequate information. This rights-based approach to sexual and reproductive health references a range of human rights treaties, as discussed in section 3, and has been reiterated

in the outcome documents of a number of international conferences.

United Nations Member States committed themselves to realizing a series of time-bound and measurable targets—the Millennium Development Goals—by signing the Millennium Declaration in 2000. The MDGs reflect a multidimensional understanding of poverty. As such, progress towards any goal contributes to the achievement of all of them. Health issues feature prominently in the MDGs (three goals, eight targets, 18 indicators). Sexual and reproductive health is not articulated in a single goal, but rather spread unevenly over four goals and numerous targets and indicators (see Box 10). Some fear that compartmentalizing sexual and reproductive health across these three goals might divert attention from the more comprehensive notion of sexual and reproductive health adopted at the ICPD. A growing body of evidence demonstrates the importance of sexual and reproductive health for all of the MDGs, with particular reference to Goals 3, 4, 5 and 6.<sup>324</sup> In response, the international community has acknowledged the close links between the ICPD PoA and realization of the MDGs.

In many ways, the MDGs echo the goals and targets put forward in the ICPD PoA: reducing maternal mortality, reducing child mortality, ensuring universal access to primary education and ensuring access to secondary education.<sup>325</sup> The twenty-first special session of the United Nations General Assembly, held to review and appraise the implementation of the ICPD PoA in 1999 (ICPD +5), outlined additional benchmarks, including a goal for preventing HIV/AIDS, which is also included among the MDGs. At the World Summit held in September 2005, world leaders affirmed the importance of sexual and reproductive health for the achievement of all the MDGs by committing themselves to:

*...achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development, integrating this goal in strategies to attain the internationally agreed*



### Box 10: International goals and targets for sexual and reproductive health

#### Millennium Development Goals

##### *Goal 3. Promote gender equality and empower women*

Target 4. Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

Indicators:

9. Ratio of girls to boys in primary, secondary and tertiary education
10. Ratio of literate women to men, 15–24 years old
11. Share of women in wage employment in the non-agricultural sector
12. Proportion of seats held by women in national parliament

##### *Goal 4. Reduce child mortality*

Target 5: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

Indicators:

13. Under-five mortality rate
14. Infant mortality rate
15. Proportion of one-year-old children immunized against measles

##### *Goal 5. Improve maternal health*

Target 6. Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Indicators:

16. Maternal mortality ratio
17. Proportion of births attended by skilled health personnel

##### *Goal 6. Combat HIV/AIDS, malaria and other diseases*

Target 7. Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Indicators:

18. HIV prevalence among pregnant women aged 15–24 years
19. Condom use rate of the contraceptive prevalence rate
  - 19a. Condom use at last high-risk sex
  - 19b. Percentage of population aged 15–24 years with comprehensive correct knowledge of HIV/AIDS
  - 19c. Contraceptive prevalence rate
20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10–14 years

*Continued on next page*

*development goals, including those contained in the Millennium Declaration, aimed at reducing maternal mortality, improving maternal health, reducing child mortality, promoting gender equality, combating HIV/AIDS and eradicating poverty.*<sup>326</sup>

These commitments, along with human rights treaties more generally, have become a key platform for advocating the advancement of sexual and reproductive health internationally.

The Partnership for Safe Motherhood and Newborn Health, which was established in

January 2004, promotes the health of women and newborns, especially the most vulnerable. The Partnership builds on the scope of the global Safe Motherhood Initiative and the work of the Safe Motherhood Inter-Agency Group. It aims to strengthen maternal and newborn health efforts at the global, regional and national levels, in the context of equity, poverty reduction and human rights.<sup>327</sup> It focuses on the areas of advocacy and information-sharing, technical advancement and country-level support and partnership.

Acknowledging the significance of sexual and reproductive health for social and economic

*Box 10 (continued)***ICPD goals and targets**

ICPD Goals	Targets
Universal access to primary education	“...countries should....strive to ensure complete access to primary school or equivalent level of education by girls and boys as quickly as possible, and in any case before 2015” (paragraph 11.6)
Access to secondary and higher education	“Beyond the achievement of the goal of universal primary education in all countries before the year 2015, all countries are urged to ensure the widest and earliest possible access by girls and women to secondary and higher levels of education, as well as to vocational education and technical training” (paragraph 4.18)
Reduction of infant and child mortality	“By 2015, all countries should aim to achieve an infant mortality rate below 35 per 1,000 live births and an under-five mortality rate below 45 per 1,000. Countries that achieve these levels earlier should strive to lower them further” (paragraph 8.16)
Reduction of maternal mortality	“Countries should strive to effect significant reductions in maternal mortality and morbidity by the year 2015 (...) to levels where they no longer constitute a public health problem. Disparities in maternal mortality within countries and between geographical regions, socio-economic and ethnic groups should be narrowed” (paragraph 8.21)
Universal access to reproductive and sexual health services including family planning	“All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015” (paragraph 7.6)

A number of these goals and targets have been tailored to meet the specific context of the Western Pacific Region. For example, the maternal mortality goal has been recast as: “To reduce, by 2015, the maternal mortality ratio by 75% of the 1990 level, and to contribute to the reduction of infant mortality by reducing the number of neonatal deaths.”

Sources: United Nations Millennium Project. 2006; WHO Regional Office for the Western Pacific 2005b.

development worldwide, the World Health Assembly adopted WHO's first Global Reproductive Health Strategy at its fifty-seventh session in May 2004 (Box 11). The global strategy strongly urges governments to fulfil commitments made at the ICPD, the Fourth World Conference on Women and their respective five-year review conferences. The resolution recognizes that accelerated action is critical for meeting the MDGs.

To this end, the strategy is designed to mobilize action in the following areas:

- strengthening health systems capacity

- improving information for priority-setting
- mobilizing political will
- creating supportive legislative and regulatory frameworks
- strengthening monitoring, evaluation and accountability

Member States are urged to use the strategy to develop and strengthen their reproductive health programmes and to meet their specific reproductive health needs. Almost all Member States of the World Health Assembly fully endorsed the strategy.<sup>328</sup>



### Box 11: Core components of the WHO Global Reproductive Health Strategy

1. Improvement of antenatal, perinatal, postpartum and newborn care
2. Provision of high-quality services for family planning, including infertility
3. Elimination of unsafe abortion
4. Prevention and treatment of sexually transmitted infections including HIV, reproductive tract infections, cervical cancers and other gynaecological morbidities
5. Promotion of sexual health

Source: World Health Organization, 2006c.

The political commitment for sexual and reproductive health, as illustrated by the range of international treaties and commitments, has not always been backed by adequate financial resources. One 2005 estimate puts the annual cost of achieving the ICPD goals by 2015 at \$23 billion (or \$18.5 billion in 1994 dollars), with one third of this amount coming from donors.<sup>329</sup> However, the ICPD estimates were based on a more modest set of actions. More recent estimates use revised figures to estimate the resources required to meet the ICPD goals by 2015 (Table 9).

Levels of donor funding for reproductive health initially declined during the post-ICPD period. For example, the World Bank's contribution to population assistance decreased from 25% of total global resources in 1994 to 10% in 2002.<sup>330</sup> Since 2002, international assistance has begun to increase.<sup>331</sup> However, funding for ICPD goals remains consistently below the financial estimates outlined in the ICPD PoA.<sup>332</sup>

The recent trend towards increased funding for sexual and reproductive health can largely be explained by the increase in resources for HIV/AIDS programmes. Funding for the prevention and treatment of HIV/AIDS (and STIs) often comes at the expense of family planning and other reproductive health programming. A recent report on financial flows to meet the ICPD goals concludes that while funding for HIV/AIDS programmes is rising, it remains below the levels required to meet current HIV/AIDS needs, which have outpaced those anticipated in 1994. In contrast to the improved financial flows to HIV/AIDS, funding for family planning has been steadily decreasing since 1994 and now stands at below the suggested target of \$11.5 million in 2005. It is estimated that despite recent increases for sexual and reproductive health, international donors would have to triple the amount of funding dedicated to sexual and reproductive health to meet the ICPD goals.<sup>333</sup> Nevertheless, many sexual and reproductive health interventions, such as maternal health services (Box 12), are still cost-effective investments.

### National policies

Achieving the MDGs and ICPD goals, among other international commitments, requires broad and sustained political commitment for sexual and reproductive health at the national level.<sup>334</sup> As such, broad-based political support must be generated for the rights-based approaches to sexual and reproductive health, which are expressed in international declarations and commitments.

Ministries of health can lead efforts to mobilize political support and buy-in for sexual and

**Table 9: Revised total costs for achieving the ICPD Programme of Action**

	US\$ (2005) billions		
	2005	2010	2015
Basic reproductive health services (including family planning)	13.9	19.4	24.4
Sexually transmitted diseases and HIV/AIDS activities	4.1	9.7	11.1
Basic research data and population and development policy analysis	0.3	0.8	0.4
<b>Total</b>	<b>18.2</b>	<b>29.8</b>	<b>35.8</b>

Source: Vlassof and Bernstein 2006. In: United Nations Millennium Project 2006.

reproductive health from a range of stakeholders, including politicians, civil society organizations, academics, the private sector and diverse government ministries. Support from political leaders is vital to ensure that appropriate policies and plans are formulated and implemented. Support from poor and marginalized communities and groups, such as urban poor organizations and women's groups, can be leveraged to sustain upward pressure on political leaders over time. Box 13 discusses some reasons why sexual and reproductive health has remained a low priority among some decision-makers.

To be effective, however, political commitment needs to be translated into clear policy goals with dedicated financial and human resources. A clearly articulated national policy on sexual and reproductive health can create a framework to guide actions at all levels of the health sector. Many countries have had national population policies for decades. Following the ICPD, many of these national policies were revised and strengthened to reflect the priorities outlined in the ICPD PoA.<sup>335</sup> According to WHO, the adoption of new reproductive health policies and programmes

has led to significant changes in the delivery of maternal and child health or family planning services in some countries.<sup>336</sup> Box 14 illustrates how enhanced political commitment has led to improvements in sexual and reproductive health in Brazil.

Of particular concern is how the goals of national sexual and reproductive health policies are worded. Evidence suggests that policies aiming to maximize health gains across the population may not have an impact on the health of marginalized or hard-to-reach populations,<sup>337</sup> and may not address the different sexual and reproductive needs of men and

#### **Box 12: Maternal health services: a cost-effective investment**

The World Bank estimates that, in developing countries, the financial cost of basic maternal and newborn health services is approximately \$3 per person, per year, while maternal services alone cost as little as \$2 per person. Safe motherhood initiatives are a sound investment, offering high social and economic returns at low cost. A recent study found that investments in maternal health, particularly antenatal care, can reduce maternal mortality in low-income countries by an average of 26%. Providing essential obstetric services can reduce that figure by a further 48%. Estimating that women with complications from unsafe abortions occupy 20% to 50% of gynaecological wards in some countries and consume up to 50% of hospital budgets, investments in maternal care can significantly reduce hospital bed use.

Sources: World Bank 1993; Jowett 2000.

#### **Box 13: Why has sexual and reproductive health not received higher priority?**

Although the benefits of improved sexual and reproductive health for women's empowerment, gender equality and poverty reduction have been clearly documented, decision-makers and leaders at the national and international levels have not prioritized sexual and reproductive health for a number of reasons.

1. Sexual and reproductive health, as comprehensively defined in the ICPD PoA, recognizes the complex influences of economic factors, social dynamics and power relationships. This multifaceted understanding of sexual and reproductive health does not lend itself to a "quick fix" approach. Instead, it implies the need for a long-term multidimensional and multisectoral response. The responsibility for various aspects of sexual and reproductive health is distributed across different government departments and managers within departments, just as the concept is fragmented across assorted MDGs and other international goals.
2. Many core sexual and reproductive health approaches are preventive in nature. As with other preventive measures, it is difficult to measure progress and attribute success.
3. Many aspects of sexual and reproductive health are politically sensitive. Politicians and other community leaders are often hesitant to support such issues publicly.

Source: United Nations Millennium Project 2006.

#### Box 14: Political support for health reform enhances reproductive health in Brazil

In 1984, Brazil developed a comprehensive approach to women's health that included nearly all of the elements called for 10 years later at the ICPD in Cairo. However, for more than a decade, the programme remained isolated and under-funded and was never integrated into the national health system. Political turmoil and economic crises also hampered progress in reproductive health.

Since 1995, Brazil has had greater institutional capacity and a political climate favourable to the Cairo agenda. Reproductive health and rights also gained greater visibility as a result of Brazil's active participation in the 1995 Fourth World Conference on Women in Beijing. This renewed political interest, combined with reform of the health system, paved the way for substantial progress in the provision of reproductive health services.

The Government has advanced primary health care through community-based strategies that emphasize family health and has pushed for the decentralization of health services. Decentralization of the health system has put municipalities in control of budgets and the provision of services, which they can accomplish either through public health providers or contracts with private providers. Under the health system, all individuals are guaranteed access to a minimum package of basic health services, which includes family planning, prenatal care, maternity assistance and preventive services.

Is Brazil a model for other countries? Health systems cannot be replicated easily in another country because of unique social, political and economic circumstances. Nevertheless, reproductive health experts in Brazil have observed that the major principles underlying health reform—universal access, comprehensive care, equity (among different population subgroups), decentralization and public accountability—are necessary elements of a comprehensive approach to reproductive health. These reforms have been critical for addressing the wide inequalities in health status and access to care among the country's citizens.

Source: Ashford 2001.

women. Therefore, sexual and reproductive health policies need to be articulated in terms of both improving the health of all women and men and the health of those who are poor and marginalized. Expressing policy goals in these terms can help to explicitly integrate poverty and gender concerns into sexual and reproductive health policies.

#### Cross-sectoral action

Many of the determinants of sexual and reproductive health lie beyond the health sector. Therefore, action needs to extend beyond the health sector, particularly to national policies and plans related to poverty reduction and gender equality. Incorporating analysis of sexual and reproductive health into national poverty reduction plans and policies on gender equality and women's empowerment can address the multiple determinants of sexual and reproductive health. Such an approach also acknowledges

the role that improved sexual and reproductive health can play in poverty reduction and women's empowerment.

The conceptualization of sexual and reproductive health adopted at the ICPD in 1994 involves a variety of interventions with a number of actors from diverse sectors, including education, finance, agriculture, youth, women's affairs and poverty reduction, among others.<sup>338</sup> Strong links between the development of sexual and reproductive health policies and programmes and those of other relevant sectors can produce synergies.<sup>339</sup> For example, improving women's education, access to economic opportunities and decision-making within households will enhance their access to sexual and reproductive health services.

At the global level, WHO has set up a Commission on the Social Determinants of Health to draw attention to how inequalities

in health are produced and sustained by social factors and processes. The Commission's mandate includes making recommendations on how to reduce such inequities and improve the health of the poor through actions related to these social determinants of health.<sup>340</sup>

At the national level, Poverty Reduction Strategy Papers (PRSPs) or other multisectoral socioeconomic planning instruments can offer an opportunity to increase policy coherence and undertake joint planning to address the determinants of sexual and reproductive health.<sup>341</sup> PRSPs also aim to promote more effective resource mobilization and allocation. However, evidence suggests that, although PRSPs recognize sexual and reproductive health as a determinant of poverty, the PRSP process has not systematically incorporated attention to sexual and reproductive health. A recent review concluded that the record of incorporating population dynamics and reproductive health into PRSPs was disappointing.<sup>342</sup> Ministries of health, therefore, need to secure a more central role in the PRSP process and to advocate for the inclusion of sexual and reproductive health within such multisectoral planning instruments. These arguments can be premised on the economic benefits of investing in sexual and reproductive health and international commitments to promote and protect sexual and reproductive health and sexual rights, especially those of youth and women.<sup>343</sup>

Similarly, creating an enabling environment for sexual and reproductive health extends beyond the health sector to include a range of national laws, regulations and policies that may determine the ability of men and women of all ages to enjoy good sexual and reproductive health. Laws and regulations in the areas of education, social welfare, infrastructure, justice, finance, employment and family affairs all impact upon sexual and reproductive health.<sup>344</sup>

A review and, where appropriate, amendment of laws, regulations and policies that affect various aspects of sexual and reproductive health can ensure that they are harmonized and that human rights of

#### **Box 15: Including men in laws and policies to prevent and control HIV/AIDS among women and girls in Cambodia**

When analysing the effect of laws, regulations and policies on particular aspects of the sexual and reproductive health of men and women, it can be useful not only to assess how a law, regulation or policy approaches a given issue or impacts different groups from a human rights and gender perspective, but also to consider what it addresses and omits. A powerful example of this approach comes from Cambodia in the area of HIV/AIDS prevention and control.

Traditionally, men of all ages have been excluded from education and services for sexual and reproductive health. The HIV/AIDS pandemic has increasingly highlighted the cost of such an omission in terms of men's health and the health and well-being of their wives, partners and children. In response, Cambodia's Ministry of Women's and Veterans' Affairs developed a gender-sensitive policy on "Women, the Girl Child and STI/HIV/AIDS". The policy acknowledges that the:

*"recognition of gender and gender inequality should not lead to a sole focus on women. Globally, we have learned that HIV/AIDS projects that have focused solely on women in recognition of their need for empowerment have failed or been unsustainable because they have failed to involve men."*

The policy is premised on the recognition that HIV/AIDS is a gender-based pandemic and that curbing the spread of HIV/AIDS among women and girls also requires concrete changes in the sexual behaviour of men. The policy aims to put men's behaviour change on the agenda of policy-makers and service providers, along with prevention, care, support and protection for women and girls. This approach guides Ministry-supported activities in education, prevention and services provision.

Source: Ministry of Women's and Veterans' Affairs, Government of Cambodia 2003. In: Greene *et al.* n.d.

men and women are respected and promoted.<sup>345</sup> Such analysis could assess whether laws adequately protect women and girls from gender-based violence, for example. This assessment should

also consider how the implementation these laws, regulations and policies affect the sexual and reproductive health of individuals who are poor as compared to those who are non-poor. A recent review of the legislation in Mongolia, as it relates to HIV/AIDS prevention and control, concluded that the current legislation outlawing sex work should be revised to outlaw the act of hiring someone for purposes of prostitution. This shift in the law would effectively make the act of buying sex illegal (instead of selling sex, as it currently stands). Such a change, it is hoped, can decrease the vulnerability of many sex workers by encouraging them to dialogue with the police and to seek out government services, such as those for STIs.<sup>346</sup> In addition, the process of developing laws, regulations and policies should respect, protect and fulfil the human rights of everyone.<sup>347</sup> Box 15 discusses how legislation in Cambodia addresses gender inequality as it relates to HIV/AIDS prevention and control.

Involving civil society organizations in processes to develop, assess and revise laws, regulations and policies can improve the transparency and accountability of such processes and thereby contribute towards building broad-based support for sexual and reproductive health.<sup>348</sup> In addition, the participation of these organizations in the assessment and revision of sexual and reproductive health laws, regulations and policies can generate consensus and support for further action and implementation.

### Health sector response

Achieving universal access to sexual and reproductive health services requires the integration of sexual and reproductive health into the institutions and structures of the health system.<sup>349</sup> During the integration process, particular attention must be paid to ensuring that a full range of sexual and reproductive health services are available to all those in need. This approach to sexual and reproductive health was first outlined in the ICPD PoA and has since been elaborated in the WHO Global Strategy for Reproductive Health.

In many countries in the Region, responsibility for the development, implementation and evaluation of policies and programmes rests with different actors or departments. As various aspects of sexual and reproductive health tend to fall under different programmatic areas, such as HIV/AIDS, maternal and child health and adolescent health, collaboration between these and other priority programmes, such as malaria and tuberculosis, is required.<sup>350</sup> In this context, the integration of sexual and reproductive health can be achieved through continuous, effective communication and collaboration between actors and departments to establish links at various levels of service delivery.

While communication and collaboration are critical to the successful integration of sexual and reproductive health services, these processes need to be supported by policies that strengthen health systems in three vital areas, namely, (1) appropriate arrangements for the financing of and payment for health services, (2) procurement and distribution of essential medicines, and (3) management of human resources. These policies are needed to ensure the integration of a full range of sexual and reproductive health services.<sup>351</sup> Box 16 considers some of these issues with regard to the case of health sector reform. The sections that follow discuss health financing, human resources and health information for sexual and reproductive health as they relate to poverty and gender inequality.

### Health financing

The manner in which revenue is raised and funds are allocated can influence access to sexual and reproductive health services for men and women, and poor and non-poor. Countries in the Region use various methods to determine how to mobilize and allocate resources in the health sector. One approach, which is becoming increasingly popular, is the sector-wide approach (SWAp). SWAps and similar methods for allocating resources tend to rely upon priority-setting measures such as DALYs. However, such measures have been demonstrated to undervalue sexual and reproductive health needs, including maternal health care.<sup>352</sup> When



### Box 16: Health sector reform and sexual and reproductive health

Health sector reform profoundly alters how health services are financed and delivered, in turn influencing how sexual and reproductive health care is provided. Many reproductive health priorities, such as improving service quality and client satisfaction, educating patients and providing more choices are consistent with health sector reform. However, reforms inevitably involve trade-offs and can have negative effects. Reproductive health managers and advocates interested in influencing how services are funded and provided need to become familiar with the objectives, principles and strategies of health sector reform and take part in policy discussions at the national and local level. The following are some ideas on what can be done:

**Engage in continuous dialogue with health planners.** Mechanisms may vary from country to country, but groups working on health sector reform and sexual and reproductive health need to share information regularly. Sexual and reproductive health specialists need to be involved when critical decisions about the financing, organization and regulation of services are made. Having allies inside the government can be essential for gaining access to the process.

**Show that reproductive health is a good investment.** To influence the reform agenda, advocates must prove to policy-makers that sexual and reproductive health accounts for a significant proportion of the country's overall disease burden and has social implications beyond the burden of disease; that interventions for sexual and reproductive health are cost effective; and that gross inequalities in reproductive health status and the allocation of resources can and should be addressed.

**Use participatory approaches to influence decisions and monitor progress.** Participatory processes that establish clear programme goals and measurable indicators of progress can be essential in bringing together health reformers and reproductive health advocates. Donors might consider investing in increasing the technical and analytical capacity of local administrators and civil society organizations to help those groups take part in shaping health reform.

Health sector reform has the potential to improve both the quality and the sustainability of sexual and reproductive health services, but its success depends in part on participation from a range of stakeholders. Local health administrators must be able to solicit and use the input of diverse stakeholders, and to address reproductive health issues in a transformed health system.

Source: Dmytrachenko *et al.* 2003.

plans for resource allocation are formulated, sexual and reproductive health must be prioritized. In a similar manner, the formulation of an essential package of services must include sexual and reproductive health services that meet the needs of the target population.

Most countries in the Region finance the health sector through a combination of revenue-raising mechanisms: taxes, social health insurance, donor funding, prepayment schemes, private health insurance, and/or out-of-pocket payments or user fees. Table 10 presents some of the public financing mechanisms employed by countries in the Region, as a percentage of the total revenue.<sup>353</sup>

In practice, private financing in most countries takes the form of out-of-pocket payments at the point of service.

Analysis suggests that taxes and social insurance schemes offer the most equitable form of health financing.<sup>354</sup> Social insurance and other prepayment schemes tend to cover services that meet the needs of the target population in a cost-effective manner; however, as with resource allocation more generally, they have also been shown to undervalue sexual and reproductive health needs. These types of schemes, for example, tend to exclude routine contraceptive and delivery care for women, thereby resulting in unnecessary

**Table 10. Public financing mechanisms for the health sector in selected countries in the Region in 2001**

Country	Tax revenue	Social insurance	External assistance
Cambodia			51.0%
China		87.0%	
Japan		89.0%	
Lao People's Democratic Republic	86.3%		
Malaysia	98.8%		
Mongolia	76.5%		
Papua New Guinea	83.5%		
Republic of Korea		71.9%	
Viet Nam	93.3%		

Source: Musgrove *et al.* 2001. In: Ravindran 2005.

Caesarean sections and other surgical procedures, which are more often covered.<sup>355</sup> Insurance schemes also tend to exclude pharmaceuticals that are not prescribed by a health provider, such as oral or emergency contraception. In addition, key aspects of sexual and reproductive health care are preventive rather than curative. As such, priority setting for social insurance and other prepayment schemes need to include other criteria to promote, rather than discourage, the availability of sexual and reproductive health services.

In addition to the range of services covered by insurance, the criteria used to identify who is eligible for coverage have important implications for sexual and reproductive health.<sup>356</sup> For example, detailed analysis suggests that women may enjoy lower access than men to social insurance schemes financed through payroll deductions, because of their lower participation in formal wage labour. Social insurance and other prepayment schemes might also exclude same-sex couples. Financing sexual and reproductive health services through tax revenue may be a more effective means of ensuring that these services are accessible to poor and marginalized groups.

Greater reliance on private for-profit health insurance and direct user fees in many countries appears to have adversely affected the access of

the poor to health services.<sup>357</sup> Reliance on for-profit service providers tends to leave poor and marginalized communities underserved. Analysis of experience in 39 countries suggests that the introduction of user fees increased revenue to the health sector only slightly, while significantly reducing access to basic health services for low-income people.<sup>358</sup> Evidence suggests that women have been disproportionately affected as compared to men by the increasing reliance on user fees and may enjoy lower coverage of health insurance schemes. While social marketing campaigns may reach some motivated individuals, they are unlikely to meet the needs of poor households who may depend on subsidized contraceptives to meet their family planning needs.

### *Human resources*

Human resource policies can have major implications for the effective delivery of sexual and reproductive health services. Human resources need be distributed in a manner that meets the health needs of the population generally, such as by ensuring adequate numbers of trained staff in rural and remote health centres and in urban poor communities. The allocation of health staff between primary, secondary and tertiary levels also influences the capability of the health system to adequately respond to the sexual and reproductive health needs of men and women. Appropriate human resource policies can create a workforce that is motivated and competent. For example, sexual and reproductive health issues remain taboo in many areas and can be a source of embarrassment where men or women are made to seek care from a health service provider of the opposite sex. Women frequently cite the absence of a woman health professional as an important reason for not seeking treatment. Because of this, it is vital to ensure the availability of both male and female health staff.

Good coordination can promote the successful delivery of sexual and reproductive health services. Timely referrals to higher levels of services are critical for obstetric emergencies, for example. Indeed, timely emergency care has been identified



**Box 17: Example of a prepayment scheme that includes reproductive health services in the benefits package**

Bolivia formulated the Maternal and Child National Insurance Plan in 1996 to improve the coverage of maternal and child health care. The programme finances the total costs of antenatal care, labour and delivery, including Caesarean sections and other obstetric emergencies, postpartum care and newborn care for women and children under five years of age. The insurance package does not cover contraceptives.

Between 1994 and 1998, the proportion of births with a skilled birth attendant increased from 43% to 59%. Disaggregating these data further shows that the use of skilled birth attendants increased from 11% to 20% among the poorest income quintile. An evaluation conducted in 1998 of the National Insurance Programme for Mothers and Children (SNMN) in Bolivia concluded that the benefits of the programme were disproportionately enjoyed by poor households. Among clients seeking care for maternal care, for example, 68% were from households classified as having low socioeconomic status and 32% were belonged to middle-socioeconomic status households.

Source: Dmytraczenko and Scribner 1999.

as a core aspect of strategies to reduce maternal mortality.<sup>359</sup> Coordination between voluntary testing and counselling for HIV and STIs and family planning services can create positive synergies for sexual and reproductive health. Links also tend to extend from the health system to volunteer or community-based health workers. Evidence suggests that trained traditional birth attendants can successfully identify early signs of complication during labour and delivery and refer women for treatment.<sup>360</sup> Other actors may also be involved in the provision of services for sexual and reproductive health, such as private providers and nongovernmental organizations (NGOs). Often, mid-level professionals and paramedical workers provide many core sexual and reproductive health services.<sup>361</sup> Respectful working relationships with

health providers beyond the health sector can further enable the delivery of comprehensive, good-quality sexual and reproductive health services.

Health workers require continuous training and capacity-building to ensure that they have up-to-date knowledge and skills. Access to current knowledge and research on various sexual and reproductive health issues can also enable health staff to better counsel and advise patients. This includes ensuring that men and women clients are fully informed of their options, such as likely benefits and potential side-effects, and that properly trained personnel obtain voluntary and informed consent from clients.

Enhancing the awareness of health staff on human rights and gender-sensitive standards can further improve the delivery of sexual and reproductive health services and ensure that they meet international standards, such as those laid out in the ICPD. Such an approach can include redesigning services and training for health workers so that they are gender-sensitive and reflect the user's perspectives with regard to interpersonal and communication skills as well as the client's right to privacy and confidentiality. Given the sensitive nature of sexual and reproductive health in many communities, health service providers need to be particularly considerate of the needs and perspectives of their men and women clients. Privacy and confidentiality are critical to young people seeking sexual and reproductive health services. Not only do health centres need private spaces for counselling and consultation, but health providers must also strive to offer confidential services to all patients.

### ***Health information***

To be effective, sexual and reproductive health policies need to be grounded in an analysis of timely and accurate data and research on the sexual and reproductive health needs of the population, including those of various groups within society, such as women and men and those who are poor or live in rural areas. In addition, policies

need to be based on a thorough understanding of the social, cultural, political and economic dynamics and trends that influence the sexual and reproductive health of men and women of all ages. This information must then be analysed and used to guide the allocation of financial and human resources for sexual and reproductive health in the most equitable and effective way.<sup>362</sup>

Equipped with sound evidence, advocates can advance efforts to build broad-based political support for sexual and reproductive health. That

is, misconceptions must often be confronted and dispelled as part of the process of mobilizing political support for sexual and reproductive health. For example, much resistance to curriculum-based sex education is premised on the notion that providing young people with such information will increase the likelihood that they engage in premarital sex. Available evidence suggests that this belief is unfounded and that curriculum-based sex education does not lead to increased risky behaviour among youth.<sup>363</sup> Those advocating for sexual and reproductive health should thus be armed with locally specific evidence and research to dispel commonly held beliefs that hinder the development and implementation of sexual and reproductive health policies. Such evidence can also be useful in training and capacity-building for health staff, as well as in setting human resource policies.

To this end, sexual and reproductive health indicators need to be integrated into national planning tools in addition to those indicators collected by the health sector. Box 18 provides a minimal list of reproductive health indicators for use at national and global levels. This is not a comprehensive set of indicators for programme monitoring and evaluation. Instead, the objective of this list is to identify a limited number of indicators that can offer a general overview of the reproductive health situation in a given setting.<sup>364</sup>

To produce a comprehensive overview of a country's sexual and reproductive health needs, data on indicators need to be collected for the population as a whole and for specific groups.<sup>365</sup> To determine how, if at all, the distribution of sexual and reproductive health varies among vulnerable groups within society, adequate data must be collected to assess these differences by sex, income, employment and education status, ethnicity, urban-rural location, region or province, or other relevant indicators of disadvantage. Box 19 describes criteria on which to base gender-sensitive indicators. Gender-sensitive indicators enable us to explore how gender inequality influences the sexual and reproductive health of men and women.

#### Box 18: Reproductive health indicators

1. Total fertility rate
2. Contraceptive prevalence rate
3. Maternal mortality ratio
4. Percentage of women attended, at least once during pregnancy, by skilled health personnel (excluding trained or untrained traditional birth attendants) for reasons of pregnancy
5. Percentage of births attended by skilled health personnel (excluding trained and untrained traditional birth attendants)
6. Number of facilities with functioning basic essential obstetric care per 500 000 population
7. Number of facilities with functioning comprehensive essential obstetric care per 500 000 population
8. Perinatal mortality rate, by sex
9. Percentage of live births with low birth weight (<2500 grams)
10. Positive syphilis serology prevalence in pregnant women aged 15 to 24
11. Percentage of women of reproductive age (15–49) screened for haemoglobin levels who are anaemic
12. Percentage of obstetric and gynaecology admissions owing to abortion
13. Reported prevalence of women who have undergone female genital mutilation
14. Percentage of women of reproductive age (15–49) at risk of pregnancy who report trying for a pregnancy for two years or more
15. Reported incidence of urethritis in men aged 15–49

Adapted from World Health Organization 1997.

### Box 19: Developing gender-sensitive indicators for reproductive health services

**Comparison to a norm:** Indicators should involve comparison to a norm, for example, the situation of men in the same country or the situation of women in another country. In this way, the indicator can focus on questions of gender equality and equity rather than only on the status of women.

**Disaggregation:** Data should be disaggregated by sex. Whenever possible, national-level indicators should also be disaggregated by age, socioeconomic grouping, urban and rural setting, ethnicity and national and/or regional origin. The time period, geographical coverage, and data sources should be noted.

**Ease of access:** Data should be easy to use and understand. Indicators should be phrased simply and should be developed at a level relevant to the institutional capabilities of the country concerned.

**Scope of availability:** Indicators should be available for the whole country.

**Reliability:** Data should be relatively reliable. No data is absolutely reliable but reliability checks should be carried out. For example, findings from consensus should be compared to findings from micro-level studies for accuracy.

**Measurability:** Indicators must be measurable. Concepts such as 'women's empowerment' and 'women's equity' may be difficult to define and measure. In this case, indicators that measure women's access to health care or education may be used instead of the less precise concepts.

**Time frame:** Gender-sensitive indicators should be reliable enough to use as a time series. The time frame that the indicator covers should be clearly specified.

**International compatibility:** Gender-sensitive indicators should use internationally accepted definitions. While definitions are sometimes imprecise, they are usually the best terms available and allow for international comparisons.

**Measuring impact:** Gender-sensitive indicators should, where possible, measure the outcome or impact of a situation rather than the input. For example, female mortality rates are a better measure of women's health status than access to health facilities.

**Participation:** Indicators should be used and developed in a participatory process. This process will involve setting up interdepartmental government committees and holding focus group meetings with the public to elicit the opinions of women and men whenever possible.

Source: Commonwealth Secretariat. In: Baume 2001.

Once collected, data should be disaggregated and analysed by socioeconomic status, sex, urban-rural location, ethnicity and other relevant indicators of social exclusion. Through this process, analysts would learn how sexual and reproductive health-related morbidity and mortality are distributed among the population generally and within specific subgroups, such as the urban poor and ethnic minorities. Disaggregated analysis can also refine understanding of unmet needs, such as family planning services. Employing gender

analysis can also reveal how gender roles, such as the gender division of labour, gender norms and access to and control over resources, influence the sexual and reproductive health of men and women across the life cycle. This analysis can then guide the identification of effective, appropriate and equitable policies and interventions for sexual and reproductive health.

Data collection and analysis should be supplemented by case studies and other

### Box 20: Strengthening reproductive health programmes

#### *Planning process questions*

- What is the current reproductive health situation? What are the needs? They should be identified through situation analysis or a needs assessment.
- What has been done to address the current situation? Programmes should be developed through strategic planning to bring about change or improve a specific situation through appropriate interventions.
- How should progress and achievements be monitored and evaluated? Programme evaluation should be integrated into the strategic plan to assess the effectiveness/impact or the outcome of its intervention(s).

#### *Programme managers should:*

- determine available resources and tools for various aspects of reproductive health;
- produce evidence-based and culturally sensitive information, education and communication messages; and
- explicitly involve all key stakeholders in the planning and implementation process.

#### *The strategic planning process should:*

- identify relevant background information based on a situation analysis;
- identify priority interventions;
- develop objectives and strategies with a work plan containing key activities, indicators, time frame, estimated cost, proposed evaluation and assignment of responsibilities.

#### *The strategic framework should take into account the following key elements:*

- creation of an enabling environment through advocacy and social mobilization that targets the relevant communities, policy-makers and all key stakeholders;
- promotion of healthy reproductive health behaviour;
- promotion of equitable access to quality health services while improving provider-client relationships and best practices in the context of national policy;
- providing opportunities for training through workshops and other capacity-building activities;
- fostering collaboration, partnership and strong reproductive health networks;
- developing a research agenda and strengthening the dissemination and utilization of research information, including a commitment to improve access to and quality of reproductive health programmes.

Adapted from World Health Organization 2002a.

qualitative methods of research in order to assess unmet needs for sexual and reproductive health services, perceived quality of health services, and various financial and non-financial barriers that poor men and women may face when accessing services for sexual and reproductive health. Case studies and other qualitative analytical methods can provide information that an analysis of data from health information systems would otherwise miss.

Once collected and analysed, quantitative and qualitative information can be harnessed to develop sexual and reproductive health policies

or to advocate for increased political and financial support for sexual and reproductive health. Box 20 provides guidance for programme managers in outlining a strategic plan for developing and strengthening reproductive health plans at the national and district level. Such strategic planning entails the adaptation of norms and/or tools to a given or changing situation. It takes into account the underlying determinants or variables that affect the delivery of reproductive health care such as gender and sociocultural perspectives.

Building coalitions with diverse organizations can also ensure that the process for formulating sexual

and reproductive health policies and plans are informed by the needs of the poor and of men and women. Strong links with marginalized groups, for example through civil society organizations, can help to elucidate the views and needs of poor individuals and of men and women. This can be achieved through participatory methods, community consultation or identification of representatives from these groups to sit on a policy advisory board. Involving men and women and those who are poor and marginalized can ensure that policies and plans are better tailored to meet their sexual and reproductive health needs.

### Service delivery

Providing sexual and reproductive health care in an integrated manner has important implications for how services are delivered. The aim of integration is to improve the overall effectiveness and efficiency of service delivery and to meet the needs of all people for “accessible, acceptable, convenient and client-centred comprehensive care.”<sup>366</sup> At the point of service delivery, the integration of sexual and reproductive health care means bringing together all aspects, such as those outlined in Box 10, and building strong working relations with other health services and, where appropriate, with related social services. Ideally, this approach should include preventive measures, the provision of information and counselling to clients in addition to screening, diagnosis and curative care.

All of these services do not need to be provided in the same health clinic or site. Instead, health service providers need to be equipped with the knowledge and skills to provide an appropriate package of basic services and to refer patients to required services that are lodged in other areas or levels of the health care system. Decisions concerning which services to offer and which to link through referral systems need to take into account the capacity of the health system, including the knowledge and skills of health service providers, and the perspectives of local communities. The manner in which these services are delivered also needs to respond to gender and

poverty concerns to address inequalities in sexual and reproductive ill-health.

The following section presents information on innovative strategies that health professionals are employing to improve the accessibility of health care for the poor and to ensure that men and women benefit equally from resources allocated to sexual and reproductive health. These interventions are still in their early stages and have not yet been rigorously evaluated or standardized. However, they suggest some ways forward. Each strategy must be refined based on further analysis and country-specific situations. This is not an exhaustive list of strategies, as the evidence base for equity-promoting and gender-sensitive strategies needs to be augmented through more systematic operational research.

### *Addressing geographical barriers*

The coverage of health services in many developing countries in the Region remains incomplete and the distribution of available services often benefits non-poor communities to a greater extent than those that are poor. Among countries in the Pacific, for example, health services may not effectively cover remote and small island communities. Limited coverage of health facilities constitute geographical barriers that may prevent or delay care-seeking by poor individuals. Travelling long distances for health care may be more difficult for women than for men, whose mobility may be restricted by social norms or by limited access to cash income and household resources.

Primary health facilities are often more accessible for poor households than are services offered in secondary or tertiary level facilities, which tend to be concentrated in urban centres. This greater accessibility of primary health facilities was recognized in the ICPD PoA, which committed countries to provide a full range of sexual and reproductive health services in an integrated manner within the primary health system. Prioritizing sexual and reproductive health services that can be successfully integrated into primary health facilities can be an effective method of

increasing the geographical accessibility of these services to poor men and women.

An approach that prioritizes the delivery of sexual and reproductive health services through primary care facilities may require improved coverage of appropriate diagnosis and treatment methods. That is, primary health care facilities require simple, low-cost methods for the diagnosis and treatment. Box 21 discusses advances in simple, low-cost technologies to diagnosis cervical cancer.

While the primary health care system in many countries is quite extensive, some areas remain beyond its reach. Financial incentives can encourage local NGOs and private providers to offer appropriate sexual and reproductive health services in such areas. Partnering with NGOs might be especially fruitful for scaling up sensitive components of sexual and reproductive health

services.<sup>367</sup> NGOs working with youth in rural and remote communities, for example, may be persuaded to integrate adolescent reproductive health services into their programming. Financial incentives may also motivate alternative health service providers to enter into underserved areas. Cambodia, for example, has successfully employed a strategy of contracting NGOs to provide health services in several districts, thereby increasing the accessibility of health services, often to the benefit of the poor.<sup>368</sup> Contracting with private providers is increasingly used to improve the accessibility of sexual and reproductive health services.<sup>369</sup> In areas where poor individuals consult private practitioners, coordinating between private and public providers can improve the coverage and quality of services.

Regular outreach services in poor and remote communities can bring sexual and reproductive

#### Box 21: Visual inspection with acetic acid wash for cervical cancer

Cervical cancer is one of the most common forms of cancer among women in low-income settings. An estimated 80% of deaths from cervical cancer occur in developing countries. Among women in low- and middle-income countries, the majority of cervical cancer cases are caused by infection with a subtype of human papillomavirus (HPV). HPV is a sexually transmitted virus that infects cells and may lead to precancerous lesions and invasive cancer.

Cervical cytology programmes, which screen sexually active women annually or once every two to five years, have resulted in a large decline in cervical cancer incidence and mortality in developed countries. To be effective, cervical cytology programmes require established laboratories, highly trained cytotechnologists and up to three visits for screening, evaluation of cytologic abnormalities and treatment. This approach has remained largely ineffective in developing countries, where organized programmes are limited and testing is often of poor quality and performed inadequately. In recognition of these constraints, alternative methods based on visual examination of the cervix have been investigated.

Among these approaches, visual inspection with acetic acid (VIA) has received the most attention. VIA involves swabbing the cervix with diluted (3%–5%) acetic acid and then examining it with the naked eye, i.e. without any magnification; illumination is provided by a bright source of light. Nurses or other paramedical health workers usually perform this test. To be considered positive, the test detects well-defined, dull acetowhite lesions on the cervix. This detection aims for the early diagnosis of high-grade cervical intraepithelial neoplasia and early preclinical, asymptomatic invasive cancer.

Evidence suggests that VIA has similar sensitivity to that of cervical cytology, but with lower specificity. Because the outcome of VIA is known immediately, it reduces the amount of time women must devote to screening procedures. VIA has been found to be cost effective, as it decreases the direct medical cost of screening to the health system and the patient.

Sources: Sankaranarayanan *et al.* 2001; Goldie *et al.* 2005; World Health Organization 2002c.



health services closer to those in need. Outreach services include regular health staff visits, mobile clinics and village health posts. Outreach services have been used to provide contraceptives in hard-to-reach communities. Outreach services need to be tailored to meet the needs of specific sub-populations, such as ethnic minorities, island communities and migrants. A case study from Viet Nam (Box 22) provides an example of how one

**Box 22: Reaching the poor and ethnic minority families in Viet Nam**

Ethnic minorities account for more than half of the population in three of the provinces served by the Population and Family Health Project in Viet Nam. To ensure that women in remote mountainous areas have access to improved health and family planning services, two model outreach programmes are being tested. Village health posts are being established together with a hamlet-based “collaborator” network. Locally selected collaborators are being provided with bicycles to ensure that health care is available to settlements when they need it.

Staff trained within the ethnic communities supplement the hamlet-based collaborators. Improved clinical training is also being provided to women health and family planning workers. More women are being trained as health workers, nurses, midwives and doctor’s assistants. If successful, these outreach programmes will be replicated in the other 12 provinces of Viet Nam, where the project is upgrading and expanding health and family planning services.

To reach women unfamiliar with the services being offered, the project includes the use of innovative social marketing methods, such as the use of non-traditional outlets to promote new services. Through the project, thousands of Vietnamese women are starting to experience improved care in pregnancy and during deliveries. Access to a wider range of contraceptives is now available for women and men. As their health improves and they are able to control the birth spacing of their families, women are becoming better equipped to move out of poverty and into a productive life.

Source: Asian Development Bank 2002.

programme addressed the problem of providing effective and accessible reproductive health care to an ethnic minority group. Box 23 discusses the mobile reproductive health clinics run by the Self-Employed Women’s Association (SEWA).

Communities play an important role in the delivery of health services in countries throughout the Region. Their involvement ranges from the recruitment of community-based health workers to increasing reliance on home-based care for chronic illnesses, such as HIV/AIDS. Other approaches aim to mobilize the participation of communities in decisions that affect their health. While such strategies can effectively extend the reach of the health system and improve its responsiveness to communities, the benefits of community-based approaches cannot be guaranteed. For example, power dynamics within communities may silence the voices of marginalized members, such as women and individuals from poor households; youth may also experience difficulty expressing their opinions in arenas that include their parents, teachers and community leaders. Care also needs to be taken to ensure that women’s unpaid work burden is not increased in the process, as in many areas, the work of caring for the ill at home is often viewed to be the responsibility of women and girls. Approaches that are sensitive to these and other issues can better ensure that the interests of such groups feature in planning and implementation processes.

***Addressing economic barriers***

The mix of financing mechanisms adopted to fund health services largely determines the economic accessibility of sexual and reproductive health services. As discussed above, careful planning can tailor the mix in such a way as to reduce the possible adverse effects on women as compared with men and those who are poor as compared with those who are better-off. Once these mechanisms have been decided upon, additional strategies can be employed to further improve the economic accessibility of sexual and reproductive health services. To be effective, such strategies

### Box 23: Mobile reproductive health clinics serving the very poor in India

The Self-Employed Women's Association (SEWA), a trade union of informal women workers, was founded in 1972 in Ahmedabad, Gujarat. The aims of SEWA are: (1) to organize women to achieve full employment (work security, income security, food security and social security), and (2) to make women independently and collectively self-reliant, economically independent and capable of making their own decisions.

SEWA has been involved in public health initiatives and the delivery of health services to members and non-members since the early 1970s. The primary objective of these initiatives has been to provide services to the very poor, particularly those who live in areas that are not otherwise served by the government or NGOs.

In response to the need for reproductive health services for women in remote and underserved areas, SEWA organized mobile reproductive health clinics in 1999. The mobile clinics initially provided services in slum areas of Ahmedabad city and villages in three districts. The clinics are largely funded by UNFPA and the Government of India.

The mobile clinics usually operate for three to four hours in the afternoon and provide health education and training, examination and diagnostic tests (including cervical examination and Pap smears), treatment, referral and yearly follow-up visits to each target area. Physicians and community health workers staff the mobile clinics, which see an average of 30 women per month. Women who attend the mobile clinics are requested to make a contribution of 5 rupees (\$0.11) and to pay one third of the total costs of the medicines provided.

More recently, SEWA has been collaborating with the government of Gujarat to hold mobile camps in public health centres in rural areas of the province. In contrast to the standard mobile clinics, services are provided by public doctors and nurses and medication is available free of charge. In addition, SEWA covers the transportation costs of women living in neighbouring villages.

A recent evaluation concluded that the urban mobile clinics were successful in reaching the very poorest, while the rural camps were less effective. The success of urban camps was attributed to design of the mobile clinics, which brings services and education to poor people and incorporates poor people into the delivery of many, if not all, health services. In addition, the mobile clinics are often combined with initiatives to mobilize and educate the larger community and the costs of services are significantly lower than those by other local service providers. Finally, SEWA is a well known and trusted institution in Ahmedabad city. SEWA health providers also attributed their success to the warm and respectful way they treat their clients and that fact that most health providers are women.

While the reasons for the limited success of the rural clinics in reaching the poorest remain largely unexplored, some contend that the registration fee may prevent very poor women from seeking care and that the clinic hours tend to conflict with the working hours of many rural women.

Source: Ranson *et al.* 2005.

should be informed by research and analysis that considers how the various financial mechanisms adopted affect the accessibility of sexual and reproductive health services for various groups. For example, evidence from Cambodia suggests that, in some areas, condoms are available free of charge to women sex workers, while in others they must be bought from health facilities, brothel owners or NGOs.<sup>370</sup> Such detailed analysis can

identify how to address economic barriers, such as through exemptions targeting vulnerable groups of adolescents, unmarried mothers or ethnic minorities. Other strategies can include exempting priority health services from user fees. Ghana, for example, adopted a policy of free delivery care for all women. Instead of financing deliveries through user fees, as is the case with other health services, the Government opted to finance this priority service

#### **Box 24: Improving the economic accessibility of delivery care for women in Nepal**

The costs associated with delivery care in Nepal, most notably transportation, are considerable. Evidence shows that they prevent or deter women from accessing delivery care, thereby hindering progress towards the Government's goal of increased skilled attendance at birth.

To address the economic barriers to delivery care, the Government of Nepal, in July 2005, introduced a new policy that provides:

1. transportation allowances for all women who deliver with a skilled attendant (payment varies depending upon the topology of the area);
2. financial incentives for skilled birth attendants who assist deliveries; and
3. free institutionalized delivery care in the poorest districts.

During the first year of implementation, less than half of the districts had initiated the new policy measures. While an increase in deliveries with skilled birth attendants has been observed, it is still too early to assess the impact of this policy on the poorest districts and on the health of women and children in Nepal.

Source: Borghi *et al.* 2006.

through the PRSP process.<sup>371</sup> Box 24 describes the Government of Nepal's policy to provide cash payments to women for transportation costs and free institutional delivery for women residing in the poorest districts.

Financial incentives constitute an innovative approach to improving access to sexual and reproductive health services by stimulating demand among specific groups. For example, conditional cash transfers have been shown to be an effective method for improving access to selected sexual and reproductive health services for poor households in Latin American countries. Conditional cash transfers aim to mobilize demand for a given health service among the targeted community. More specifically, these schemes transfer a set amount of money to pre-identified families, or individuals within families,

conditional on certain behaviours or actions, such as their use of specific services. Evaluations report that conditional cash transfer schemes have increased uptake of antenatal care by 8% during the first trimester of pregnancy in Mexico, and by 15%–20% in Honduras, especially among poorer households.<sup>372</sup>

Many developing countries have used voucher schemes to generate demand for sexual and reproductive health services. This approach provides vouchers to targeted individuals or households, which can be exchanged for a pre-identified service, such as maternal care or diagnosis and treatment for STIs. These services are often delivered in health facilities that have been contracted in advance to provide the redeemable services. This approach is seen to be particularly effective because it overcomes the challenges associated with cost-sharing schemes that require advanced payment for care.<sup>373</sup> Box 25 describes the experience with vouchers in meeting the sexual and reproductive health needs of adolescents in low-income areas of Managua, Nicaragua.

Community-based health insurance schemes, which generally operate on a much smaller scale than other types of insurance schemes, have been established in many areas. Such schemes spread the financial burden of ill-health across households in the community and over predictable periods of time. However, community-based insurance schemes may not cover sexual and reproductive health services that are considered sensitive, such as family planning and post-abortion care. Similarly, these schemes may exclude people who are deemed to not need particular services, such as unmarried adolescents and ageing men and women. Experience also shows that these schemes are not always accessible to poor households, who may not be able to make the required prepayments.

#### ***Addressing sociocultural barriers***

While prevention, diagnosis and treatment can improve the well-being of men and women, the

**Box 25: Meeting the sexual and reproductive health needs of female adolescents in low-income urban areas through a voucher scheme in Managua, Nicaragua**

Nicaragua is one of the poorest countries in Latin America. Of the 5.2 million people living in the nation's capital, Managua, 25% are between the ages of 10 and 20 years. The adolescent fertility rate is one of the highest in Latin America, with 119 births per 1000 women (15–19 years of age). By the age of 19 years, 45% of young women either are mothers or are pregnant. Contraceptive use among adolescents is low, as is the use of sexual and reproductive health services. Limited access to information and poor quality of care have been held responsible.

In response, the Central American Health Institute (ICAS), in partnership with the London School of Tropical Medicine and Hygiene, launched an innovative pilot project to improve the use of quality sexual and reproductive health care among adolescents in poor and underserved areas of Managua. The pilot project, which was funded by the Department for International Development of the United Kingdom, aimed to increase demand for sexual and reproductive health services through a competitive voucher scheme.

Through the project, 28 711 vouchers were distributed to male and female adolescents in poor and underserved areas of Managua from September 2000 to July 2001. The vouchers were issued by ICAS and distributed by ICAS and NGOs in markets, outside public schools, in clinics, on streets and in poor neighbourhoods (house-to-house).

Valid for three months, the vouchers were redeemable for one consultation and one follow-up visit for counselling, family planning, pregnancy testing, antenatal care, STI treatment or a combination of these services. The voucher did not have to be used by the person who originally received it and could instead be passed on to another adolescent. Adolescents who redeemed their vouchers for services also received a booklet on adolescent health, two condoms as well as any necessary laboratory tests, drugs and contraceptives.

*Continued on next page*

promotion of sexual and reproductive health must often confront sensitive and contentious issues. This is because sexual and reproductive health initiatives often need to challenge social norms, conventions and stereotypes. Sociocultural issues also influence the appropriateness and efficiency of policies and programmes for sexual and reproductive health in different settings.<sup>374</sup> Experience suggests that local ownership and the empowerment of stakeholders is fundamental to the success of development programmes, including sexual and reproductive health initiatives. As such, sociocultural barriers need to be identified and acknowledged as both challenges and opportunities for the realization of sexual and reproductive health.<sup>375</sup>

Approaches to sexual and reproductive health that seek to tackle sociocultural barriers can create tension and conflict with local communities, particularly where efforts aim to change social

norms, social relations and power dynamics in households, communities and societies.<sup>376</sup> Individuals or groups who feel threatened by the intervention may react negatively and hinder activities. However, individuals, communities, their representatives and institutions are the main drivers of change. Thus, to influence social norms to improve the sexual and reproductive health of men and women, strategic alliances need to be forged with these actors to mobilize support and strengthen ownership.

Efforts to tackle sociocultural barriers, such as gender norms and notions of appropriate sexual behaviour for young men and women, must be founded on an understanding and appreciation of local cultures and the differences, conflicts or hierarchies between various actors. To this end, health staff need to listen and learn from communities. Partnerships based on trust and open dialogue can be supportive of positive

*Box 25 (continued)*

The vouchers were redeemable at 20 clinics: four public, five private and 11 run by NGOs. These clinics were selected on the basis of suitability (such as prior experience with sexual and reproductive health) and proximity to the targeted areas. Staff at participating clinics attended a short introduction to the programme and were encouraged to attend training sessions on counselling, adolescent sexuality and sexual abuse. Clinics received reimbursement according to agreed-upon fees. The average price per consultation and follow-up visit was \$4.56.

Of the vouchers distributed, 20% of those issued to girls and 6% of those issued to boys were redeemed. In total, 3067 female adolescents used 3301 vouchers, of which 34% were for family planning, 31% for treatment of RTIs and STIs, 28% for antenatal care, 28% for counselling, 18% for pregnancy testing and 15% for other reasons. The majority of vouchers were redeemed at NGO clinics.

An evaluation of the impact of the pilot programme on female adolescents concluded that, after controlling for different characteristics, the vouchers had significantly increased the use of sexual and reproductive health services, knowledge of contraceptives and knowledge of STIs and prevention with condoms among those who had redeemed vouchers as compared with those who had not. The increase in use of sexual and reproductive health care was most marked among younger female adolescents, those still in school and those with the lowest level of education. In particular, female adolescents who were neither pregnant nor mothers were found to benefit the most from increased access to sexual and reproductive health services.

The results of focus group discussions revealed that the voucher programme had increased the use of sexual and reproductive health services by eliminating out-of-pocket payments for services, removing the need to make an appointment, and informing female adolescents of clinic hours of operation and locations. In addition, the guarantee of confidentiality by a health provider of choice was identified as key in convincing adolescents to seek sexual and reproductive health services.

Sources: Meuwissen *et al.* 2006a, 2006b and 2006c.

change and knowledge-sharing for improved sexual and reproductive health. In particular, it is vital that sexual and reproductive health initiatives avoid language and practices that are judgmental of cultures and social practices. For example, an effective way of engaging with cultural norms and institutions is to make no value judgement on particular cultural practices, while advocating against traditional practices that breach human rights and have negative effects on maternal and child health. One strategy that has proven to be effective is to engage local power structures and faith-based institutions (Box 26). Such organizations are often willing to cooperate on sexual and reproductive health initiatives when they are engaged in a culturally informed and sensitive manner based on relevant evidence and information.<sup>377</sup> As well, these types of interventions often need to be carried out over time, as short-term change may not be unsustainable.<sup>378</sup>

Participatory methods that engage with and respond to the perceptions, views and needs of all community members are often more effective in creating social change than are top-down interventions initiated by organizations or individuals outside the community. Such participatory approaches can be used to determine the sexual and reproductive health needs of communities and to build support for sexual and reproductive health services across diverse stakeholders.

Care needs to be taken, however, to ensure that the voices of all community members are heard. This requires efforts to ensure the inclusion and equal participation of men and women and those from poor or ethnic minority households. Where women are especially disempowered, they may be enabled to speak in focus group discussions held separately from those held with the men. Similarly, it may be better to seek the input of

### Box 26: Partnering with Buddhist monks and nuns to curb the HIV/AIDS epidemic in Cambodia

Most ethnic Cambodians are Theravada Buddhists. While the constitution of Cambodia protects religious freedom, Buddhism is the dominant religion. The Government promotes national Buddhist holidays and provides education, training and other support to monks. Close associations exist between Buddhism, Khmer cultural tradition and daily life in Cambodia. Buddhist traditions are widespread and dynamic in all provinces and have been enjoying a revival following the decades of civil war.

Buddhist monks and the *wat* (spiritual centre) are core components of Buddhism. Each village traditionally has a *wat*, which houses anywhere from five to 70 monks depending upon the local population. About 80% of monks join the monkhood temporarily; boys and young men join for a variety of reasons, ranging from the need for shelter and protection to seeking an education.

Monks occupy high moral status in Cambodian society and often wield great influence. Although monks are expected to remain politically neutral, many have become active in the fight against HIV/AIDS. The Supreme Patriarchs of the two monastic orders spoke of the urgent need to prevent the spread of HIV/AIDS in their discourses during the 1990s. The Supreme Patriarchs have also encouraged monks and nuns to provide services to their communities. Monks and nuns in many parts of the country have become advocates of reducing discrimination against people affected by HIV/AIDS. While monks rarely talk explicitly about sexual issues, they tend to preach precepts, such as value of abstaining from sexual harassment and the virtue of fidelity and chastity.

In response to the influence of Buddhist monks and nuns in Cambodia, UNFPA has sought to forge strategic partnerships to further efforts to curb the HIV/AIDS epidemic and achieve improved reproductive health. According to UNFPA, monks and nuns have been largely involved in four main types of activities: (1) preventing the spread of HIV/AIDS through information and education campaigns inside and outside monasteries; (2) providing care and support to people living with HIV and AIDS; (3) training other monks to handle young people with HIV/AIDS; and (4) eliminating the stigma of HIV/AIDS through preaching the teachings of the Buddha, emphasizing compassion and easing the burdens of those affected by the epidemic. Given the position of monks and nuns in Cambodian society, many other strategic entry points have been identified. For example, efforts to integrate information on HIV/AIDS, reproductive health and gender equality into the Buddhist educational system could reach a large number of boys and young men. Encouraging monks to speak with couples about reproductive health when blessing newly married couples could improve the knowledge of young men and women on reproductive health issues and the threat of HIV/AIDS.

Source: United Nations Population Fund 2004b.

marginalized groups in a forum where powerful members of the community are not present. Box 27 discusses an initiative that used participatory methods to challenge gender norms among young male and female factory workers in Chiang Mai, Thailand.

### *Improving the quality of health services*

In order for the health system to integrate sexual and reproductive health care, health service providers must have the capacity to offer a basic

package of quality services and to refer clients to other service providers as necessary. For example, antenatal and maternal service providers need to be able to care for, or refer, a woman who is HIV positive; health workers providing HIV treatment and care need to be able to diagnose and treat other STIs.<sup>379</sup>

Health service providers require knowledge and skills to provide a range of services to individuals with different needs and who may enter the health system through various points. For example,



### Box 27: Using peer education to challenge gender norms among young male and female factory workers in Chiang Mai, Thailand

With rapid social change in many countries across the Region, women are increasingly engaging in non-traditional forms of employment. Many in Cambodia, China, the Philippines and Viet Nam, among other countries, are leaving their rural homes to work in electronics and garment factories. The demand for female labour in factories is high, and wages and working conditions are perceived as being better than that in other sectors. Women who migrate to urban areas are often far from parents, families and traditional social norms. This detachment can alter perceptions of acceptable male-female behaviour.

A study among young male and female factory workers in Chiang Mai City, Thailand, revealed that social norms in the city associate masculinity with sexual prowess and that men prefer women who are sexually inexperienced. Young men and women agree that it is the responsibility of the woman to prevent pregnancy. With regard to HIV and STI prevention, few men take precautions unless the woman is perceived to be infected, while fear of being perceived as socially undesirable often prevents young women from adopting preventive behaviour. In combination, these social norms may place young men and women at high risk of STIs, including HIV.

In response, a peer education programme was set up to explore how gender roles and social norms influenced sexual behaviour, attitudes, relationships and communication patterns. The initiative aimed to increase awareness among young factory workers (aged 15–25 years) who had never been married. Eighteen peer leaders were trained to facilitate small groups through a variety of activities, including reading comic books and romance novels.

An evaluation of the programme found that peer education increased awareness and reduced risky behaviour among participants. An increased proportion of respondents were able to identify challenges to adopting risk reducing behaviour, such as peer pressure and male promiscuity. Following peer education, 42.3% of participants said that it was acceptable for women to raise the issue of HIV with men, compared to 29.9% before the programme. An increasing number of participants also felt it was appropriate for women to carry condoms. This suggests that both men and women developed an awareness of gender norms and how they influence the practice of safe sex.

Source: Cash *et al.* 1997. In: Boender *et al.* 2004.

voluntary counselling and/or testing for HIV, family planning and RTIs/STIs should be equally accessible to a man who seeks treatment from a STI clinic and a woman who attends an antenatal clinic. Again, as noted above, these services can be housed in a single clinic or linked through an effective referral system. However, when determining which services should be offered under one roof and which should be integrated through a referral system, the social norms and expectations of the target communities need to be considered to ensure that the system responds adequately to their needs.<sup>380</sup> For example, adolescents may not be comfortable seeking care from a clinic that has traditionally offered only antenatal and maternal care. Similarly, women may not be willing to sit in

a waiting room together with men. In these cases, it may be more effective to link these services together through referral networks rather than housing them in a single clinic.

Besides integrating sexual and reproductive health services, the health system needs to be sensitive to how men and women's sexual and reproductive health needs change throughout their lifecycle and to respond with an appropriate range of services. This comprehensive approach requires a different set of skills. It also demands that health providers have information on the health care previously received by a man or woman and the health outcomes. The integration of sexual and reproductive health services over time has crucial

### Box 28: Enhancing the quality of care of reproductive health services in Bangladesh

A reproductive health initiative in Bangladesh was developed to deliver a comprehensive package of reproductive health services in urban and under-served areas, with a special emphasis on quality of care. The main lessons from this project are as follows:

#### *Quality of care increases client satisfaction.*

In Bangladesh, health providers have a reputation for mistreating clients. Traditionally, poor community members were hesitant to visit clean and well-decorated clinics, assuming that the services were not meant for them or would be too expensive. The Government tried to change this perception by introducing reproductive health service protocols and teaching service providers how to treat and communicate with clients. At the same time, clients were educated on the type of care they should expect. Clients were asked to rate the conduct of service providers during exit interviews; most expressed an increase in satisfaction. At the same time, clients were educated in the type of care they should expect.

#### *If possible, adapt existing protocols and guidelines.*

The availability of standard protocols and guidelines for clinical services, which were developed by the Government in collaboration with nongovernmental organizations, saved time and resources. In addition, the adaptation of existing protocols contributed to an internally coherent and homogenous approach to family planning and reproductive health services in Bangladesh.

#### *The process of improving the quality of care is lengthy and should be uninterrupted.*

Improving the quality of care is a labour-intensive process that requires time, effort and motivation. This holds particularly true for behavioural change, which is necessary if a better understanding of the client situation is to be achieved. Service providers need encouragement to see the value in using service protocols and giving time to communicate with clients. Close monitoring and supervision are required, as well as regular refresher training to sustain quality and to compensate for the dropout of service providers.

#### *Quality of care increases client attendance.*

Investing in the quality of care pays off in the end. Improvements in the management of clinics, service-delivery procedures, staff attitudes and behaviour towards clients, as well as cleanliness, led to a substantial increase in clients (between 19% and 48%, depending on the facility, within one year). For example, one of the project hospitals expanded their facilities from 10 beds to 35 beds, introduced blood bank services, and continued to offer reproductive health services, including family planning. As a result, the number of total services rendered increased from 23 861 in 2000 to 35 527 in 2001.

Source: EC/UNFPA 2002.

implications for health information systems, particularly continued maintenance of client records.<sup>381</sup> Box 28 discusses a reproductive health initiative in Bangladesh, which aimed to deliver a comprehensive package of reproductive health services to poor communities.

The manner in which health providers interact with men and women is a core aspect of the overall quality of health services. In addition to the knowledge and skills required to provide a range of services for sexual and reproductive health, training and awareness-building at all

levels of the health system are required to improve the sensitivity and responsiveness of health service providers to the needs of their clients. This is particularly true in the area of sexual and reproductive health because of its sensitive nature in many communities. For example, it is vital that health professionals be aware of and responsive to patients' feelings and concerns and do not belittle them. Demeaning treatment from health workers is a common complaint among women, which deters them from seeking care. In particular, efforts should be made to increase awareness, sensitivity and skills of health service providers

### Box 29: Challenging service providers to explore their attitudes and values regarding post-abortion care in the Philippines

One approach that can improve the sensitivity and responsiveness of service providers to the needs of their men and women clients is for providers to explore and challenge their own values and attitudes. An example of this approach comes from the Philippines, where a programme to improve post-abortion care encouraged service providers to become self-reflective.

An initial situation analysis identified a number of weaknesses in post-abortion care in the Philippines. Post-abortion care clients rarely received routine counselling, referrals to family planning or other reproductive health services. Clients were treated poorly and punitive treatment was common.

In response, EngenderHealth, an international NGO, implemented a programme from 2001 to 2002 that aimed to improve the skills of health providers in post-abortion care. The Prevention and Management of Abortion Complications programme adopted a two-pronged approach. The first aspect consisted of a forum wherein participatory methods were used to enable service providers to explore their attitudes and values concerning post-abortion clients. The second aspect consisted of a technical working group made up of representatives from the Department of Health, academia, doctors, nursing and midwifery associations, NGOs and tertiary hospitals. This working group was tasked to formulate a national work plan for post abortion care.

The programme trained health providers in post-abortion care counselling, family planning counselling, infection prevention and clinical post-abortion skills. As a result, the attitudes of health staff towards post-abortion clinics were found to change significantly; health service providers sought to improve both their behaviour and practice. Providers were more sensitive to and aware of the needs of their clinics. This encouraged them to treat their clients with dignity and respect. Preserving confidentiality and privacy during procedures and counselling became paramount.

Source: EngenderHealth 2003. In: United Nations Population Fund 2004b.

in dealing with marginalized communities, such as ethnic minorities and migrant communities, to ensure that all clients, especially those who are poor, are treated with dignity and respect. For example, in the city of Chengdu, China, the Gay Men's Community Care Organisation works with doctors in local STI clinics to ensure that men who have sex with men are treated with respect and dignity and that their needs are understood.<sup>382</sup>

Health service providers need to be trained to deal with men and women patients as both clients and partners of other clients. This approach, coupled with an understanding of gender issues and communication and power dynamics in sexual relations between partners, can inform effective counselling and interventions with couples. It can also help ensure that women's rights and safety are maintained.<sup>383</sup> Box 29 discusses one approach that has been used to improve the awareness and

sensitivity of health service providers to the needs of their clients.

Sensitivity to the needs of individuals and communities extends beyond the interaction between clients and providers into the space where health services are offered. For example, efforts to incorporate services for unmarried women, adolescents and men into health centres that have traditionally catered to married women, such as maternal and antenatal clinics, often require innovative strategies to ensure responsiveness to the specific needs of each of these groups. Catering to a variety of groups may require separate entrances and waiting rooms or different hours of service to create a sense of privacy and confidentiality. In some cases, separate youth-friendly services may be required (see Box 30).<sup>384</sup> Box 31 describes how to make sexual and reproductive health services "male friendly."

### ***Improving health communication and awareness***

Advocacy or health communication strategies are often used in sexual and reproductive health

#### **Box 30: Strategies to create youth-friendly services**

Young people can face many barriers when seeking to access sexual and reproductive health services. Experience shows that, to make services more accessible to young people, the following strategies can be adopted.

##### **Service providers:**

- Have specially trained staff.
- Show respect for young people.
- Honour privacy and confidentiality.
- Devote adequate time for client–provider interaction.
- Make peer counsellors available.

##### **Health facilities:**

- Set aside separate space or special times.
- Ensure convenient hours and location.
- Provide adequate space and sufficient privacy.
- Have comfortable surroundings.

##### **Program design:**

- Involve youth in design, service outreach and delivery, and continuing feedback.
- Welcome drop-in clients or arrange their appointments rapidly.
- Reduce overcrowding and waiting times.
- Ensure affordable fees.
- Adopt publicity and recruitment that inform and reassure youth.
- Welcome and serve boys and young men.
- Make a wide range of services available.
- Make necessary referrals available.

##### **Other possible characteristics:**

- Ensure availability of educational material.
- Make group discussions available.
- Set timing of pelvic examination and blood tests to meet needs.
- Provide alternative ways to access information, counselling and services.

Source: United Nations Population Fund 2003.

programmes to communicate information strategically, with the aim of changing the perceptions and influencing the decision-making of individuals. Indeed, interventions that encourage the adoption of risk-reducing practices and actions remain a core aspect of sexual and reproductive health promotion. Education and raising awareness are key to improving the health of populations, communities and individuals. Providing information on preventive practices, such as family planning and condom use, and the signs and symptoms of STIs and maternal health, can enable people to make decisions that positively influence their sexual and reproductive health.

Health communication strategies typically focus on creating change at the level of individual or household. With regard to sexual and reproductive health, experience has shown that such strategies

#### **Box 31: Strategies to create male-friendly services**

Experience shows that a number of strategies can contribute to creating sexual and reproductive health services that are responsive to men.

- Use a name for the programme and/or facility that welcomes men and women.
- Decorate the facility in a way that appeals to men and women.
- Designate a male restroom.
- In waiting areas, include reading materials that interest men.
- Make information, education and communication materials readily available to men.
- Make condoms easily available.
- Create an individual medical chart for each man, rather than keeping his medical information in his woman partner's file.
- Provide facility space and time for seeing couples so that men and women can receive counselling together, if desired.
- Create awareness of men's reproductive health in the community. Advertise the availability of men's reproductive health services.
- Adapt clinic hours to meet men's needs.

Source: United Nations Population Fund n.d.

are unlikely to lead to sustained changes in behaviour and perceptions. This is because these approaches may fail to recognize the influence that broad sociocultural elements can have on individuals. To be effective, these strategies need to target the individual and aim to create an environment that supports the advocated social or behavioural change. For example, to promote safe sexual practices, a health communication campaign can be combined with counselling and training on safe sex negotiation among young men and women. A wider advocacy campaign could then address the social norms that work against the adoption of safe sex practices.<sup>385</sup>

Health communication strategies also need to be tailored to the specific characteristics and needs of the intended population group. For example, school-based sex education has been found to improve the knowledge of risk-reduction strategies among youth.<sup>386</sup> Targeting communication strategies to in-school youth, the military, women and farmers, among other groups, requires collaboration between various ministries, including health, education, defence women's affairs and agriculture. The ministry of health should play a leading role in formulating and providing appropriate educational materials. It should also establish and maintain the relationships with other government ministries that are required to implement effective sexual education programmes for multiple groups.<sup>387</sup>

Such health communication materials need to be developed to pique the users' interest and meet their needs. For example, UNFPA explains how HIV- and STI-related materials need to be developed from a men's perspective and that materials that address issues of pleasure, power and security have been found to be particularly effective.<sup>388</sup> Often, community members are a means of disseminating information, as they are trusted and well-versed in the local situation. This approach was harnessed to advocate for vasectomies among men in Kiribati (Box 32).

Health communication and advocacy initiatives that target the general population may not

reach poor households because of generally lower levels of education and lower access to modes of communication, such as television and radio. Numerous factors, including distance, cultural and linguistic barriers, may prevent health communication messages from reaching ethnic minority communities. Communication strategies and messages, therefore, must be tailored to these groups, such as through illustrated messages for those with low literacy levels. When targeting minority groups, culturally appropriate messages delivered in local languages are required. Outreach strategies may likewise be undertaken by health staff or community-based health workers to increase knowledge and

**Box 32: Satisfied men as advocates and community-based promoters for vasectomies in Kiribati**

UNFPA supported a vasectomy project in Kiribati to improve the health of men and women and to enhance male involvement in family planning. The project enlisted the support of men from the target communities who were satisfied with their vasectomies to disseminate information and to encourage men to consider the procedure (instead of female modes of family planning). These men promoted family planning and worked as health personnel. Their advocacy was based on their personal experience, which testified to the simplicity, safety and effectiveness of the method. Mobile family planning teams offered a range of family planning services, including vasectomy, to all outer islands and rural areas.

The efforts of the community advocates were supplemented with health communication materials (pamphlets, posters, videos and calendars). Primary health staff further encouraged men who had had vasectomies to share their experiences in peer meetings, seminars, radio and video programmes and through one-to-one communication. As a result, the number of men who have had vasectomies is greater than the number of sterilized women.

Source: UNFPA Country Support Team in Fiji. In: United Nations Population Fund n.d.

awareness among hard-to-reach groups and low-income settings.

Women may be similarly hard to reach through conventional health promotion campaigns because of lower levels of literacy than men and gender norms that may restrict women's access to mainstream media. Because women tend to gather health-related information from relatives and social networks, interpersonal modes of communication may be more effective than print media, for example. Involving poor individuals and women in the design and implementation of health communication campaigns can ensure that local knowledge, priorities and needs are understood and subsequently addressed. These strategies may likewise ensure that the message and medium of health promotion campaigns are accessible for women.

Young people who have access to accurate information and the opportunity to discuss sexual and reproductive health issues have been found to change their behaviour to reduce their risk of disease.<sup>389</sup> Responsibility for providing adolescents with the information they need to protect their sexual and reproductive health lies with parents and teachers, with the support of the wider community.<sup>390</sup> Peer counselling and other means of involving informed youth in educating other young people have also been found to be successful.

Age-appropriate sexual and reproductive health information can empower youth to make responsible decisions.<sup>391</sup> Some examples of these approaches are as follows:

- The Youth Zone Project in the Philippines provides a safe space for young people to learn about HIV/AIDS through a variety of innovative strategies. It provides services, including medical care, to around 20–25 young people each day, particularly vulnerable groups.
- Peer education was used to promote negotiation skills and safe sex practices among women working in bars in the Lao People's Democratic Republic and

Cambodia. Women working in bars tend to engage in casual commercial sex but do not necessarily identify themselves as sex workers.<sup>392</sup>

### *Monitoring and evaluation and research*

Despite the growing recognition of ongoing and often increasing health inequities both in developing and developed countries, health information systems have, to date, been weak in yielding information needed to assess and address health inequities. The challenges are to determine the information needs for addressing health inequities; to shape health information systems to meet those needs; to promote sensitization to equity issues; and to develop the skills required to use information for effective planning and policy-making.<sup>393</sup>

The Health Metrics Network has begun work on the construction of equity indicators and on creating mechanisms to link records between data sources.<sup>394</sup> Complementary measures to the global Health Metrics Network for sexual and reproductive health can be undertaken at the country level.

At the national level, disaggregated data are required to assess and analyse the extent of inequalities in the determinants of sexual and reproductive ill-health and related morbidity and mortality, as well as to monitor changes in these patterns over time. Likewise, disaggregated data are required to identify priority areas and interventions that will benefit poor individuals and how interventions may differently affect men as compared to women. Table 11 presents an example applying a human rights-based approach to health indicators to the reproductive health strategy endorsed by the World Health Assembly in May 2004.

Data collected routinely within the health system should be disaggregated and analysed by socioeconomic status, gender, urban-rural location, by region or province, by level of educational, occupation, or other indicators of disadvantages identified through a poverty analysis.



Monitoring and evaluation also should consider these variables. These efforts can be supplemented with appropriate research, including qualitative data to assess unmet needs, perceived quality of health care services, and various financial and non-financial barriers that poor men and women may face when accessing sexual and reproductive health services.

**Table 11: Right to health indicators: applying a human rights-based approach to WHO's reproductive health strategy, 2004**

	Structural indicators	
<b>Basic legal context</b>	<p>S1. Has the State ratified the following international treaties recognizing the right to health:</p> <ul style="list-style-type: none"> <li>a. ICESCR? <i>yes/no.</i></li> <li>b. CRC? <i>yes/no.</i></li> <li>c. CEDAW? <i>yes/no.</i></li> <li>d. ICERD? <i>yes/no.</i></li> </ul> <p>S2. Does the State's constitution include the right to health? <i>yes/no.</i></p> <p>S3. Does State legislation expressly recognize the right to health, including sexual and reproductive health rights? <i>yes/no.</i></p>	
<b>Basic financial context</b>	<p>S4. Does the State have a law to ensure <i>universal access</i> to sexual and reproductive health care? <i>yes/no.</i></p>	
<b>National strategy and plan of action</b>	<p>S5. Does the State have a national sexual and reproductive health strategy and plan of action? <i>yes/no.</i></p> <p>S6. Does the strategy and plan of action provide for <i>universal access</i> to sexual and reproductive health care? <i>yes/no.</i></p> <p>S7. Does the strategy and plan of action:</p> <ul style="list-style-type: none"> <li>a. expressly recognize sexual and reproductive health rights? <i>yes/no.</i></li> <li>b. clearly identify: <ul style="list-style-type: none"> <li>i. objectives? <i>yes/no.</i></li> <li>ii. time frames? <i>yes/no.</i></li> <li>iii. duty holders and their responsibilities? <i>yes/no.</i></li> <li>iv. reporting procedures? <i>yes/no.</i></li> </ul> </li> <li>c. specifically include measures to benefit vulnerable groups? <i>yes/no.</i></li> </ul>	
<b>Participation</b>	<p>S8. Does the strategy and plan of action establish a procedure for the State to regularly consult with a wide range of representatives of the following groups when formulating, implementing and monitoring sexual and reproductive health policy:</p> <ul style="list-style-type: none"> <li>a. nongovernmental organizations? <i>yes/no.</i></li> <li>b. health professional organizations? <i>yes/no.</i></li> <li>c. local governments? <i>yes/no.</i></li> <li>d. community leaders? <i>yes/no.</i></li> <li>e. vulnerable groups? <i>yes/no.</i></li> <li>f. private sector? <i>yes/no.</i></li> </ul>	
<b>Information</b>	<p>S9. Does State law protect the right to seek, receive and impart information on sexual and reproductive health? <i>yes/no.</i></p> <p>S10. Does the State have a strategy and plan of action to disseminate information on sexual and reproductive health to the public? <i>yes/no.</i></p> <p>S11. Does the strategy and plan of action establish a procedure for the State to regularly disseminate information on its sexual and reproductive health policies to:</p> <ul style="list-style-type: none"> <li>a. nongovernmental organizations? <i>yes/no.</i></li> <li>b. health professional organizations? <i>yes/no.</i></li> <li>c. local governments? <i>yes/no.</i></li> <li>d. media accessible in rural areas? <i>yes/no.</i></li> </ul> <p>S12. Does State law protect the confidentiality of personal health information?</p> <p>S13. Does State law require informed consent of the individual to accept or refuse treatment?</p>	

Process indicators	Outcome indicators
<p>P1. Number of reports the State has submitted to the treaty-based bodies monitoring the following treaties:</p> <ul style="list-style-type: none"> <li>a. ICESCR</li> <li>b. CRC</li> <li>c. CEDAW</li> <li>d. ICERD</li> </ul> <p>P2. Number of national judicial decisions that considered sexual and reproductive health rights in the last five years</p>	
<p>P3. Percentage of government budget allocated to health</p> <p>P4. Percentage of government <i>health budget</i> allocated to sexual and reproductive health</p> <p>P5. Percentage of government <i>health expenditure</i> directed to sexual and reproductive health</p> <p>P6. Per capita <i>expenditure</i> on sexual and reproductive health</p>	
<p>P7. Does the State collect data adequate to evaluate performance under the strategy and plan of action, particularly in relation to vulnerable groups? <i>yes/no.</i></p>	
<p>P8. Does the State regularly consult with a wide range of representatives of the following groups when formulating, implementing and monitoring sexual and reproductive health policy:</p> <ul style="list-style-type: none"> <li>a. nongovernmental organizations? <i>yes/no.</i></li> <li>b. health professional organizations? <i>yes/no.</i></li> <li>c. local governments? <i>yes/no.</i></li> <li>d. community leaders? <i>yes/no.</i></li> <li>e. vulnerable groups? <i>yes/no.</i></li> <li>f. private sector? <i>yes/no.</i></li> </ul>	
<p>P9. Percentage of people exposed to information on:</p> <ul style="list-style-type: none"> <li>a. maternal and newborn care</li> <li>b. family planning services</li> <li>c. abortion and post-abortion care</li> <li>d. prevention and treatment of sexually transmitted infections</li> <li>e. prevention and treatment of cervical cancer and other gynaecological morbidities</li> </ul> <p>P10. Does the State regularly disseminate information on its sexual and reproductive health policies to:</p> <ul style="list-style-type: none"> <li>a. nongovernmental organizations? <i>yes/no.</i></li> <li>b. health professional organizations? <i>yes/no.</i></li> <li>c. local governments? <i>yes/no.</i></li> </ul>	<p>O1. Percentage of women who know about contraceptive methods traditional or modern. <i>disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.</i></p> <p>O2. Percentage of people 15–24 years old who know how to prevent HIV infection <i>disaggregated at least by sex, race, ethnicity, socioeconomic status and rural/urban.</i></p> <p>O3. Percentage of people who believe that personal information disclosed to health professionals remains confidential <i>disaggregated at least by age, sex, race, ethnicity, socioeconomic status and rural/urban.</i></p>

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Table 11 (continued)

Structural indicators		
National human rights institutions	S14.	Does the State have a national human rights institution with a mandate that includes sexual and reproductive health rights? <i>yes/no.</i>
International assistance and cooperation these indicators are for donors.	S15.	Is the State's overseas development assistance policy rights-based? <i>yes/no.</i>
	S16.	Does the State's overseas development policy include specific provisions to promote and protect sexual and reproductive health rights? <i>yes/no.</i>
Priority Aspect 1: Improving antenatal, delivery, post-partum and newborn care	S17.	Does the State have a strategy and plan of action:
		a. to reduce maternal deaths and their causes? <i>yes/no.</i> b. to ensure a universal system of referral for obstetric emergencies? <i>yes/no.</i> c. for access to care, treatment and support for HIV-infected pregnant women? <i>yes/no.</i>
Priority Aspect 2: Delivering high-quality services for family planning	S18.	Does State law:
		a. require third-party authorization for women to receive family planning services? <i>yes/no.</i> b. specify that only married women may receive family planning services? <i>yes/no.</i>
	S19.	Does the national essential medicines list include:
		a. condoms? <i>yes/no.</i> b. hormonal contraceptives, including emergency contraceptives? <i>yes/no.</i>

Process indicators	Outcome indicators
<p>d. media accessible in rural areas? <i>yes/no</i>.</p> <p>P11. Percentage of health facilities with protocols on the confidentiality of personal health information</p> <p>P12. Percentage of health professionals who have received training on:</p> <p>a. the confidentiality of personal health information</p> <p>b. the requirement of informed consent to accept or refuse treatment</p>	
<p>P13. Number of the following activities the institution has run on sexual and reproductive health rights in the last five years:</p> <p>a. training programmes</p> <p>b. public campaigns</p> <p>P14. Number of complaints concerning sexual and reproductive health rights the institution has considered in the last five years</p>	
<p>P15. Percentage of overseas development assistance directed to sexual and reproductive health</p> <p>P16. Do the State's reports to the human rights treaty-based bodies include a detailed account of the international assistance and cooperation it is providing, including in relation to sexual and reproductive health? <i>yes/no/not applicable</i>.</p> <p>P17. Does the State provide a country-specific annual report of its international assistance and cooperation, including in relation to sexual and reproductive health:</p> <p>a. to the government of the recipient country? <i>yes/no</i>.</p> <p>b. to the public of the recipient country? <i>yes/no</i>.</p>	
<p>P18. Number of facilities per 500 000 population providing:</p> <p>a. basic obstetric care</p> <p>b. comprehensive obstetric care</p> <p>P19. Percentage of births attended by skilled health personnel* <i>disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban</i>.</p> <p>P20. Percentage of pregnant women counselled and tested for HIV/AIDS <i>disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban</i>.</p> <p>P21. Percentage of pregnant women screened for syphilis <i>disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban</i>.</p>	<p>O4. Percentage of women with <i>access</i> to antenatal, delivery, post-partum and newborn care <i>disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban</i>.</p> <p>O5. Maternal mortality ratio number of maternal deaths per 100 000 live births.* <i>disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban</i>.</p> <p>O6. HIV prevalence among pregnant women who are 15–24 years old* <i>disaggregated at least by race, ethnicity, socioeconomic status and rural/urban</i>.</p> <p>O7. Syphilis prevalence among pregnant women who are 15–24 years old <i>disaggregated at least by race, ethnicity, socioeconomic status and rural/urban</i>.</p> <p>O8. Neonatal mortality rate number of infant deaths within one month of birth per 1000 live births. <i>disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban</i>.</p>
<p>P22. Percentage of primary health care facilities providing comprehensive family planning services full range of contraceptive information, counselling and supplies for at least six methods, including male and female, temporary, permanent and emergency contraception.</p>	<p>O9. Percentage of people with <i>access</i> to comprehensive family planning services <i>disaggregated at least by age, sex, race, ethnicity, socioeconomic status and rural/urban</i>.</p> <p>O10. Percentage of women at risk of pregnancy who are using or whose partner is using, a contraceptive</p>

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Table 11 (continued)

Structural indicators		
<b>Priority Aspect 3: Eliminating unsafe abortion</b>	S20.	Does State law allow abortion: a. on request? <i>yes/no</i> . b. for economic or social reasons? <i>yes/no</i> . c. for the physical and/or mental health of the woman? <i>yes/no</i> . d. to save the life of the woman? <i>yes/no</i> . e. for cases of rape or incest? <i>yes/no</i> . f. for foetal impairment? <i>yes/no</i> . g. in no circumstances? <i>yes/no</i> .
	S21.	Does State law criminalize abortion? <i>yes/no</i> .
	S22.	Does the State have a strategy and plan of action to: a. prevent unsafe abortion? <i>yes/no</i> . b. provide post-abortion care? <i>yes/no</i> .
	S23.	Does the State have a strategy and/or plan of action: a. to prevent sexually transmitted infections, including HIV? <i>yes/no</i> . b. to treat sexually transmitted infections? <i>yes/no</i> . c. to make antiretroviral treatment available for people living with HIV? <i>yes/no</i> . d. to prevent cervical cancer? <i>yes/no</i> .
	S24.	Does State law require comprehensive sexual health education during the compulsory school years? <i>yes/no</i> .
<b>Priority Aspect 4: Combating sexually transmitted infections, cervical cancer and other gynaecological morbidities</b>	S25.	Does the State have a strategy and/or plan of action to promote adolescent sexual and reproductive health? <i>yes/no</i> .
	S26.	Does State law prohibit sexual violence, including marital rape? <i>yes/no</i> .
	S27.	Does State law prohibit female genital mutilation and other harmful traditional practices? <i>yes/no</i> .
	S28.	Does State law prohibit marriage for both men and women prior to age 18? <i>yes/no</i> .
	S29.	Does State law require full and free consent of the parties to a marriage? <i>yes/no</i> .
<b>Priority Aspect 5: Promoting sexual health including for adolescents</b>	S24.	Does State law require comprehensive sexual health education during the compulsory school years? <i>yes/no</i> .
	S25.	Does the State have a strategy and/or plan of action to promote adolescent sexual and reproductive health? <i>yes/no</i> .
	S26.	Does State law prohibit sexual violence, including marital rape? <i>yes/no</i> .
	S27.	Does State law prohibit female genital mutilation and other harmful traditional practices? <i>yes/no</i> .
	S28.	Does State law prohibit marriage for both men and women prior to age 18? <i>yes/no</i> .
	S29.	Does State law require full and free consent of the parties to a marriage? <i>yes/no</i> .

CEDAW = Convention on the Elimination of All Forms of Discrimination Against Women; CRC = United Nations Convention on the Rights of the Child; ICERD = International Convention on the Elimination of All Forms of Racial Discrimination; ICESCR = International Covenant on Economic, Social and Cultural Rights

\* Indicates a Millennium Development Goal indicator

Note: This illustration was developed by Prof Paul Hunt, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, in his report to the Sixty-second session of the Commission on Human Rights in March 2006.



Process indicators	Outcome indicators
	method all methods.* <i>disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.</i>
P23. Percentage of service delivery points providing abortion and/or post-abortion care	O11. Percentage of women at risk of pregnancy who desire to avoid pregnancy, but who are not using and whose partner is not using, a contraceptive method <i>disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.</i>
P24. Percentage of practitioners trained in abortion and/or post-abortion care	O12. Percentage of women with <i>access</i> to abortion and/or post-abortion care <i>disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.</i>
	O13. Abortion rate number of abortions per 1000 women of reproductive age. <i>disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.</i>
	O14. Percentage of maternal deaths attributed to unsafe abortion <i>disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.</i>
P25. Number of condoms available for distribution nationwide during the preceding 12 months. per population aged 15–49 years	O15. Percentage of people with <i>access</i> to: a. health care for sexually transmitted infections b. preventative care for cervical cancer and other gynaecological morbidities <i>disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.</i>
P26. Percentage of family planning service delivery points offering counselling on dual protection from sexually transmitted infections including HIV and unwanted pregnancies	O16. Percentage of people with self-reported or diagnosed symptoms of sexually transmitted infections, classified by condition <i>disaggregated at least by age, sex, race, ethnicity, socioeconomic status and rural/urban.</i>
P27. Percentage of women screened for cervical cancer within the past five years <i>disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.</i>	O17. HIV prevalence in subpopulations with high-risk behaviour <i>disaggregated at least by age, sex, race, ethnicity, socioeconomic status and rural/urban.</i>
	O18. Percentage of women with cervical cancer <i>disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.</i>
P28. Percentage of people 15–19 years old who have received comprehensive sexual health education in school <i>disaggregated at least by sex, race, ethnicity, socioeconomic status and rural/urban.</i>	O19. Percentage of 15–19 year olds who know how to prevent HIV infection
P29. Number of incidents of sexual violence, including marital rape, reported to law enforcement and/or health professionals in the past five years	O20. Age-specific fertility rate 15–19 and 20–24 year olds. <i>disaggregated at least by race, ethnicity, socioeconomic status and rural/urban.</i>
	O21. Age at marriage <i>disaggregated at least by sex, race, ethnicity, socioeconomic status and rural/urban.</i>
	O22. Percentage of women who have undergone female genital mutilation – <i>disaggregated at least by sex, race, ethnicity, socioeconomic status and rural/urban.</i>

## 5. Facilitator's notes



## 5. Facilitator's notes

These notes are provided to support facilitators as they work with learners on integrating poverty and gender issues into specific health topics. Facilitators are recommended to refer to Section 5 of the foundational modules of this Sourcebook, dealing respectively with poverty and gender, which contain additional notes on the target audience, role of the facilitator and suggested methodologies for learning sessions and evaluation.

The learning sessions and exercises that follow are practical and oriented toward “active learning.” That is, they are designed to promote group discussion and presentation in analysing sexual and reproductive health in terms of gender and poverty. The time required for all learning sessions is approximately eight hours.

### Expected learning outcomes

Upon completion of this module, participants will be able to:

- demonstrate an understanding of sexual and reproductive health and rights, including measurement challenges and the global burden of mortality and morbidity related to sexual and reproductive health;
- demonstrate an understanding of WHAT the links are between poverty, gender and sexual and reproductive health;
- explain WHY it is important for health professionals to address poverty and gender concerns in sexual and reproductive health;
- indicate HOW health professionals and the health system as a whole can address poverty and gender in sexual and reproductive health programme; and
- demonstrate familiarity with some tools, resources and references available to support health professionals in dealing with poverty and gender in sexual and reproductive health.

### Lesson plans

#### *Session 1: Exploring beliefs, values and prejudices in reproductive and sexual health*

**Objective:** To promote exploration of participant's

beliefs, values, assumptions and prejudices related to sexual and reproductive health

**Time allotted:** 90 minutes

**Materials:** flip charts, markers and masking tape

**Pre-reading:** Sections 1 and 2

*Activity 1: Recognizing one's own beliefs, values, assumptions and biases in providing sexual and reproductive health services*

Before the group convenes, write the following statements on a flip chart. Leave about an 18-inch gap between each statement where you can write the group's responses. The intention here is to unearth and examine the differing perspectives, opinions and prejudices that are present within any group of people. The statements are:

Prostitutes are\_\_\_\_\_.

Poor women who have many children are \_\_\_\_\_.

Women who obey their husbands are\_\_\_\_.

People who abuse drugs and alcohol are \_\_\_\_\_.

Women who leave their children to go to work are\_\_\_\_\_.

Men who attend antenatal care with their wives are \_\_\_\_\_.

Girls who gets pregnant while unmarried are\_\_\_\_\_.

Women from differing ethnic groups who have large families are\_\_\_\_\_.

Government officials who say that reproductive health cannot be provided for all, especially those who cannot pay are\_\_\_\_\_.

Ask each participant to write their answers on a piece of paper. In pairs, ask participants to share and discuss their completed statements with one another. Then, read each statement out loud and ask the paired participants to share their responses, if they wish. Try to engage the quieter members of the group. Ask participants to listen respectfully to the differing points of view presented. Write the responses under each statement. Continue to do this until the group has commented on each statement. Try to bring out the quieter members of the group. Ask the group if there are differing opinions. At this time, do not ask the group to debate their remarks. Just write each response down. Remove the completed pages from the flip chart and fasten them on the walls of the room.

Once the responses to each statement have been written on the flip chart, invite the participants to express how they are feeling about the exercise. Explain to the group that these differing opinions, biases and judgements exist in every health care setting. It is important to unearth these opinions and to let others hear them. Strong feelings may emerge; the aim is to provide a safe environment in which such discussions can be undertaken in a respectful manner. Allow the feelings to be explored, so as to raise participants' awareness of the impact of their beliefs, values, assumptions and biases on the provision of sexual and reproductive health services. In this way, some of the challenges in providing gender and poverty sensitive reproductive health care can be examined.

#### *Activity 2: Brainstorming: taking action*

This exercise intends to help participants move from 'issues' to 'action'. Ask the group to shout out strategies they might consider in providing accessible and respectful reproductive and sexual health programmes to persons from differing age, gender, socioeconomic, ethnic and cultural backgrounds. You might wish to ask the following questions to prompt the group.

- What are the barriers to effective and respectful sexual and reproductive health services?
- How can those barriers be overcome?
- What do you consider to be the most

difficult barrier to overcome?

- What would have to be in place to overcome this barrier?
- What issues would you need to take into consideration in planning and developing a sexual and reproductive health service?
- What can you do as health practitioners to provide respectful and effective reproductive and sexual health services, particularly for vulnerable population groups?

**Note to the facilitator:** The intent of this final brainstorming session is to provide an opportunity for participants to move from their personal beliefs, values and biases to considering strategies for action to provide respectful reproductive and sexual health services.

#### *Session 2: Educating the public*

**Objective:** To develop sexual and reproductive health educational materials for different groups of clients

**Materials:** flip chart paper for each group and coloured markers and/or pencils

**Time allotted:** 70 minutes

**Pre-reading:** Sections 1 and 2

Explain to the group that they will be creating educational materials for a variety of target audiences. These educational materials can include posters, pamphlets, advertisements, collages or any other visual information for the general public.

Divide participants into groups of four or five. Encourage them to work with people they have not worked with before. Provide each group with one of the following educational topics:

1. You have been asked to develop an advertising campaign to encourage adolescents to attend a sexual and reproductive health centre.

**Note to the facilitator:** The issues that should be highlighted include: youth friendly

advertisements, social marketing to youth, geared to the literacy level of the youth.

2. You have been asked to create educational material to help women understand how sexually transmitted infections are transmitted and how they can be prevented. Many of these women are semi-literate.

**Note to the facilitator:** The issues that should be highlighted include: focus on material that is acceptable and accessible to semi-literate women, attention to sensitivity of subject matter, ensuring that materials are culturally acceptable to the women and that the diagrams and drawings will be easily understood.

3. Management is promoting the involvement of men in your reproductive and sexual health programme. You have been asked to create a poster or other visual aid to encourage men's involvement.

**Note to the facilitator:** The issues that should be highlighted include: acceptability to men, social marketing that attracts men and sensitivity to cultural norms and practices.

4. You have been asked to develop educational material to help people in your community understand the value of family planning.

**Note to the facilitator:** The issues that should be highlighted include: acceptability to women and men, social marketing that attracts women and men, sensitivity to cultural norms and practices, clear messages about the value of family planning and the involvement of both women and men.

5. You have been asked to develop educational material on gender-based violence. Many of the women who live in your community are semi-literate.

**Note to the facilitator:** Highlight methods of challenging views and attitudes about

gender-based violence, by using, for example: statistical evidence in picture form of the incidence of gender-based violence in the country or community; drawings that illustrate the different forms of violence against women; safe places for women to go; NGOs active in addressing gender-based violence; and, emergency numbers of police and health facilities.

6. During a recent reproductive health survey, it was noted that teenage pregnancies had risen sharply. You have been asked to develop educational materials to raise awareness of this problem and to develop some prevention messages.

**Note to the facilitator:** The issues that should be highlighted include: statistics of teenage pregnancies, reasons for increase in teenage pregnancies, cultural and social pressures for teenagers to engage in unprotected sexual intercourse, methods of contraception and places where teenage girls would be welcome for contraceptive and sexual counselling, education and services.

Give each group flip chart paper, coloured markers and/or pencils. Ask them to draw, write or consider other creative methods of providing effective messages to these target groups of people.

### Presentation of educational materials

As the groups are working on their educational materials, write the following questions on a flip chart at the front of the group.

- What is the main message you are trying to portray?
- Why do you consider this to be the most important message?
- What issues did you consider as you thought about reaching this target group?
- If you were asked to develop other educational materials (of any kind), what other methods would you like to include?
- Why do you think these methods would be particularly useful?

Ask each group to present their educational materials. A nominated spokesperson should lead the presentation; however, other group members should be encouraged to participate. Special attention should be given to the questions written on the flip chart.

This activity is intended to help participants come up with creative ways to reach target groups, justify their choices, and consider the appropriateness of the educational material.

***Session 3: Role-play: overcoming barriers hindering access to sexual and reproductive health services***

**Objective:** To explore ways of addressing barriers impacting access to sexual and reproductive health services

**Expected learning outcome:** Through role-play, participants will actively engage in overcoming barriers that may hinder client access to sexual and reproductive health services.

**Time:** 65 minutes

**Pre-reading:** Sections 1, 2 and 3

Divide participants into three large groups. Explain to the participants that role-play activities provide a safe environment within which to practise methods of addressing barriers to sexual and reproductive health services. Each group will role-play one of the following scenarios:

- **Scenario 1:** A client who is a known woman sex worker enters a health clinic in an impoverished, urban community and asks for a pregnancy test. You have treated this woman before for an STI and have been encouraging her to have an HIV test. She appears to be distraught about the pregnancy and abortion is illegal in your country.

**Note to the facilitator:** The issues that should be highlighted in this role-play

include: poverty, marginalized women, health concerns (STI and HIV/AIDS), and access to abortion.

- **Scenario 2:** A 15-year-old girl comes to a health centre and asks to talk to a nurse. She explains that she is to marry in three weeks and that she is afraid.

**Note to the facilitator:** The issues that should be highlighted in this role-play include: immaturity, coercion, powerlessness of young women, cultural norms and ignorance of sexual and reproductive health.

- **Scenario 3:** A husband comes to a family planning clinic with his wife. He explains that he wants to know what the health workers have been telling his wife, as he is insistent that they not use family planning methods of any kind.

**Note to the facilitator:** The issues that should be highlighted in this role-play include: male dominance, women's lack of power and control, male control over contraception and birth spacing, overcoming access barriers.

- **Scenario 4:** A woman from a remote area arrives at a health centre in town after having ridden on a bus for two hours to seek care. She complains of pain in her abdomen and difficulty passing urine.

**Note to the facilitator:** The issues that should be highlighted in this role-play include: problems of accessibility in rural health, delayed access to health services and possible complications due to difficulty in health-seeking practices, as well as methods of overcoming health service access barriers.

- **Scenario 5:** Two young boys come to an evening sexual health clinic. They are laughing and joking with one another. When the health care worker asks how the young boys can be helped, they look embarrassed



and say that perhaps they do not need any help after all. They prepare to leave.

**Note to the facilitator:** The issues that should be highlighted in this role-play include: improving access to sexual and reproductive health services for young men, cultural bias against acknowledging adolescent sexuality and respect for young people in adolescent health services.

Read these case scenarios out to the whole group. Allow each group to choose one of the scenarios, ensuring that two groups do not choose the same scenario. Ask the groups to select two or three volunteers to act out the situation. One volunteer will role-play the health care professional; the other(s) will act as the client(s). For each role-play, the actors should go beyond the given scenario. That is, each group should further develop the scenario.

Volunteers should practise their role-plays for about 15 minutes and then receive feedback from their groups. Volunteers should not be given too much time to practise as this usually makes them nervous.

Bring the participants back together. Ask one group to read the scenario and then to role-play the situation, including their creative additions to situation. The role-play should take about seven minutes.

After each role-play, congratulate the volunteers and then ask the following questions of the entire group:

- What were the important issues that the actors brought out?
- How did you think the actors overcame access barriers to provide helpful support, advice and/or treatment?
- What did you think was most helpful in this role-play situation? Why?
- What might you have done differently? Why?
- How might this role-play influence how you practise health service delivery in the future. Why?

Debriefing should take about 10 minutes for each group. It is important that all participants fully engage in the debriefing session. Ask participants to imagine themselves in each situation and to consider how they would work with the client(s). The intention is to help each participant consider how she/he would use “good practices” to address access barriers, and why they think such practices are “good”. Encourage participants, even reluctant ones, to critique the role-play of others. Explain that critiquing is a way to explore different options and approaches within a safe environment.

Repeat this exercise two more times until each group has performed a role-play and the others have had an opportunity to critique their “practice.”

#### ***Session 4: Submission to the Commission on Health Care Reform***

**Objective:** To develop strategies to influence political decision-making

**Time allotted:** 80 minutes

**Pre-reading:** Sections 1, 2, 3 and 4

*Setting the activity*

**Time allotted:** 20 minutes

Explain to the participants that they have been asked to present a submission to a government commission that is touring the country. The commission is listening proposals from health professionals to determine which services and programmes should be universally accessible in the country’s new health reform agenda.

Instruct participants to develop a seven minute verbal presentation that will convince the commission that sexual and reproductive health care should be a core programme in the country’s new health care system. Stress that the commission will be hearing from many special interest groups, so their submission has to be very persuasive,

because not all health programmes can become core programmes in the reformed health care system.

Divide participants into groups of six to eight participants, some of which have not worked together before. Each group is to prepare a submission. It is likely that groups will prepare fairly similar submissions; however, the intent is to see how each group presents its submission and where they put particular emphasis. You might want to pose the following questions to help the groups consider their submissions.

- What are some of the most persuasive ways of getting your points across?
- What issues do you consider the most important and therefore need to emphasize?
- How would you prioritize these issues?
- How would you organize your submission to provide organized flow with maximum impact?
- What would be your opening and closing remarks?
- What lasting impressions would you want to leave the commission members?

Give the participants 20 minutes to prepare their submission. They should access information from the pre-readings required for this learning activity.

**Note to the facilitator:** Explain to the participants that the commission's chairperson (you, as facilitator) will cut off the presenters if they go beyond their seven minute time allocation. If the participants were ever required to present to a real committee, it is very likely that they would be cut off if they went overtime. At the end of each submission the commissioners (the rest of the group) will have five minutes to ask questions of the group submitting the presentation. Make sure you set a stage that is quite formal. Such formality will mirror the reality of the atmosphere that usually pervades such submission presentations. In this way, participants have an opportunity to experience the formality that usually surrounds presenting submissions to a powerful commission.

### Presenting the submission and question time

Ask each group to choose a spokesperson to present the submission to the commission. The rest of the participants will act as commissioners and should take notes during the presentations. Following each seven-minute presentation (remember to be strict on this time frame), the "commissioners" should pose probing questions to the presenter and his or her group. Remind the group that the commission has to choose core health care programmes from a wide and disparate selection of programmes and services, and that each special interest group will be presenting submissions. For that reason, the commissioners will have to ask questions that will lead them to make the right choices for the country's reformed health care system. As such, the responses to the commission's probing questions will be as important as the submission itself. The overall intent is for participants to experience the political process that is often used to allocate resources and determine core programmes. They will experience this process by acting as activists and advocates in promoting sexual and reproductive health as a core health care programme.

### Debriefing

After the groups have presented their submissions and the questions posed by the commissioners have been answered, gather the entire group for a debriefing session. You may wish to use the following questions (or some of your own) as a guide:

- What has been your overall experience with this learning activity?
- What stands out for you most?
- What did you like most about the way the presentations were conducted?
- What did you learn from the questions that were posed by the commissioners?
- What would you have done differently now that you have experienced being both a presenter and a commissioner?
- What overall lesson will you take with you into your work as a health care practitioner?

## 6. Tools, resources and references



## 6. Tools, resources and references

### Tools

**Table 12: Integrating gender and poverty into quality assurance programmes**

Indicator	Yes	No	Plans for action and timeline
<b>Institutional policies and practices</b>			
Do agency policies that prohibit gender-based discrimination exist?			
Do agency policies that prohibit the abuse of power and sexual harassment in the institution exist?			
Do policies and procedures to ensure gender-based equity in the promotion of staff exist?			
Do mechanisms that prohibit spousal consent exist?			
Is there a declaration in the institution's mission that promotes women's empowerment?			
<b>Provider practices</b>			
Do staff address clients by their name?			
Are records kept of consultations and counselling where staff explored sexual and reproductive health?			
If records are kept, based on the total client load, do the records indicate that most clients receive such consultations?			
Are consultations geared to the client's educational level? Are pictures and diagrams used, for example?			
Do staff provide details on treatment to clients?			
Do staff have adequate time to conduct a consultation?			
Do staff provide time for clients to ask questions and express concerns?			
Do staff explain procedures undertaken on clients?			
Do staff know the agency's mission?			
<b>Convenience to client</b>			
Are the agency hours convenient to clients?			
Is child care provided at the agency?			
<b>Client satisfaction</b>			
Does the agency have methods to collect data on client satisfaction?			
Does the agency have policies to ensure client confidentiality and privacy?			
If yes, is this policy upheld?			
Is the waiting area large enough to accommodate all of the clients?			
Is the waiting area inviting to clients?			
Do clients report feeling comfortable asking questions and clarifying doubts?			
Do clients report sufficient time with staff?			
<b>Client accessibility</b>			
Are all clients able to access the agency, regardless of their ability to pay?			

*Continued on next page*

Table 12 (continued)

Indicator	Yes	No	Plans for action and timeline
Is there a waiver system for people who cannot afford the services?			
Can clients reach the agency, i.e. without transportation difficulties?			
Are people who are vulnerable or marginalized because of race, age, gender, economic status or living arrangements able to access the services?			
<b>Use of gender-sensitive language</b>			
Do staff use non-discriminatory language?			
Do staff use inclusive language?			
<b>Health communication</b>			
Do communication materials on sexual and reproductive rights (including women's rights) exist?			
If yes, are they readily available for clients?			
Do materials on sexual and reproductive health issues exist?			
If yes, are these materials easily understood by clients, regardless of their level of education?			
Do other forms of information exist, e.g. videos, posters, group education sessions, peer education, use of various media?			
<b>Monitoring and evaluation</b>			
Is staff performance monitored?			
Do staff have periodic evaluations?			
Is the overall function of the agency evaluated by clients and staff?			
Do mechanisms exist to make programmatic changes based on the information gathered from clients and staff?			

Adapted from Cardich R. *et al. Manual to evaluate quality of care from a gender perspective*. International Planned Parenthood Federation, Western Hemisphere Region, 2000.

### Box 33: Gender sensitivity checklist for programme implementation

Does your programme ...

**Yes No**

- ☐ ☐ provide child care for participants during programme activities?
- ☐ ☐ provide transportation for participants in an effort to encourage attendance?
- ☐ ☐ occur at a time and place that are convenient to all participants, especially women and girls?
- ☐ ☐ encourage community members, especially women and girls, to participate in peer education (e.g. leading segments of the workshop discussions, demonstrating condom use)?
- ☐ ☐ encourage people living with HIV/AIDS, especially women and girls, to participate in programme implementation?
- ☐ ☐ provide access to information about HIV/AIDS to all participants equally?
- ☐ ☐ encourage discussion about socially assigned gender roles affecting women, men, adolescents and elderly?
- ☐ ☐ enable women and men, and girls and boys to understand one another's needs?
- ☐ ☐ attempt to ensure that women and men, and girls and boys are listening to the needs of one another (have participants represent one another in role-play, have participants summarize and repeat the issues raised in discussion, etc.)?

*Continued on next page*

*Box 33 (continued)***Yes No**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | encourage discussion of the various social factors, such as economics, political and social structure that put women or men more at risk for HIV/AIDS?   |
| <input type="checkbox"/> | <input type="checkbox"/> | encourage discussion of how gender inequality affects HIV/AIDS prevention, transmission, treatment and care?   |
| <input type="checkbox"/> | <input type="checkbox"/> | address the financial difficulties brought on by HIV/AIDS, which often disproportionately affect women and girls (e.g. laws that do not allow women to inherit land from their husbands, the need for widows to seek out new forms of income to support their families, the burden of health care costs that often become the responsibility of women) |
| <input type="checkbox"/> | <input type="checkbox"/> | encourage discussion of the power imbalances between women and men, and between girls and boys, and how these imbalances affect the transmission and prevention of HIV/AIDS (e.g. the difficulties women face in insisting that their partners use condoms, the ability to choose when and with whom to have sex, etc.)                                |
| <input type="checkbox"/> | <input type="checkbox"/> | encourage discussion of how empowerment of women and girls could help lessen their vulnerability to HIV/AIDS? (It is crucial to include men and boys in this discussion so they can support their wives, sisters and mothers as opposed to becoming threatened by their empowerment.)  |
| <input type="checkbox"/> | <input type="checkbox"/> | work to eliminate the power imbalances between women and men and between girls and boys?   |
| <input type="checkbox"/> | <input type="checkbox"/> | address the issue of violence against women and girls?   |
| <input type="checkbox"/> | <input type="checkbox"/> | provide opportunities for women and girls to become empowered through HIV/AIDS education (e.g. enhance the self-confidence of women and girls by encouraging them to attain new skills, take on more responsibilities as desired, become local leaders in health promotion)?   |
| <input type="checkbox"/> | <input type="checkbox"/> | encourage and acknowledge the support that women and girls can provide to one another?   |
| <input type="checkbox"/> | <input type="checkbox"/> | address the double standard that exists between women and men in relation to sexual activity (e.g. men being allowed to engage in sex outside of marriage while women are not, men being expected to have sexual experience before marriage while women are not)?  |
| <input type="checkbox"/> | <input type="checkbox"/> | address the issue of sexual abuse (e.g. rape, incest)?   |
| <input type="checkbox"/> | <input type="checkbox"/> | address adolescent sexuality and the effect it may have on HIV/AIDS?   |
| <input type="checkbox"/> | <input type="checkbox"/> | address the issue of equal access to education for boys and girls?   |
| <input type="checkbox"/> | <input type="checkbox"/> | address the reproductive and sexual health needs of children and adolescents?  |
| <input type="checkbox"/> | <input type="checkbox"/> | facilitate awareness in adults of the reproductive health needs of children and adolescents?   |
| <input type="checkbox"/> | <input type="checkbox"/> | encourage adults to address the reproductive and sexual health needs of children and adolescents?  |
| <input type="checkbox"/> | <input type="checkbox"/> | provide demonstrations to all participants on how to use both male and female condoms and encourage all participants to practise their use?  |
| <input type="checkbox"/> | <input type="checkbox"/> | encourage discussion about the possible difficulties associated with condom use experienced by both women and men?   |
| <input type="checkbox"/> | <input type="checkbox"/> | address how HIV/AIDS affects how women and men make reproductive choices?  |
| <input type="checkbox"/> | <input type="checkbox"/> | encourage the involvement of both women and men in family planning?  |
| <input type="checkbox"/> | <input type="checkbox"/> | address how to avoid HIV transmission from mother to child (both before and after birth)?  |
| <input type="checkbox"/> | <input type="checkbox"/> | address the need to improve the quality of health services for women and girls?  |
| <input type="checkbox"/> | <input type="checkbox"/> | address the various health care changes that occur over a lifetime and how those changes affect HIV/AIDS treatment and prevention? (For example, a woman's health needs and HIV/AIDS susceptibility may change significantly as her body changes through adolescence, childbearing years, and menopause.)  |
| <input type="checkbox"/> | <input type="checkbox"/> | encourage men and boys to participate equally in HIV/AIDS prevention efforts?  |
| <input type="checkbox"/> | <input type="checkbox"/> | encourage men and boys to help with domestic tasks as HIV impacts women's lives? (Greater assistance with domestic tasks may be needed if a mother, sister or wife becomes ill, if she has to care for infected loved ones, if she has to begin to generate the family income.)  |
| <input type="checkbox"/> | <input type="checkbox"/> | encourage men and boys to become more involved in the care of their families?  |

Source: Joint United Nations Programme on HIV/AIDS n.d.



## Resources

**World Health Organization** offers comprehensive family planning resources, tools and information ([www.who.int/reproductive-health/publications/family\\_planning.html](http://www.who.int/reproductive-health/publications/family_planning.html)).

**United Nations Population Fund** ([www.unfpa.org](http://www.unfpa.org)) has a wide range of resources and information for diverse sexual and reproductive health issues.

**Joint United Nations Programme on HIV/AIDS** ([www.unaids.org](http://www.unaids.org)) has a number of resources and publications on HIV/AIDS and other STIs, including links to organizations working on HIV/AIDS.

**Eldis** ([www.eldis.org](http://www.eldis.org)) provides a searchable database of research and organizations working in the area of sexual and reproductive health. **Eldis** has also produced a key issues guide to sexual and reproductive health and rights (<http://www.eldis.org/go/about-eldis&id=21582&type=Document>).

**ID21** ([www.id21.org/index.html](http://www.id21.org/index.html)) communicates development research on health, including sexual and reproductive health.

**BRIDGE** ([www.bridge.ids.ac.uk/](http://www.bridge.ids.ac.uk/)), which supports research on gender and development, has produced a number of useful publications that summarize available evidence on gender and sexual and reproductive health, including a recent publication on women living with HIV/AIDS and gender and sexuality.

**Alan Guttmacher Institute** ([www.guttmacher.org](http://www.guttmacher.org)) is a NGO dedicated to reproductive health research, policy analysis and public education.

**The Population Council** ([www.popcouncil.org](http://www.popcouncil.org)) is an international NGO based in the United States of America that carries out research, including reproductive health issues.

**International Centre for Reproductive Health** ([www.icrh.org](http://www.icrh.org)) aims to improve the acceptability, accessibility and quality of sexual and reproductive health services.

**Center for Gender, Sexuality and Health** ([www.mailman.hs.columbia.edu/sms/cgsh.html](http://www.mailman.hs.columbia.edu/sms/cgsh.html)) promotes research and training on sexuality, sexual rights and sexual education.

**The South and Southeast Asia Resource Centre on Sexuality** website ([www.asiasrc.org/index.php](http://www.asiasrc.org/index.php)) has a wide range of information on sexuality.

### *Working with men*

EngenderHealth published a **Men's Reproductive Health Curriculum** ([www.engenderhealth.org/res/offc/map/mrhc/index.html](http://www.engenderhealth.org/res/offc/map/mrhc/index.html)) that aims to provide health providers with the skills and sensitivity required to work with male clients and provide reproductive health services for men.

**Involving men** is a key theme of UNFPA's **Promoting Gender Equality** programme. A number of resources are available at: [www.unfpa.org/gender/men.htm](http://www.unfpa.org/gender/men.htm)

BRIDGE's **Engaging men in gender equality: positive strategies and approaches – overview and**

**annotated bibliography** includes a number of references, resources and experiences on involving men in gender and development work. This publication is available at: [www.bridge.ids.ac.uk/bibliographies.htm](http://www.bridge.ids.ac.uk/bibliographies.htm)

### ***Sexual and reproductive rights***

**World Health Organization** maintains a number of resources on health and human rights, including those specific sexual and reproductive health. These can be found at: [www.who.int/topics/human\\_rights/en/](http://www.who.int/topics/human_rights/en/).

The Swedish Association for Sexuality Education published ***Breaking through: a guide to sexual and reproductive health and rights***, which is available in PDF format on the Internet ([www.reproductiverights.org/pdf/pdf\\_BreakingThrough\\_04.pdf](http://www.reproductiverights.org/pdf/pdf_BreakingThrough_04.pdf)).

The **Office of the United Nations High Commissioner on Human Rights** has considered international human rights treaties with regards to HIV ([www.ohchr.org/english/issues/hiv/index.htm](http://www.ohchr.org/english/issues/hiv/index.htm)). The Commission on Human Rights has appointed a Special Rapporteur on the right to health ([www.ohchr.org/english/issues/health/right/](http://www.ohchr.org/english/issues/health/right/)).

## REFERENCES

- ActionAid. *Time to Act: HIV/AIDS in Asia*. Bangkok, ActionAid, 2003.
- Adair L., Guilkey D. Age-specific determinants of stunting in Filipino children. *The Journal of Nutrition*, 1997, 127(2):314–320.
- Ahmad O., Lopez A., Inoue M. The decline in child mortality: a reappraisal. *Bulletin of the World Health Organization*, 2000, 78(10):1175–1191 ([www.who.int/bulletin/pdf/2000/issue10/bu0792.pdf](http://www.who.int/bulletin/pdf/2000/issue10/bu0792.pdf), accessed 15 November 2007).
- Ashford L.S. Redefining reproductive health and the history leading up to the Cairo conference. *Population Bulletin*, 2001, 56(1):1–44.
- Asian Development Bank. *Gender issues in reproductive health*. Manila, ADB, 2002 ([http://www.adb.org/Documents/Manuals/Gender\\_Checklists/Health/health0500.asp?p=gencheck](http://www.adb.org/Documents/Manuals/Gender_Checklists/Health/health0500.asp?p=gencheck), accessed 9 September 2005).
- Asian Development Bank. *Country assistance plans - Vanuatu: country performance assessment*. Manila, ADB, 2003a (<http://www.adb.org/Documents/CAPs/VAN/0100.asp>, accessed 7 May 2007).
- Asian Development Bank. *Millennium Development Goals in the Pacific: relevance and progress*. Manila, ADB, 2003b ([http://www.adb.org/Documents/Books/MDG\\_Pacific/default.asp](http://www.adb.org/Documents/Books/MDG_Pacific/default.asp), accessed 7 May 2007).
- Asian Development Bank. *Health and education needs of ethnic minorities in the Greater Mekong Subregion*. Manila, ADB, 2001 ([http://www.adb.org/Documents/Studies/Health\\_Education\\_GMS/default.asp](http://www.adb.org/Documents/Studies/Health_Education_GMS/default.asp), accessed 7 May 2007).
- Asian Development Bank and World Health Organization. *Localizing MDGs for poverty reduction in Viet Nam: improving health status and reducing inequalities. Strategies for achieving the Viet Nam development goals*. Hanoi, Poverty Task Force, 2002.
- Asian-Pacific Resource and Research Centre for Women. *Monitoring Ten Years of ICPD Implementation, The Way Forward to 2015. Asian Country Reports*. Kuala Lumpur, Asian-Pacific Resource and Research Centre for Women, 2005 (<http://www.arrow.org.my/>, accessed 7 February 2007).
- Australian Agency for International Development and United Nations Development Programme. *Impact of HIV/AIDS on household vulnerability and poverty in Viet Nam*. Hanoi, United Nations Development Programme, 2005 (VIE/98/006).
- Baume E. *et al.* *Resource guide on gender and health equity*. Brighton, Institute of Development Studies, 2001 (<http://www.ids.ac.uk/ghen/resources/index.html>, accessed 15 November 2007).
- Bearinger L.H. *et al.* Adolescent Health 2. Global perspectives on the sexual and reproductive health of adolescents: patterns, prevention, and potential. *The Lancet*, 2007, 369:1220–1231.
- Bennett A. HIV prevention for mobile and displaced populations in Africa. *AIDS Infothek Magazine*, 2000, 2.
- Bloom D. *et al.* *Health, wealth, AIDS and poverty*. Manila and Geneva, UNAIDS and Asian Development Bank, 2002 ([www2.unescobkk.org/hivaids/FullTextDB/aspUploadFiles/HWAP.pdf](http://www2.unescobkk.org/hivaids/FullTextDB/aspUploadFiles/HWAP.pdf), accessed 26 February 2007).
- Borghi J. *et al.* Maternal Survival 4. Mobilizing financial resources for maternal health. *The Lancet*, 2007, 368:1457–1465.

- Braveman P, Gruskin S. Theory and methods: defining equity in health. *Journal of Epidemiology and Community Health*, 2003, 57:254–258.
- Campbell O.M.R. *et al.* Maternal Mortality 2. Strategies for reducing maternal mortality: getting on with what works. *The Lancet*, 2006, 368:1284–1299.
- Cardich R. *et al.* *Manual to evaluate quality of care from a gender perspective*. New York, International Planned Parenthood Federation, Western Hemisphere Region, 2000.
- Carr D. Improving the health of the world's poorest people. *Health Bulletin*. Washington, D.C., Population Reference Bureau, 2004 ([http://www.prb.org/pdf04/ImprovingtheHealthbrief\\_Eng.pdf](http://www.prb.org/pdf04/ImprovingtheHealthbrief_Eng.pdf), accessed 7 May 2007).
- Cash K. *et al.* 1997. In: Boender C. *et al.* *The 'So What?' Report: A look at whether integrating a gender focus into programs makes a difference to outcomes*. Washington D.C. and Geneva, Interagency Gender Working Group Task Force Report, 2004.
- Centers for Disease Control and Prevention. State-specific prevalence of selected health behaviours by race and ethnicity: behavioural risk factor surveillance system (1997), *Mortality and Morbidity Weekly Summaries*, 2000, 49(SS06):1–39 ([http://www.cdc.gov/mmwr/indss\\_2000.html](http://www.cdc.gov/mmwr/indss_2000.html), accessed 8 September 2005).
- Chalker J. *et al.* STD management by private pharmacies in Hanoi: practice and knowledge of drug sellers. *Sexually Transmitted Infections*, 2000, 76:299–302.
- Chen Z.Q. *et al.* Syphilis in China: results of a national surveillance programme. *The Lancet*, 2007, 369:132–38.
- Cleland J. *et al.* Family planning: the unfinished agenda. *The Lancet*, 2006, 368:1810–1827.
- Darmstadt G.L. *et al.* Neonatal Survival 2. Evidence-based, cost-effective interventions: how many newborn babies can we save? *The Lancet*, 2005, 365:977–988.
- David Lowe Consulting-Asia. *Perceptions of the Cambodian 100% Condom Use Program: documenting the experience of sex workers*. A report to the POLICY project. March 2003.
- Dehne K.L., Riedner G. *Sexually transmitted infections among adolescents: the need for adequate services*. Geneva, World Health Organization, 2005.
- Dehne K.L. *et al.* Integration of prevention and care of sexually transmitted infections with family planning services: what is the evidence for public health benefits? *Bulletin of the World Health Organization*, 2000, 78:628–639.
- Delvaux T. *et al.* The need for family planning and safe abortion services among women sex workers seeking STI care in Cambodia. *Reproductive Health Matters*, 2003, 11(21):88–95.
- Department for International Development. *Better health for poor people: strategies for achieving the international targets*. London, Department for International Development, 2000.
- Department of International Organizations, Ministry of Foreign Affairs, People's Republic of China and the United Nations Country Team in China. *China's progress towards the Millennium Development Goals 2005*. Beijing, Department of International Organizations, Ministry of Foreign Affairs, People's Republic of China and the United Nations Country Team in China, 2005.
- Diamond I. Child mortality: the challenge now. *Bulletin of the World Health Organization*, 2000, 78(10):1174

(<http://whqlibdoc.who.int/bulletin/2000/Number%2010/>, accessed 15 November 2007).

Dmytraczenko T., Scribner S. *Reducing maternal and child mortality in Bolivia*. Bethesda, Partners for Health Reformplus, 1999 ([www.phrplus.org/Pubs/ess1.pdf](http://www.phrplus.org/Pubs/ess1.pdf), accessed 9 September 2005).

Dmytraczenko T. *et al.* *Health sector reform: how it affects reproductive health*. New York, Population Reference Bureau, 2003 (<http://www.eldis.org/dbtw-wpd/exec/dbtwpcgi.exe?>, accessed 9 September 2005).

Doyal L. Sex, gender, and health: the need for a new approach. *British Medical Journal*, 2001, 323:1061–1063.

EC/UNFPA. *Initiative for reproductive health in Asia: lessons learned*. New York, EC/ UNFPA, 2002.

Ensor T. *et al.* Do essential service packages benefit the poor? Preliminary evidence from Bangladesh. *Health Policy and Planning*, 2002, 17(3):247–256.

EngenderHealth. *Men's reproductive health curriculum*. New York, EngenderHealth, 2003 (<http://www.engenderhealth.org/res/offc/map/mrhc/index.html#mrhc>, accessed 24 May 2007).

Evans T. *et al.*, eds. *Challenging inequities in health: from ethics to action*. New York, Oxford University Press, 2001.

Ezzati M. *et al.* Selected major risk factors and the global and regional burden of disease. *The Lancet*, 2002, 360:1347–1360.

Family Health International. Male responsibility for reproductive health. *Network*, Spring 1998, 18(3) ([http://www.fhi.org/en/rh/pubs/network/v18\\_3/nw183ch1.htm](http://www.fhi.org/en/rh/pubs/network/v18_3/nw183ch1.htm), accessed 8 September 2005).

Fathalla M.F. *et al.* Sexual and Reproductive Health 6. Sexual and reproductive health for all: a call for action. *The Lancet*, 2006, 368:2095–2100.

Filippi V. *et al.* Maternal Survival 5. Maternal health in poor countries: the broader context and a call for action. *The Lancet*, 2006, 368:1535–1541.

Ford N., Koetsawang S. The sociocultural context of the transmission of HIV in Thailand. *Social Science and Medicine*, 1991, 33(4):405–414.

Gakidou E., Vayena E. Use of modern contraception by the poor in falling behind. *PLoS Medicine*, 2007, 4(2):e31.

Ganatra B. *et al.* From research to reality: the challenge of introducing medical abortion into service delivery in Vietnam. *Reproductive Health Matters*, 2004, 12(24-Supplement):105–113.

Gao J. *et al.* Changing access to health care services in urban China: implications for equity. *Health Policy and Planning*, 2001, 16(3):302–312.

Germain A., Kidwell J. The unfinished agenda for reproductive health: priorities for the next 10 years. *International Family Planning Perspectives*, 2005, 31(2):90–93.

Gibson J., Rozelle S. *Poverty and access to infrastructure in Papua New Guinea*. Department of Agriculture and Resource Economics, University of California, Davis, 2002 (Working Paper No. 02-008) ([www.agecon.ucdavis.edu/facultypages/rozelle/pdfs/Poverty\\_png\\_edcc.pdf](http://www.agecon.ucdavis.edu/facultypages/rozelle/pdfs/Poverty_png_edcc.pdf), accessed 14 November 2007).

Gillespie D. The meeting that did not happen: Cairo, 10 years on. *The Lancet*, 2004, 364:1566–1567.

Glasier A. *et al.* Sexual and Reproductive Health 1. Sexual and reproductive health: a matter of life and death. *The Lancet*, 2006, 368:1595–1607.

Global Health Council. *Banking on reproductive health: the World Bank's support for population, the Cairo agenda and the Millennium Development Goals*. Washington, D.C., Global Health Council, 2004.

Goldie S. *et al.* Cost-effectiveness of cervical-cancer screening in five developing countries. *The New England Journal of Medicine*, 2005, 353(20):2158–2168.

Government of Cambodia. *UNGASS country progress report: Cambodia, Reporting period January 2006 – December 2007*. Phnom Penh, National AIDS Authority, Government of Cambodia, 2008 ([http://data.unaids.org/pub/Report/2008/cambodia\\_2008\\_country\\_progress\\_report\\_en.pdf](http://data.unaids.org/pub/Report/2008/cambodia_2008_country_progress_report_en.pdf), accessed 17 September 2008).

Government of Lao People's Democratic Republic. *National Poverty Eradication Programme*. Vientiane, Lao People's Democratic Republic, 2003.

Government of Malaysia. *UNGASS country progress report: Malaysia, Reporting period January 2006 – December 2007*. Kuala Lumpur, Government of Malaysia, 2008 ([http://data.unaids.org/pub/Report/2008/malaysia\\_2008\\_country\\_progress\\_report\\_en.pdf](http://data.unaids.org/pub/Report/2008/malaysia_2008_country_progress_report_en.pdf), accessed 17 September 2008.)

Government of Mongolia. *Millennium Development Goals: national report on the status of implementation in Mongolia*. Ulaanbaatar, Government of Mongolia, 2004.

Government of Mongolia. *Research report on the impact of legal regulations in environment fighting against HIV and AIDS*. Ulaanbaatar, Ministry of Health, Government of Mongolia, 2006.

Government of Mongolia. *Economic growth support and poverty reduction strategy*. Ulaanbaatar, Government of Mongolia, 2003.

Government of Mongolia and United Nations Development Programme. *Human development report Mongolia 2003: urban-rural disparities in Mongolia*. Ulaanbaatar, United Nations Development Programme, 2003.

Government of Papua New Guinea. *UNGASS country progress report: Papua New Guinea, Reporting period January 2006 – December 2007*. Port Moresby, Government of Papua New Guinea, 2008 ([http://data.unaids.org/pub/Report/2008/papua\\_new\\_guinea\\_2008\\_country\\_progress\\_report\\_en.pdf](http://data.unaids.org/pub/Report/2008/papua_new_guinea_2008_country_progress_report_en.pdf), accessed 17 September 2008.)

Government of Papua New Guinea and United Nations in Papua New Guinea. *Millennium Development Goals progress report 2004*. Port Moresby, Government of Papua New Guinea and United Nations in Papua New Guinea, 2004.

Government of the Philippines. *Country report of the Philippines, January 2006 to December 2007: Follow-up to the Declaration of Commitment on HIV and AIDS, United Nations General Assembly Special Session (UNGASS)*. Manila, Philippine National AIDS Council (PNAC), Government of the Philippines, 2008 ([http://data.unaids.org/pub/Report/2008/philippines\\_2008\\_country\\_progress\\_report\\_en.pdf](http://data.unaids.org/pub/Report/2008/philippines_2008_country_progress_report_en.pdf), accessed 17 September 2008).

Government of Solomon Islands and United Nations Development Programme. *Human development report 2002: building a nation*. Honiara, Government of Solomon Islands, 2002.

Government of Viet Nam. *The third country report on following up the implementation to the Declaration of*



*Commitment on HIV and AIDS, Reporting period: January 2006 – December 2007.* Hanoi, Government of Viet Nam. 2008 ([http://data.unaids.org/pub/Report/2008/viet\\_nam\\_2008\\_country\\_progress\\_report\\_en.pdf](http://data.unaids.org/pub/Report/2008/viet_nam_2008_country_progress_report_en.pdf), accessed 17 September 2007).

Greene M., Merrick T. *Poverty reduction: does reproductive health matter?* Washington, D.C., World Bank, 2005 (<http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/GreenePovertyReductionFinal.pdf>, accessed 23 May 2007).

Greene M. *et al.* *Involving men in reproductive health: contributions to development.* Background paper to the report *Public choices, private decisions: sexual and reproductive health and the Millennium Development Goals.* New York, United Nations Millennium Project, n.d.

Griffen S. *Literature review on sexual and reproductive health rights: universal access to services, focussing on East and Southern Africa and South Asia.* London and Brighton, RELAY and Reasling Rights, 2007.

Grimes D.A. *et al.* Sexual and Reproductive Health 4. Unsafe abortion: the preventable pandemic. *The Lancet*, 2006, 368:1908–1919.

Gwatkin D. The current state of knowledge about: targeting the health programs to reach the poor. Washington D.C., World Bank, 2000.

Gwatkin D. *Who would gain most from efforts to reach the Millennium Development Goals for health? An inquiry into the possibility of progress that fails to reach the poor.* Health, Nutrition and Population Discussion Paper. Washington D.C., World Bank, 2002.

Gwatkin D. Critical reflection. Health inequalities and the health of the poor: What do we know? What can we do? *Bulletin of the World Health Organization*, 2000, 78(1):3–18.

Gwatkin D. *et al.* *Socioeconomic differences in health, nutrition, and population in Cambodia.* Washington, D.C., World Bank, 2007a.

Gwatkin D. *et al.* *Socioeconomic differences in health, nutrition, and population in Philippines.* Washington, D.C., World Bank, 2007b.

Gwatkin D. *et al.* *Socioeconomic differences in health, nutrition, and population in Vietnam.* Washington, D.C., World Bank, 2007c.

Hawkes S. Why include men? Establishing sexual health clinics for men in rural Bangladesh. *Health Policy and Planning*, 1998, 13(2):121–130.

Health Action Information Network. *2005 Philippine HIV and AIDS country profile.* Health Action Information Network, Philippine National AIDS Council, UNAIDS Philippines, 2005.

Human Rights Watch. *Fiji: sodomy law convictions violate constitution.* New York, Human Rights Watch, 2004 (<http://hrw.org/english/docs/2005/04/12/fiji10466.htm>, accessed 20 June 2007).

Hunt P. *Economic, social and cultural rights: report of the special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.* Sixty-second session item 10 of the provisional agenda, 3 March 2006, Geneva, Commission on Human Rights, 2006.

Hunt P. *Economic, social and cultural rights: the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.* Sixtieth session item 10 of the provisional agenda, 16 February 2004, Geneva,

Commission on Human Rights, 2004.

Hutton G. *The effect of maternal–newborn ill-health on households: economic vulnerability and social implications*. Geneva, World Health Organization, 2006.

Id21. *The price of women's health: safe motherhood in low income countries*. Brighton, Institute of Development Studies, 2001 ([www.id21.org/health/h8mj1g2.html](http://www.id21.org/health/h8mj1g2.html), accessed 8 September 2005).

Id21. *Place matters: the challenges of survival in remote rural areas*. Brighton, Institute of Development Studies, 2002 (<http://www.id21.org/society/s5bkb1g1.html>, accessed 8 September 2005).

Ilkcaracan P., Jolly S. *Cutting Edge Pack - Gender and sexuality: overview report*. Brighton, BRIDGE, Institute of Development Studies, 2007.

International Council on Management of Population Programmes. *Violence against women*. Ampang, International Council on Management of Population Programmes, 2001 (<http://www.icomp.org.my/Publish/volume9.htm>, accessed 8 September 2005).

Islam M.K., Gerdham U.G. *The costs of maternal-newborn illness and mortality. Moving towards universal coverage: issues in maternal-newborn health and poverty*. Geneva, World Health Organization, 2006.

Jing F. Health sector reform and reproductive health services in poor rural China. *Health Policy and Planning*, 2004, 19(Suppl. 1):i40–i49.

Joint United Nations Programme on HIV/AIDS. *AIDS epidemic update: 2007*. Geneva, UNAIDS and World Health Organization, 2007.

Joint United Nations Programme on HIV/AIDS. *AIDS epidemic update: special report on HIV/AIDS: December 2006*. Geneva, UNAIDS and World Health Organization, 2006a.

Joint United Nations Programme on HIV/AIDS. *2006 Report on the global AIDS epidemic: A UNAIDS 10<sup>th</sup> anniversary special edition*. Geneva, UNAIDS, 2006b.

Joint United Nations Programme on HIV/AIDS. *Setting national targets for moving towards universal access. Operational Guidance*. Geneva, UNAIDS, 2006c.

Joint United Nations Programme on HIV/AIDS. *UNAIDS policy brief: HIV and sex between men*. Geneva, UNAIDS, 2006d ([http://data.unaids.org/pub/BriefingNote/2006/20060801\\_Policy\\_Brief\\_MSM\\_en.pdf](http://data.unaids.org/pub/BriefingNote/2006/20060801_Policy_Brief_MSM_en.pdf), accessed 7 December 2006).

Joint United Nations Programme on HIV/AIDS. *UNAIDS statement on the political declaration on HIV/AIDS*. Geneva, UNAIDS, 2006e ([http://data.unaids.org/pub/PressStatement/2006/20060620\\_PS\\_HLM\\_en.pdf](http://data.unaids.org/pub/PressStatement/2006/20060620_PS_HLM_en.pdf), accessed 1 December 2006).

Joint United Nations Programme on HIV/AIDS. *Men who have sex with men, HIV prevention and care: Report of a UNAIDS stakeholder consultation, Geneva, 10–11 November 2005*. Geneva, UNAIDS, 2005.

Joint United Nations Programme on HIV/AIDS. *Impact of HIV and sexual health education on the sexual behaviour of young people: a review update*. Geneva, UNAIDS, 1997.

Joint United Nations Programme on HIV/AIDS. *Gender and AIDS: gender sensitivity checklist*. Geneva, UNAIDS, n.d. ([http://data.unaids.org/Topics/Gender/genderchecklist\\_en.pdf](http://data.unaids.org/Topics/Gender/genderchecklist_en.pdf), accessed 15 November 2007).

- Jowett M. Safe motherhood in low income countries: an economic justification and evidence of cost effectiveness. *Health Policy*, 2000, 53 (3):201–228.
- Kaufman J., Jing F. Privatization of health services and the reproductive health of rural Chinese women. *Reproductive Health Matters*, 2002, 10(20):108–116.
- King E., Mason A. *Engendering development through gender equality in rights, resources and voice*, Washington, D.C., World Bank, 2001.
- Klingberg-Allvin M. *et al.* Ethics of justice and ethics of care, values and attitudes among midwifery students on adolescent sexuality and abortion in Vietnam and their implications for midwifery education: a survey by questionnaire and interview. *International Journal of Nursing Studies*, 2007, 44:37–46.
- Krueger L. *et al.* Poverty and HIV seropositivity: the poor are more likely to be infected. *AIDS*, 1990, 4(8):811–14.
- Labrecque M. *et al.* Vasectomy surgical techniques in South and South East Asia. *BMC Urology*, 2005, 5:10 doi:10.1186/1471-2490-5-10.
- Lacey C. *et al.* Analysis of the sociodemography of gonorrhoea in Leeds. *British Medical Journal*, 1997, 314(1):715–718.
- Lampietti J., Stalker L. *Consumption expenditure and female poverty: a review of the evidence*. Policy Research Report on Gender and Development Working Paper Series No. 11. Washington, D.C., World Bank, 2000.
- Lawn J.E. *et al.* Neonatal Survival 1. 4 million neonatal deaths: When? Where? Why? *The Lancet*, 2005, 365:891–900.
- Li J. Gender inequality, family planning and maternal and child care in a rural Chinese county. *Social Science and Medicine*, 2004, 59(4):695–708.
- Lightfoot C., Ryan T. *Is poverty an issue in the Pacific?* Paper presented at the Asia and Pacific Forum on Poverty: Reforming Policies and Institutions for Poverty Reduction. Manila, Asian Development Bank, 2001 ([http://www.adb.org/Poverty/Forum/frame\\_lightfoot.htm](http://www.adb.org/Poverty/Forum/frame_lightfoot.htm), accessed 17 July 2007).
- Liu A. *et al.* Sexual initiation, substance use, sexual behaviour and knowledge among vocational students in northern Thailand. *International Family Planning Perspectives*, 2006, 32(3):126–135.
- Low N. *et al.* Sexual and Reproductive Health 5. Global control of sexually transmitted infections. *The Lancet*, 2006, 368, 2001–2016.
- Lubben M. *et al.* Reproductive health and health sector reform in developing countries: Establishing a framework for dialogue. *Bulletin of the World Health Organization*, 2002, 80(8):667–674.
- Maman S. *et al.* The intersections of HIV and violence: directions for future research and interventions. *Social Science and Medicine*, 2000, 50:459–478.
- Martin S.L. *et al.* Domestic violence and sexually transmitted diseases: The experience of prenatal care patients. *Public Health Reports*, 1999, 114(3):262–268.
- Meuwissen L.E. *et al.* Does a competitive voucher program for adolescents improve the quality for reproductive health care? A simulated patient study in Nicaragua. *BMC Public Health*, 2006a, 6:204.

- Meuwissen L.E. *et al.* Impact of accessible sexual and reproductive health care on poor and underserved adolescents in Managua, Nicaragua: a quasi-experimental intervention study. *Journal of Adolescent Health*, 2006b, 38:56.e1–56.e9.
- Meuwissen L.E. *et al.* Uncovering and responding to needs for sexual and reproductive health care among poor urban female adolescents in Nicaragua. *Tropical Medicine and International Health*, 2006c, 11(12):1858–1867.
- Mirsky J. *Birth rights. New approaches to safe motherhood*. London, The Panos Institute, 2001 (<http://www.panos.org.uk/resources/reportdetails.asp?id=1026>, accessed 17 July 2007).
- Molesworth K. Negotiating sexual and reproductive health: culture matters. *Bulletin of Medicus Mundi Switzerland*, April 2006, 100.
- Moss N.E. Gender equity and socioeconomic inequality: a framework for the patterning of women's health. *Social Science and Medicine*, 2002, 54(5):649–661.
- Muller I. *et al.* The effect of distance from home on attendance at a small rural health centre in Papua New Guinea. *International Journal of Epidemiology*, 1998, 27:878–884.
- Mueller T., Rogerson S., Reeder J. Malaria among pregnant women in Papua New Guinea. *PREMA-EU Newsletter*, March 2005, Issue 4.
- Nanda P. Gender dimensions of user fees: implications for women's utilization of health care. *Reproductive Health Matters*, 2002, 10(20):127–134.
- National Institute of Statistics, Directorate General for Health (Cambodia), and ORC Macro. *Cambodia Demographic and Health Survey 2000*. Phnom Penh and Maryland, National Institute of Statistics, Directorate General for Health and ORC Macro, 2001.
- Panis C., Lillard L. Health inputs and child mortality: Malaysia. *Journal of Health Economics*, 1994, 13:455–489.
- Passey M. *et al.* Community based study of sexually transmitted diseases in rural women in the highlands of Papua New Guinea: prevalence and risk factors. *Sexually Transmitted Infections*, 1998, 74:120–127.
- The Partnership for Maternal, Newborn and Child Health. Geneva, World Health Organization (<http://www.who.int/pmnch/en/>, accessed 17 July 2007).
- PATH. *Gender inequities and women's health. Outlook*, 1999, 16(4):1–8.
- Population Action International. *Fact sheet: Why good sexual and reproductive health is critical to the well-being of youth*. Washington, D.C., Population Action International, 2004 ([http://www.populationaction.org/Publications/Fact\\_Sheets/FS19/Summary.shtml](http://www.populationaction.org/Publications/Fact_Sheets/FS19/Summary.shtml), accessed 17 July 2007).
- Östlin, P. Gender in health research: past, present and future. *Global Forum Update on Research for Health*, 2005.
- Organisation for Economic Co-operation and Development and World Health Organization. *DAC guidelines and reference series: poverty and health*. Paris, OECD Development Assistance Committee, 2003.
- Raju S., Leonard A., eds. *Men as supportive partners in reproductive health: moving from rhetoric to reality*. Population Council, New Delhi, 2000 (<http://www.popcouncil.org/pdfs/menaspartners.pdf>, accessed 8

September 2005).

Rani M., Lule E. Exploring the socioeconomic dimension of adolescent reproductive health: a multicountry analysis. *International Family Planning Perspectives*, 2004, 30(30):110–117.

Ranson M.K. *et al.* Reproductive health services through mobile camps: SEWA experience in Gujarat. *Development Outreach*, May 2005.

Ravi K. *et al.* A study of male sexual health problems in a Mumbai slum population. *Culture, Health & Sexuality*, 2001, 3(3) (<http://taylorandfrancis.metapress.com/app/home/contribution.asp?>, accessed 8 September 2005).

Ravindran T.K.S. Financing pregnancy-related health services in an era of health sector reforms [PowerPoint presentation]. 2005.

Ravindran T.K.S., de Pinho H., eds. *The right reforms? Health sector reforms and sexual and reproductive health*. Johannesburg, Women's Health Project, School of Public Health, University of Witwatersrand, 2005.

Reproductive Health Outlook. *Men and reproductive health: overview and issues*. Seattle, Reproductive Health Outlook, 2005a ([www.rho.org/html/menrh\\_overview.htm](http://www.rho.org/html/menrh_overview.htm), accessed 8 September 2005).

Reproductive Health Outlook. *Family planning programme issues: overview and lessons learned*. Seattle, Reproductive Health Outlook, 2005b ([www.rho.org/html/fpp\\_overview.html](http://www.rho.org/html/fpp_overview.html), accessed 8 September 2005).

Reproductive Health Outlook. *Gender and sexual health: overview and lessons learned*. Seattle, Reproductive Health Outlook, 2005c ([www.rho.org/html/gsh\\_overview.htm](http://www.rho.org/html/gsh_overview.htm), accessed 8 September 2005).

Rivers K. Aggleton P. *Working with young men to promote sexual and reproductive health*. Southampton, Safe Passages to Adulthood, 2002.

Rojanapithayakorn W. The 100% condom use programme in Asia. *Reproductive Health Matters*, 2006, 14(28):41–52.

Ronsmans C. *et al.* Maternal Survival 1. Maternal mortality: who, when, where, and why. *The Lancet*, 2006, 368:1189–1200.

Sankaranarayanan R. *et al.* Effective screening programmes for cervical cancer in low- and middle-income developing countries. *Bulletin of the World Health Organization*, 2001, 79:954–1062.

Schoemaker J. Contraceptive use among the poor in Indonesia. *International Family Planning Perspectives*, 2005, 31(3):106–114.

Schuler M. *Freedom from violence: women's strategies from around the world*. Washington, D.C., OEF International, 1992.

Schuler S.R. *et al.* Paying for reproductive health services in Bangladesh: intersections between cost, quality and culture. *Health Policy and Planning*, 2002, 17(3):273–280.

Schwebke J.R. *et al.* Sexually transmitted diseases in Ulaanbaatar, Mongolia. *International Journal of STD and AIDS*, 1998, 9(6):354–358.

Segal L. *Slow motion: changing masculinities, changing men*. London, Virago, 1990.

- Seth T. *et al.* Common cancers in India: knowledge, attitudes and behaviours of urban slum dwellers in New Delhi. *Public Health*, 2005, 119:87–96.
- Senauer B. *The impact of the value of women's time on food and nutrition in developing countries*. St. Paul, University of Minnesota, 1988 (Staff Paper Series P88-41).
- Sims J. Malaria control and pregnancy. In: Sims J. *Anthology on Women, Health, Environment*. Geneva, World Health Organization, 1994.
- Sinding S.W. Health and hope, rights and responsibilities: action agenda, global roundtable: countdown 2015. *Reproductive Health Matters*, 2004, 12(24):154–159.
- Soucat A. *HNP and the poor: the health system and the poor* [PowerPoint presentation]. 2002.
- Swedish Association for Sexuality Education. *Breaking through: a guide to sexual and reproductive health and rights*. Stockholm, The Swedish Association for Sexuality Education, 2004.
- Sychareun V. Meeting the contraceptive needs of unmarried young people: attitudes of formal and informal sector providers in Vientiane Municipality, Lao PDR. *Reproductive Health Matters*, 2004, 12(23):155–165.
- The Yogyakarta Principles: Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity*. Yogyakarta, 2007 ([http://www.yogyakartaprinciples.org/docs/File/Yogyakarta\\_Principles\\_EN.pdf](http://www.yogyakartaprinciples.org/docs/File/Yogyakarta_Principles_EN.pdf), accessed 17 July 2007).
- Thorson A. *et al.* Health-seeking behaviour of individuals with cough of more than 3 weeks. *The Lancet*, 2000, 356:1823–1824.
- Toan N. *et al.* Public health services use in a mountainous area, Vietnam: implications for health policy. *Scandinavian Journal of Public Health*, 2002, 30(2):86–93.
- Tran T.M. *et al.* HIV prevalence and factors associated with HIV infection among male injecting drug users under 30: a cross-sectional study in Long An, Vietnam. *BMC Public Health*, 2006, 6:248.
- Tu X. *et al.* Do family-planning workers in China support provision of sexual and reproductive health services to unmarried young people? *Bulletin of the World Health Organization*, 2004, 82(4):274–280.
- United Nations. *Vanuatu common country assessment*. Suva, Office of the United Nations Resident Coordinator, 2002.
- United Nations. *Beijing Declaration and Platform for Action*, New York, United Nations, 1995 (<http://www.un.org/womenwatch/daw/beijing/platform/declar.htm>, accessed 9 September 2005).
- United Nations Administrative Committee on Coordination Sub-Committee on Nutrition. *Fourth Report on the World Nutritional Status*. Geneva, Administrative Committee on Coordination Sub-Committee on Nutrition in collaboration with International Food Policy Research Institute, 2000.
- United Nations Children's Fund. *State of the world's children*. New York, UNICEF, 2006.
- United Nations Children's Fund. *Facts for life*. New York, UNICEF, 2002 (<http://www.unicef.org/fll>, accessed 23 February 2007).



United Nations Children's Fund. *Progress since the world summit for children: a statistical review*. New York, UNICEF, 2001 ([http://www.unicef.org/pub\\_wethechildren\\_stats\\_en.pdf](http://www.unicef.org/pub_wethechildren_stats_en.pdf), accessed 15 November 2007).

United Nations Children's Fund, East Asia and Pacific Regional Office. *Towards a region fit for children: an atlas for the Sixth East Asia and Pacific Ministerial Consultation*. Bangkok, UNICEF, 2003.

United Nations Country Team Viet Nam. *International development targets/Millennium Development Goals progress - Viet Nam*. Hanoi, United Nations Country Team, 2001.

United Nations Development Programme. *Human development report 2003: Millennium Development Goals: a compact among nations to end human poverty*. New York, Oxford University Press, 2003.

United Nations Development Programme. *National human development report Lao PDR 2001: advancing rural development*. Vientiane, UNDP, 2001.

United Nations Development Programme. *Human development report 1995: gender and human development*. New York, Oxford University Press, 1995.

UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, Department of Reproductive Health and Research. *Progress in reproductive health research*. Geneva, World Health Organization, 2004.

United Nations Division for the Advancement of Women. *Women and HIV/AIDS concerns: a focus on Thailand, Philippines, India and Nepal*. New York, 2005 (<http://www.un.org/womenwatch/daw/csw/hiv.htm>, accessed 30 August 2005).

United Nations Millennium Project. *Public choices, private decisions: sexual and reproductive health and the Millennium Development Goals*. New York, United Nations Millennium Project, 2006.

United Nations Millennium Project *Who's got the power? Transforming health systems for women and children*. Task Force on Child Health and Maternal Health. New York, United Nations Millennium Project, 2005.

United Nations Population Fund. *Flows for population activities in 2004*. New York, UNFPA, 2006a (<http://www.resourceflows.org/index.php?module=uploads&func=download&fileId=276>, accessed 28 May 2007).

United Nations Population Fund. *Maternal and neonatal health in East and South-East Asia*. New York, UNFPA, 2006b.

United Nations Population Fund. *Reducing poverty and achieving the Millennium Development Goals: arguments for investing in reproductive health and rights*. New York, UNFPA, 2005.

United Nations Population Fund. *Sexually transmitted infections: breaking the cycle of transmission*. New York, UNFPA, 2004a.

United Nations Population Fund. *Culture matters. Working with communities and faith-based organizations: case studies from country programmes*. New York, UNFPA, 2004b.

United Nations Population Fund. *State of world population 2004: the Cairo consensus at ten: population, reproductive health and the global effort to end poverty*. New York, UNFPA, 2004c.

United Nations Population Fund. *State of world population 2003: investing in adolescent reproductive health*. New

York, UNFPA, 2003.

United Nations Population Fund. *Asia and the Pacific: a region in transition*. New York, UNFPA, 2002.

United Nations Population Fund. *Programme of Action of the International Conference on Population and Development, Cairo, 5–13 September 1994*. New York, United Nations, 1996.

United Nations Population Fund. *It takes 2: partnering with men in reproductive and sexual health*. New York, UNFPA, n.d.

United Nations Population Fund and Population Reference Bureau. *Country profiles for population and reproductive health, policy developments and indicators 2005*. New York, UNFPA and Population Reference Bureau, 2005 ([http://www.unfpa.org/upload/lib\\_pub\\_file/524\\_filename\\_country\\_profiles\\_2005.pdf](http://www.unfpa.org/upload/lib_pub_file/524_filename_country_profiles_2005.pdf), accessed 23 May 2007).

Wagstaff A., Claeson M. *The Millennium Development Goals for health: rising to the Challenge*. Washington, D.C., World Bank, 2004.

Wagstaff A. *et al.* *Inequalities in child health: are we narrowing the gap?* [Discussion Paper]. Health, Nutrition and Population, World Bank and World Health Organization, 2003.

Warwick I., Aggleton P. *The role of education in promoting young peoples sexual and reproductive health*. Southampton, Safe Passages to Adulthood, 2002.

Wellings K. *et al.* Sexual and Reproductive Health 2. Sexual behaviour in context: a global perspective. *The Lancet*, 2006, 368:1706–1728.

Wong E. *et al.* Accessibility, quality of care and prenatal care use in the Philippines. *Social Science and Medicine*, 1987, 24(11):927–944.

Wong M.L. *et al.* Social and behavioural factors associated with condom use among direct sex workers in Siem Reap, Cambodia. *Sexually Transmitted Infections*, 2003, 79:163–165.

World Bank. *Development and poverty reduction. Looking back, looking ahead*. Prepared for the 2004 annual meetings of the World Bank and International Monetary Fund. Washington, D.C., World Bank, 2004.

World Bank. *World development report 2004: making services work for poor people*. New York, Oxford University Press, 2003.

World Bank. *Filipino report card on pro-poor services: summary*. World Bank, Environment and Social Development Unit, East Asia and Pacific Region, 2001 ([http://siteresources.worldbank.org/INTEMPowerment/Resources/14875\\_FilipinoReportCard-web.pdf](http://siteresources.worldbank.org/INTEMPowerment/Resources/14875_FilipinoReportCard-web.pdf), accessed 15 November 2007).

World Bank. *World development report 1993: investing in health*. New York, Oxford University Press, 1993.

World Health Organization. *Female Genital Mutilation*. Geneva, WHO, 2007 (<http://www.who.int/reproductive-health/fgm/>, accessed 17 July 2007).

World Health Organization. *Accelerating progress towards the attainment of international reproductive health goals: a framework for implementing the WHO Global Reproductive Health Strategy*. Geneva, WHO, 2006a.

World Health Organization. Creating a supportive legislative and regulatory framework. *Policy Brief 3*:

*Implementing the Global Reproductive Health Strategy*. Geneva, WHO, 2006b.

World Health Organization. Financing sexual and reproductive health-care services. *Policy Brief 1: Implementing the Global Reproductive Health Strategy*. Geneva, WHO, 2006c.

World Health Organization. Integrating sexual and reproductive health-care services. *Policy Brief 2: Implementing the Global Reproductive Health Strategy*. Geneva, WHO, 2006d.

World Health Organization. Promoting and safeguarding the sexual and reproductive health of adolescents. *Policy Brief 4: Implementing the Global Reproductive Health Strategy*. Geneva, WHO, 2006e.

World Health Organization. *Integrating equity into health information systems*. Geneva, WHO, Health Metrics Network, May 2005a ([http://www.who.int/healthmetrics/library/issue\\_3\\_05apr.doc](http://www.who.int/healthmetrics/library/issue_3_05apr.doc), accessed 19 May 2005).

World Health Organization. *WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses*. Geneva, WHO, 2005b ([http://www.who.int/gender/violence/who\\_multicountry\\_study/en/index.html](http://www.who.int/gender/violence/who_multicountry_study/en/index.html), accessed 3 March 2007).

World Health Organization. *World health report 2005: making every mother and child count*. Geneva, WHO, 2005c.

World Health Organization. *PRSPs, their significance for health: second synthesis report*. Geneva, WHO, 2004a.

World Health Organization. *Reproductive health* (fifty-seventh World Health Assembly provisional agenda item 12.10). Geneva, WHO, 2004b.

World Health Organization. *World health report 2004: changing history*. Geneva, WHO, 2004c.

World Health Organization. Violence against women and HIV/AIDS: critical intersections intimate partner violence and HIV/AIDS. *World Health Organization Information Bulletin Series, Number 1*. Geneva, WHO and the Global Coalition on Women and AIDS, 2004d (<http://www.who.int/entity/gender/violence/en/vawinformationbrief.pdf>, accessed 15 November 2007).

World Health Organization. *Fact sheets: human rights, women and HIV/AIDS*. Geneva, WHO, 2003a (<http://www.who.int/mediacentre/factsheets/fs247/en/>, accessed 9 September 2005).

World Health Organization. *World health report 2003: shaping the future*. Geneva, WHO, 2003b.

World Health Organization. *A framework to assist countries in the development and strengthening of national and district health plans and programmes in reproductive health*. Geneva, WHO, 2002a.

World Health Organization. 25 questions and answers on health and human rights. *Health and Human Rights Publication Series*. Issue no.1, July 2002b.

World Health Organization. *Report of a WHO consultation: cervical cancer screening in developing countries*. Geneva, WHO, 2002c.

World Health Organization. *Gender and health: technical paper*. Geneva, WHO, 2001a.

World Health Organization. *Making pregnancy safer: towards better maternal and perinatal health*. Geneva, WHO, 2001b.

World Health Organization. *Reproductive health indicators for global monitoring*. Geneva, WHO, 2001c.

World Health Organization. *Transforming health systems: gender and rights in reproductive health. A training curriculum for health programme managers*. Geneva, WHO, 2001d.

World Health Organization. *A strategic assessment of reproductive health in the Lao People's Democratic Republic*. Geneva, WHO, 2000a.

World Health Organization. *Gender, health and poverty*. Geneva, WHO, 2000b.

World Health Organization. *World health report 2000: health systems: improving performance*. Geneva, WHO, 2000c.

World Health Organization. *Monitoring reproductive health: selecting a short list of national and global indicators*. Geneva, WHO, 1997.

World Health Organization. *Women, ageing and health: achieving health across the lifespan*. Geneva, WHO, 1996.

World Health Organization, Department of Gender and Women's Health. *Module 2: Addressing gender in a health problem/issue*. WHO Mainstreaming Gender in Public Health. Geneva, WHO, n.d. (unpublished document).

World Health Organization, Department of Gender and Women's Health. *Gender, health and ageing*. Geneva, WHO, 2003.

World Health Organization and Stop TB Partnership. *Human rights approach to tuberculosis: Stop TB guidelines for social mobilization*. Geneva, World Health Organization and Stop TB Partnership, 2001.

World Health Organization Regional Office for South-East Asia. *Women of South-East Asia: a health profile*. New Delhi, WHO Regional Office for South-East Asia, 2000.

World Health Organization Regional Office for the Western Pacific. *Sexual and reproductive health of adolescents and youth in Mongolia: a review of literature and projects 2002*. Manila, WHO Regional Office for the Western Pacific, 2007.

World Health Organization Regional Office for the Western Pacific. *Reaching the poor: challenges for child health in the Western Pacific Region*. Manila, WHO Regional Office for the Western Pacific, 2007b.

World Health Organization Regional Office for the Western Pacific. *Gender-based violence in the Western Pacific Region. A hidden epidemic? Special issue on women's health*. Manila, WHO Regional Office for the Western Pacific, 2006.

World Health Organization Regional Office for the Western Pacific. *Core indicators 2005*. Manila, WHO Regional Office for the Western Pacific, 2005a ([http://www.wpro.who.int/information\\_sources/databases/core\\_indicators/](http://www.wpro.who.int/information_sources/databases/core_indicators/), Accessed 4 October 2006).

World Health Organization Regional Office for the Western Pacific. *Making pregnancy safer*. Manila, WHO Regional Office for the Western Pacific, 2005b.

World Health Organization Regional Office for the Western Pacific. *Maternal mortality in Viet Nam 2000–2001: an in-depth analysis of causes and determinants*. Manila, WHO Regional Office for the Western Pacific,

2005c.

World Health Organization Regional Office for the Western Pacific. *Sexual and reproductive health of adolescents and youth in Cambodia: a review of literature and projects 1995–2003*. Manila, WHO Regional Office for the Western Pacific, 2005d.

World Health Organization Regional Office for the Western Pacific. *Sexual and reproductive health of adolescents and youth in China: a review of literature and projects*. Manila, WHO Regional Office for the Western Pacific, 2005e.

World Health Organization Regional Office for the Western Pacific. *Sexual and reproductive health of adolescents and youth in Laos: a review of literature and projects 1994–2003*. Manila, WHO Regional Office for the Western Pacific, 2005f.

World Health Organization Regional Office for the Western Pacific. *Sexual and reproductive health of adolescents and youth in Malaysia: a review of literature and projects 2005*. Manila, WHO Regional Office for the Western Pacific, 2005g.

World Health Organization Regional Office for the Western Pacific. *Sexual and reproductive health of adolescents and youth in the Philippines: a review of literature and projects 1995–2003*. Manila, WHO Regional Office for the Western Pacific, 2005h.

World Health Organization Regional Office for the Western Pacific. *Sexual and reproductive health of adolescents and youth in Viet Nam: a review of literature and projects 1995–2002*. Manila, WHO Regional Office for the Western Pacific, 2005i.

World Health Organization Regional Office for the Western Pacific. *Sexually transmitted infections*. Manila, WHO Regional Office for the Western Pacific, 2005j ([http://www.wpro.who.int/health\\_topics/sexually\\_transmitted\\_infections/](http://www.wpro.who.int/health_topics/sexually_transmitted_infections/), accessed 17 July 2007).

World Health Organization Regional Office for the Western Pacific. *Turning promises into progress: attaining the health MDGs in Asia and the Pacific*. Manila, WHO Regional Office for the Western Pacific, 2005k.

World Health Organization Regional Office for the Western Pacific, Ministry of Health Republic of Kiribati, University of New South Wales, Australia. *Prevalence survey of sexually transmitted infections among seafarers and their women attending antenatal clinics in Kiribati*. Manila, WHO Regional Office for the Western Pacific, 2004.

World Health Organization Regional Office for the Western Pacific, United Nations Population Fund, United Nations Children's Fund. *Investing in our future: a framework for accelerating action for the sexual and reproductive health of young people*. Manila, WHO Regional Office for the Western Pacific, 2006.

Worth D. Sexual decision-making and AIDS: Why condom promotion among vulnerable women is likely to fail. *Studies in Family Planning*, 1989, 20(6): 297–307.

Wright D. *et al.* Limits of teacher delivered sex education: interim behavioural outcomes from a randomized trial. *British Medical Journal*, 2001, 324:1430–1433.

Zaidi S. Gender perspectives and quality of care in underdeveloped countries: disease, gender and contextuality. *Social Science and Medicine*, 1996, 43(5):721–730.

Zierler S., Krieger N. Reframing women's risk: social inequalities and HIV infection. *Annual Review of Public Health*, 1997, 18:401–436.

## ENDNOTES

- <sup>1</sup> World Bank 2004.
- <sup>2</sup> United Nations Development Programme 1995.
- <sup>3</sup> Vlassoff *et al.* 2004. In: United Nations Millennium Project 2006.
- <sup>4</sup> Gillespie 2004.
- <sup>5</sup> DeJong 2000; Germain and Kidwell 2005.
- <sup>6</sup> United Nations Population Fund 2004c; Baume *et al.* 2001.
- <sup>7</sup> Paragraph 7.2 in United Nations Population Fund 1996 and repeated in paragraph 94 of United Nations 1995.
- <sup>8</sup> Glasier *et al.* 2006; United Nations Millennium Project 2006.
- <sup>9</sup> Glasier *et al.* 2006.
- <sup>10</sup> Paragraph 7.3 of United Nations Population Fund 1996 and repeated in paragraph 95 of United Nations 1995.
- <sup>11</sup> Wellings *et al.* 2006.
- <sup>12</sup> United Nations 1995.
- <sup>13</sup> Glasier *et al.* 2006; World Health Organization 2001d.
- <sup>14</sup> World Health Organization 2001d.
- <sup>15</sup> This working definition of sexual health was put forward by members of a technical consultation on sexual health, which met in January 2002, and has since been refined by an international working group. As a working definition, it is not attributed to WHO.
- <sup>16</sup> UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, Department of Reproductive Health and Research, World Health Organization 2004.
- <sup>17</sup> Hunt 2004.
- <sup>18</sup> UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, Department of Reproductive Health and Research, World Health Organization 2004.
- <sup>19</sup> *Ibid.*
- <sup>20</sup> Ilkkaracan and Jolly 2007.
- <sup>21</sup> Griffen 2007.
- <sup>22</sup> Swedish Association for Sexuality Education 2004.
- <sup>23</sup> Paragraph 96 of United Nations 1996.
- <sup>24</sup> Swedish Association for Sexuality Education 2004.
- <sup>25</sup> World Health Organization 2001d.
- <sup>26</sup> These working definitions were elaborated as a result of a WHO-convened international technical consultation on sexual health in January 2002, and subsequently revised by a group of experts from different parts of the world. They are presented here as a contribution to ongoing discussions about sexual health, but do not represent an official WHO position, and should not be used or quoted as WHO definitions.
- <sup>27</sup> UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, Department of Reproductive Health and Research, World Health Organization 2004.
- <sup>28</sup> Griffen S 2007.
- <sup>29</sup> United Nations Millennium Project 2006.
- <sup>30</sup> *Ibid.*
- <sup>31</sup> Murray and Lopez 1998. In: United Nations Millennium Project 2006.
- <sup>32</sup> Vlassoff *et al.* 2004. In: United Nations Millennium Project 2006.
- <sup>33</sup> Bearinger *et al.* 2007.
- <sup>34</sup> *Ibid.*
- <sup>35</sup> United Nations Population Fund 2006b.
- <sup>36</sup> Glasier *et al.* 2006.
- <sup>37</sup> Ronsmans *et al.* 2006.
- <sup>38</sup> World Health Report 2005b.
- <sup>39</sup> Glasier *et al.* 2006
- <sup>40</sup> *Ibid.*
- <sup>41</sup> World Health Organization 2005c.
- <sup>42</sup> Ronsmans *et al.* 2006.
- <sup>43</sup> *Ibid.*
- <sup>44</sup> WHO defines “unsafe abortion” as a procedure for terminating an unintended pregnancy either by an individual without the necessary skills or in an environment that does not conform to the minimum medical standards or both. Grimes *et al.* 2004.
- <sup>45</sup> Grimes *et al.* 2004.
- <sup>46</sup> Ronsmans *et al.* 2006.
- <sup>47</sup> United Nations Millennium Project 2006.
- <sup>48</sup> World Health Organization Regional Office for the Western Pacific 2005b.
- <sup>49</sup> World Health Organization Regional Office for the Western Pacific 2005c.
- <sup>50</sup> World Health Organization Regional Office for the Western Pacific 2006.
- <sup>51</sup> For more information on child health, please see World Health Organization Regional Office for the Western Pacific 2007b.
- <sup>52</sup> World Health Organization Regional Office for the Western Pacific 2005h.
- <sup>53</sup> UNICEF 2003 in United Nations Millennium Project 2006.



- <sup>54</sup> Vlassoff *et al.* 2004. In: United Nations Millennium Project 2006.
- <sup>55</sup> United Nations Population Fund 2006b.
- <sup>56</sup> Rahman *et al.* 2003. In: Hutton 2006.
- <sup>57</sup> United Nations Population Fund 2002.
- <sup>58</sup> Glasier *et al.* 2006.
- <sup>59</sup> EngenderHealth 2003.
- <sup>60</sup> Raju and Leonard (eds.) 2000.
- <sup>61</sup> Hawkes 1998.
- <sup>62</sup> Glasier *et al.* 2006.
- <sup>63</sup> World Health Organization Regional Office for the Western Pacific 2006.
- <sup>64</sup> Cleland *et al.* 2006.
- <sup>65</sup> *Ibid.*
- <sup>66</sup> World Health Organization Regional Office for the Western Pacific 2005d.
- <sup>67</sup> United Nations Population Fund 2002.
- <sup>68</sup> Glasier *et al.* 2006.
- <sup>69</sup> Alan Guttmacher Institute 1999. In: Glasier *et al.* 2006.
- <sup>70</sup> United Nations Millennium Project 2005b. In: United Nations Millennium Project 2006.
- <sup>71</sup> Labrecque 2005.
- <sup>72</sup> United Nations Millennium Project 2006.
- <sup>73</sup> Ezzati *et al.* 2002.
- <sup>74</sup> Vlassof *et al.* 2004. In: United Nations Millennium Project 2006.
- <sup>75</sup> Glasier *et al.* 2006.
- <sup>76</sup> *Ibid.*
- <sup>77</sup> Glasier *et al.* 2006; Bearinger *et al.* 2007.
- <sup>78</sup> World Health Organization Regional Office for the Western Pacific 2005.
- <sup>79</sup> Chen *et al.* 2007.
- <sup>80</sup> World Health Organization Regional Office for the Western Pacific 2004.
- <sup>81</sup> Glasier *et al.* 2006.
- <sup>82</sup> Joint United Nations Programme on HIV/AIDS 2007.
- <sup>83</sup> World Health Organization 2004d.
- <sup>84</sup> Joint United Nations Programme on HIV/AIDS 2006a.
- <sup>85</sup> Joint United Nations Programme on HIV/AIDS 2006b.
- <sup>86</sup> A generalized epidemic is one where the adult HIV prevalence exceeds 1% in the general population and HIV transmission mostly occurs through heterosexual sex.
- <sup>87</sup> World Health Organization 2005b.
- <sup>88</sup> World Health Organization 2004b and 2005b.
- <sup>89</sup> International Council on Management of Population Programmes 2001.
- <sup>90</sup> Diamond 2000.
- <sup>91</sup> Department for International Development 2000.
- <sup>92</sup> For more information on how poverty is conceptualized and measured, please refer to the foundational module on poverty in this series.
- <sup>93</sup> The vulnerability of many Pacific island developing nations to external shocks (including natural disasters and market failures) and their small resource base have led to their inclusion among least developed countries. For more information on least developed countries, visit the website of the United Nations Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States: <http://www.un.org/special-rep/ohrlls/ldc/default.htm>.
- <sup>94</sup> Wagstaff *et al.* 2003.
- <sup>95</sup> Bloom *et al.* 2002.
- <sup>96</sup> Pitanyanon S *et al.* 1997. In: Bloom *et al.* 2002.
- <sup>97</sup> Wong *et al.* 2003.
- <sup>98</sup> UNFPA 2003. In: Australian Agency for International Development and United Nations Development Programme 2005.
- <sup>99</sup> Bennett 2000.
- <sup>100</sup> Wan and Zhang 2006. In: Joint United Nations Programme on HIV/AIDS 2006a.
- <sup>101</sup> World Health Organization 2000b.
- <sup>102</sup> UNICEF 2002.
- <sup>103</sup> World Health Organization Regional Office for the Western Pacific 2007.
- <sup>104</sup> World Health Organization Regional Office for the Western Pacific 2005f.
- <sup>105</sup> World Health Organization Regional Office for the Western Pacific 2005h.
- <sup>106</sup> Sandoval 2000. In: World Health Organization Regional Office for the Western Pacific 2005h.
- <sup>107</sup> Lacey *et al.* 1997; Krueger *et al.* 1990.
- <sup>108</sup> Tran *et al.* 2006.
- <sup>109</sup> United Nations Children's Fund 2003.
- <sup>110</sup> Panis and Lillard 1994.
- <sup>111</sup> World Health Organization 2000b.
- <sup>112</sup> World Bank 2002. In: United Nations Children's Fund 2003.
- <sup>113</sup> United Nations Children's Fund 2001.
- <sup>114</sup> Carr 2004.
- <sup>115</sup> Government of Mongolia and United Nations Development Programme 2003.
- <sup>116</sup> Pokin and Solon 1976. In: Adair and Guilkey 1997.
- <sup>117</sup> Senaur 1988. Children born earlier in the birth order are similarly observed to be favoured in the intrahousehold allocation of calories.
- <sup>118</sup> King and Mason 2001.

- 119 United Nations Administrative Committee on Coordination Sub-Committee on Nutrition 2000.
- 120 Soucat 2002.
- 121 Glasier *et al.* 2006.
- 122 Wagstaff and Claeson 2004.
- 123 Darmstadt *et al.* 2005.
- 124 World Health Organization 2005c.
- 125 *Ibid.*
- 126 World Health Organization Regional Office for the Western Pacific 2005b.
- 127 Government of Papua New Guinea and United Nations in Papua New Guinea 2004.
- 128 Health Action Information Network 2005.
- 129 United Nations Population Fund and Population Reference Bureau 2005.
- 130 Cleland *et al.* 2006.
- 131 *Ibid.*
- 132 Carr 2004.
- 133 Gwatkin *et al.* 2007b.
- 134 Asian Development Bank and World Health Organization 2002.
- 135 Mehrotra and Delamonica forthcoming. In: United Nations Development Programme 2003.
- 136 United Nations 1996. In: Asian Development Bank 2003a.
- 137 United Nations Development Programme 2003.
- 138 Government of Mongolia and United Nations Development Programme 2003.
- 139 Government of Mongolia 2003.
- 140 Health Action Information Network 2005.
- 141 United Nations Development Programme 2001.
- 142 United Nations 2002.
- 143 Gibson and Rozelle 2002.
- 144 World Health Organization Regional Office for the Western Pacific 2007.
- 145 Passey *et al.* 1998.
- 146 World Health Organization 2000a.
- 147 World Health Organization Regional Office for the Western Pacific 2005c.
- 148 Gwatkin *et al.* 2007a.
- 149 Gwatkin *et al.* 2007b.
- 150 Department of International Organizations, Ministry of Foreign Affairs, the People's Republic of China and the United Nations Country Team in China 2005.
- 151 Government of Solomon Islands and United Nations Development Programme 2002.
- 152 World Health Organization Regional Office for South-East Asia 2000.
- 153 Lao People's Democratic Republic 2003.
- 154 Gao *et al.* 2001.
- 155 Lui *et al.* In: Evans *et al.* (eds.) 2001.
- 156 Ravindran 2005.
- 157 Borghi *et al.* 2006.
- 158 Moses *et al.* 1992. In: Nanda 2002.
- 159 Mirsky 2001.
- 160 Kaufman and Jing 2002.
- 161 Kowalewski *et al.* 2002. In: Borghi *et al.* 2006; Borghi *et al.* 2003. In: Borghi *et al.* 2006.
- 162 Toan *et al.* 2002.
- 163 \$1 = 6500 kip
- 164 World Health Organization 2000a.
- 165 Doyal 2001.
- 166 World Health Organization Regional Office for the Western Pacific 2007.
- 167 United Nations Country Team Viet Nam 2001, World Bank 2001.
- 168 World Health Organization 2000a.
- 169 Delvaux *et al.* 2003.
- 170 Seth *et al.* 2005.
- 171 Ganatra *et al.* 2004.
- 172 World Health Organization 2000a.
- 173 Schoemaker 2005.
- 174 World Health Organization 2000a.
- 175 Id21 2002.
- 176 Government of Solomon Islands and United Nations Development Programme 2002.
- 177 World Health Organization 2000a.
- 178 World Health Organization, Department of Gender and Women's Health 2003a.
- 179 World Health Organization 2000a.
- 180 Gakidou and Vayena 2007.
- 181 Passey *et al.* 1998.
- 182 Chalker *et al.* 2000.
- 183 Schuler *et al.* 2002.
- 184 World Health Organization 2000a.
- 185 World Health Organization Regional Office for the Western Pacific 2005i.
- 186 Organisation for Economic Co-operation and Development and World Health Organization 2003.
- 187 World Health Organization Regional Office for the Western Pacific 2007.
- 188 Department for International Development 2001.
- 189 National Institute of Statistics, Directorate General for Health (Cambodia) and ORC Macro 2001; Gwatkin *et al.* 2007a, 2007b and 2007c; Asian Development Bank and World Health Organization 2002.
- 190 Asian Development Bank 2003b.
- 191 World Health Organization Regional Office for the Western Pacific, 2005j.
- 192 Kaufman and Jing 2002.
- 193 Gwatkin *et al.* 2007b.

- 194 World Health Organization 2000a.
- 195 *Ibid.*
- 196 Government of Mongolia 2003.
- 197 Malnutrition was defined as a body mass index (BMI) of less than 18.5 (based on weight in kilograms divided by height in metres squared). Carr 2004.
- 198 Government of Mongolia 2003.
- 199 National Institute of Statistics, Directorate General for Health (Cambodia) and ORC Macro 2001.
- 200 World Health Organization Regional Office for the Western Pacific 2007.
- 201 World Health Organization 2000a.
- 202 Gakidou and Vayena 2007.
- 203 United Nations Population Fund 2006b.
- 204 World Health Organization Regional Office for the Western Pacific 2005c.
- 205 *Ibid.*
- 206 United Nations Population Fund 2006b.
- 207 UNDP 2003. In: ActionAid 2003.
- 208 Glasier *et al.* 2006.
- 209 Bailey and Bruno 2001. In: Greene and Merrick 2005.
- 210 Buvinic 1998. In: Greene and Merrick 2005.
- 211 Greene and Merrick 2005.
- 212 Haberland *et al.* 2004. In: Greene and Merrick 2005.
- 213 Jensen and Ahlburg 1999. In: Greene and Merrick 2005.
- 214 National Research Council and Institution of Medicine 2002. In: United Nations Millennium Project 2006.
- 215 Katz *et al.* 2003. In: Filippi *et al.* 2006.
- 216 Islam and Gerdham 2006.
- 217 Gertler *et al.* 2003. In: Greene and Merrick 2005.
- 218 United Nations Population Fund 2005.
- 219 World Health Organization, Department of Gender and Women's Health 2006a.
- 220 Bearinger *et al.* 2007.
- 221 Lawn *et al.* 2005.
- 222 Division for the Advancement of Women, United Nations, 2005.
- 223 Sims 1994.
- 224 Mueller, Rogerson and Reeder 2002.
- 225 Gray *et al.* 2005. In: Ronsmans *et al.* 2006.
- 226 Segal 1990.
- 227 World Health Organization Regional Office for the Western Pacific 2005h.
- 228 Upadhyay *et al.* 2006. In: World Health Organization Regional Office for the Western Pacific 2005h.
- 229 World Health Organization Regional Office for the Western Pacific 2005d.
- 230 Ford and Koetsawang 1991.
- 231 World Health Organization Regional Office for the Western Pacific 2005d.
- 232 United Nations Population Fund 2004b.
- 233 World Health Organization 2000a.
- 234 Ilkkaracan and Jolly S. 2007.
- 235 Greig 2006. In: Griffen 2007.
- 236 Griffen 2007.
- 237 Human Rights Watch 2004.
- 238 Ilkkaracan and Jolly 2007.
- 239 Reproductive Health Outlook 2005c.
- 240 Reproductive Health Outlook 2005b.
- 241 World Health Organization Regional Office for the Western Pacific 2005i.
- 242 United Nations Population Fund 2004b.
- 243 Li 2004.
- 244 Family Health International 1998.
- 245 Reproductive Health Outlook 2005a.
- 246 World Health Organization Regional Office for the Western Pacific 2007.
- 247 World Health Organization Regional Office for the Western Pacific 2005h.
- 248 United Nations Population Fund 2004b.
- 249 Wellings *et al.* 2006.
- 250 World Health Organization Regional Office for the Western Pacific 2005i.
- 251 World Health Organization Regional Office for the Western Pacific 2007.
- 252 NSC/UNFPA 2002. In: World Health Organization Regional Office for the Western Pacific 2005f.
- 253 Chhun *et al.* 1995. In: World Health Organization Regional Office for the Western Pacific 2005d.
- 254 Cabigon 1999. In: World Health Organization Regional Office for the Western Pacific 2005h.
- 255 World Health Organization Regional Office for the Western Pacific 2005g.
- 256 World Health Organization Regional Office for the Western Pacific 2005h.
- 257 World Health Organization Regional Office for the Western Pacific 2005f.
- 258 For more information please refer to the *Module on Gender-Based Violence*.
- 259 Centers for Disease Control and Prevention 2000.
- 260 Glasier *et al.* 2006.
- 261 Reproductive Health Outlook. 2005c.
- 262 Gwatkin *et al.* 2007b. Among children sick with fever in 2002, 45.0% of boys and 47.7% of girls were seen medically. When suffering from acute respiratory infections, 55.1% of boys and 54.4%

- of girls were seen medically.
- 263 Gwatkin *et al.* 2007c.
- 264 Muller *et al.* 1998.
- 265 Kaufman and Jing F 2002.
- 266 Gakidou and Vayena 2007.
- 267 World Health Organization 2000a.
- 268 Path Foundation 1999.
- 269 This study analysed the results of a random sample of 3327 rural and urban women who gave birth between 1 May 1983 and 30 April 1984 in 33 sample *barangays*, combined with the results of a survey of public and private health facilities in these 33 *barangays*. Wong *et al.* 1987.
- 270 See, for example, Thorson *et al.* 2000 to learn how women's lack of mobility affected their access to care for tuberculosis in Viet Nam.
- 271 Gao *et al.* 2001.
- 272 Asian-Pacific Resource and Research Centre for Women 2005.
- 273 United Nations Population Fund 2002.
- 274 Beegle, Frankenberg and Thomas 2001. In: Wagstaff *et al.* 2003.
- 275 The survey was conducted by the National Nutritional Council and Department of Agriculture of the Philippines, with the assistance of the International Food Policy Research Institute 1988.
- 276 World Health Organization 1996.
- 277 World Health Organization 2000a.
- 278 Gakidou and Vayena E 2007.
- 279 Asian-Pacific Resource and Research Centre for Women 2005; World Health Organization 2000a.
- 280 Care Cambodia 2002. In: Asian-Pacific Resource and Research Centre for Women 2005.
- 281 Joint United Nations Programme on HIV/AIDS 2005.
- 282 Mirsky 2001.
- 283 Kaufmann and Jing F 2002.
- 284 United Nations Population Fund 2004b.
- 285 Sychareun 2004.
- 286 World Health Organization Regional Office for the Western Pacific 2005f.
- 287 World Health Organization Regional Office for the Western Pacific 2005i.
- 288 CARE International 2003. In: World Health Organization Regional Office for the Western Pacific 2005d.
- 289 Government of Solomon Islands and United Nations Development Programme 2002.
- 290 Reproductive Health Outlook 2005a.
- 291 Grimes *et al.* 2006.
- 292 World Health Organization Regional Office for the Western Pacific 2005i.
- 293 World Health Organization Regional Office for the Western Pacific 2007.
- 294 World Health Organization 2003b. India, Nepal and Pakistan are also exceptions to the global trend.
- 295 United Nations Population Fund 2004a.
- 296 Joint United Nations Programme on HIV/AIDS 2007.
- 297 Government of Cambodia, 2008.
- 298 Government of the Philippines, 2008.
- 299 Government of Viet Nam, 2008.
- 300 Government of Malaysia, 2008.
- 301 Government of Papua New Guinea, 2008.
- 302 World Health Organization Regional Office for the Western Pacific 2006.
- 303 World Health Organization Regional Office for the Western Pacific 2005h.
- 304 World Health Organization Regional Office for the Western Pacific, United Nations Population Fund, United Nations Children's Fund 2006.
- 305 World Health Organization Regional Office for the Western Pacific 2005d.
- 306 World Health Organization Regional Office for the Western Pacific 2005h.
- 307 World Health Organization Regional Office for the Western Pacific 2005d.
- 308 World Health Organization Regional Office for the Western Pacific 2005h.
- 309 Reproductive Health Outlook 2005c.
- 310 EngenderHealth 2003.
- 311 World Health Organization Regional Office for the Western Pacific 2005d.
- 312 World Health Organization Regional Office for the Western Pacific 2005h.
- 313 United Nations Millennium Project 2006.
- 314 Evans *et al.* 2001.
- 315 World Health Organization 2001d.
- 316 World Health Organization and Stop TB Partnership 2001.
- 317 Hunt P 2004.
- 318 Swedish Association for Sexuality Education 2004.
- 319 The Yogyakarta Principles 2007.
- 320 World Health Organization 2002b. General comment on the right to the highest attainable standard of health, article 12 ICESCR.
- 321 Population Action International 2004.
- 322 Glasier *et al.* 2006.
- 323 Fathalla *et al.* 2006.
- 324 Glasier *et al.* 2006.
- 325 United Nations Millennium Project 2006.
- 326 *Ibid.*

- <sup>327</sup> The Partnership for Maternal, Newborn and Child Health 2007.
- <sup>328</sup> The notable exception was the United States of America.
- <sup>329</sup> Sinding 2004.
- <sup>330</sup> Global Health Council 2004.
- <sup>331</sup> United Nations Population Fund 2006a.
- <sup>332</sup> United Nations Population Fund 2006a.
- <sup>333</sup> Sinding SW 2004.
- <sup>334</sup> World Health Organization 2006d; United Nations Millennium Project 2006.
- <sup>335</sup> United Nations Millennium Project 2006.
- <sup>336</sup> World Health Organization 2006d.
- <sup>337</sup> Gwatkin 2002.
- <sup>338</sup> United Nations Millennium Project 2006.
- <sup>339</sup> World Health Organization 2006a.
- <sup>340</sup> For more information on the Commission on Social Determinants of Health, please see: [http://www.who.int/social\\_determinants/en/](http://www.who.int/social_determinants/en/).
- <sup>341</sup> World Health Organization 2004. A review of PRSPs undertaken by the World Health Organization found that, although the value of a cross-sectoral approach to health is often recognized in the health section of PRSPs, little evidence is available to show that this concern is translated into strategy.
- <sup>342</sup> Danguilan/UNIFEM 2005. In: United Nations Millennium Project 2006.
- <sup>343</sup> Dehne *et al.* 2000.
- <sup>344</sup> World Health Organization 2006b.
- <sup>345</sup> World Health Organization 2006d and 2006b.
- <sup>346</sup> Government of Mongolia 2006.
- <sup>347</sup> World Health Organization 2006b.
- <sup>348</sup> *Ibid.*
- <sup>349</sup> United Nations Millennium Project 2006; World Health Organization 2006d.
- <sup>350</sup> World Health Organization 2006a.
- <sup>351</sup> *Ibid.*
- <sup>352</sup> de Pinho *et al.* 2005. In: Ravindran and de Pinho, eds. 2005.
- <sup>353</sup> Musgrove *et al.* 2001. In: Ravindran 2005.
- <sup>354</sup> Östlin 2005.
- <sup>355</sup> Ravindran 2005.
- <sup>356</sup> World Health Organization 2006c.
- <sup>357</sup> Östlin 2005.
- <sup>358</sup> UNRISD 2000. In: Ravindran 2005.
- <sup>359</sup> Filippi *et al.* 2006.
- <sup>360</sup> Campbell *et al.* 2006.
- <sup>361</sup> World Health Organization 2006d.
- <sup>362</sup> United Nations Millennium Project 2006.
- <sup>363</sup> Fathalla *et al.* 2006.
- <sup>364</sup> World Health Organization 1997b.
- <sup>365</sup> United Nations Millennium Project 2006.
- <sup>366</sup> World Health Organization 2006a.
- <sup>367</sup> Fathalla *et al.* 2006.
- <sup>368</sup> World Bank 2003.
- <sup>369</sup> Family Health International 2004. In: World Health Organization 2006a.
- <sup>370</sup> David Lowe Consulting-Asia 2003.
- <sup>371</sup> Borghi *et al.* 2006.
- <sup>372</sup> Gertler and Boyce 2001, and Morriss *et al.* 2004. In: Borghi *et al.* 2006.
- <sup>373</sup> Borghi J *et al.* 2006.
- <sup>374</sup> United Nations Population Fund 2004b.
- <sup>375</sup> *Ibid.*
- <sup>376</sup> Molesworth 2006.
- <sup>377</sup> United Nations Population Fund 2004b.
- <sup>378</sup> Molesworth K. 2006.
- <sup>379</sup> World Health Organization 2006a.
- <sup>380</sup> *Ibid.*
- <sup>381</sup> World Health Organization 2006d; United Nations Millennium Project 2006.
- <sup>382</sup> Ilkharacan and Jolly S. 2007.
- <sup>383</sup> United Nations Population Fund n.d.
- <sup>384</sup> United Nations Population Fund 2004a.
- <sup>385</sup> Wellings *et al.* 2006.
- <sup>386</sup> *Ibid.*
- <sup>387</sup> Dehne and Riedner 2005.
- <sup>388</sup> United Nations Population Fund 2003.
- <sup>389</sup> Warwick and Aggleton 2002.
- <sup>390</sup> World Health Organization 2006e.
- <sup>391</sup> Joint United Nations Programme on HIV/AIDS 1997.
- <sup>392</sup> United Nations Population Fund 2004b.
- <sup>393</sup> World Health Organization 2005a.
- <sup>394</sup> *Ibid.*









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