

Healthy Expectations

Celebrating Achievements
of the Cairo Consensus
and Highlighting the
Urgency for Action



International Conference on Population and Development in Cairo, 15 years later





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A MESSAGE FROM THORAYA AHMED OBAID, UNFPA EXECUTIVE DIRECTOR.

The 1994 International Conference on Population and Development changed the way the world views issues of population — moving away from a focus on numbers to a focus on human rights and dignity. To commemorate the 15th anniversary, UNFPA is pleased to issue this chartbook in cooperation with the Population Reference Bureau. Pointing to the connections between population, poverty, education, environment and health, it highlights areas that require urgent action and investment.

At the Cairo Conference, 179 governments agreed to work together with partners to achieve universal access to education, especially for girls, to reduce infant, child and maternal mortality and to guarantee reproductive health, including family planning by 2015. Delegates from all regions agreed that every person has the right to sexual and reproductive health and that empowering women is a highly important end in itself that is essential to improving the quality of life of everyone. These goals and principles have been incorporated in the Millennium Development Goals that now provide a unifying framework for international development cooperation.

While a solid legal and policy foundation has been laid in the last 15 years to improve living standards and equity, there remains a large gap between what is written down and people's daily realities. While girls' enrolment in school has risen along with access to family planning and care during pregnancy and childbirth, maternal mortality still represents the world's largest health inequity, with a woman continuing to die each and every minute. Little improvement in this area points to the need for urgent action to strengthen health systems and protect the rights of girls and women.

We hope that you use the facts, figures and messages in this report to promote universal access to reproductive health and education by 2015 and to accelerate progress to end discrimination and extreme poverty.

WHAT IS THE CAIRO CONSENSUS AND WHY DOES IT STILL MATTER?

Fifteen years ago, in 1994, the world's nations forged a visionary plan in Cairo, Egypt, to foster economic development and reduce poverty, with a focus on promoting human rights, empowering women and erasing inequities within societies. The agreement emerging from the 1994 International Conference on Population and Development in Cairo represented a new global consensus to integrate population dynamics fully into development strategies. It provided a 20-year blueprint that required actions and commitments from both rich and poor countries.

Today, the goals of Cairo remain as relevant as ever. Despite progress on many fronts, a billion people still live in abject poverty. Every year, more than half a million women still die of causes related to pregnancy and childbirth, Three million infants die in the first week of life, most of causes related to the mother's health and to pregnancy and delivery.¹ An additional one million infants die in the first month of life. Most deaths to mothers and infants occur among the poor and could have been prevented, often through simple and cost-effective strategies.²

Women in poor countries are almost as likely to die as a result of pregnancy or childbirth in 2009 as in 1990. At a global level, 13 per cent of maternal deaths are due to unsafe abortion, but in parts of sub-Saharan Africa, unsafe abortion is responsible for 30 to 40 per cent of maternal deaths. Preventing unintended pregnancies by meeting the unmet need for contraception among more than 200 million women is an essential strategy for reducing maternal deaths and long-term disabilities related to pregnancy.

UNFPA is taking stock of what has been achieved in the first 15 years of the 20-year Cairo Programme of Action, and the challenges that must be met to realize the promise of Cairo. Investment in providing universal modern contraception and maternal and newborn health services would result in large, measurable improvements in health and well-being — more than paying for itself in terms of lives and resources saved and productivity enhanced.

Achieving Cairo's Promise Requires Action on Several Fronts

Many of the goals put forth in the Cairo Consensus are intertwined: A prime example is that progress to prevent unintended pregnancies also advances goals to reduce poverty, promote women's empowerment and save lives. Conversely, persistent poverty or lack of access to family planning services undermines efforts to improve girls' schooling or women's participation in the paid labour force, both of which would advance the status of women.

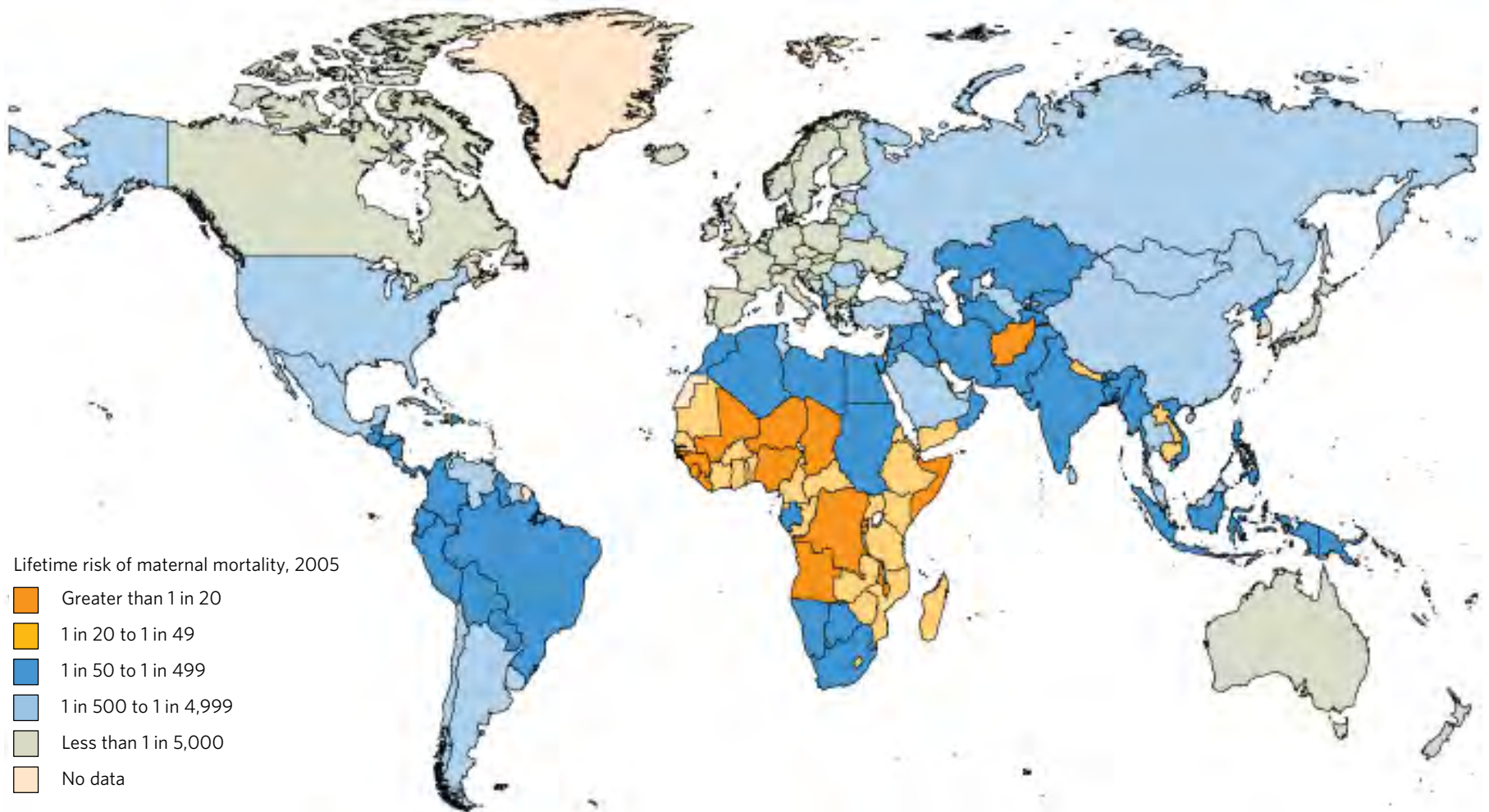
We highlight the urgency for action to attain the broader goals of Cairo, saving millions of lives by:

- Reducing poverty and inequity
- Providing universal access to family planning
- Ensuring safe pregnancy and childbirth
- Empowering women and constructively engaging men
- Keeping children, especially girls, in school longer
- Investing in young people
- Protecting the environment
- Demonstrating political leadership
- Upholding financial commitments

In 2005, the lifetime risk of death from maternal causes was 1 in 22 for women in sub-Saharan Africa, compared with less than 1 in 6,000 for women in more developed countries. For each woman who dies, 20 additional women suffer pregnancy-related disabilities; two million women now live with obstetric fistula caused by injury during childbirth,

a condition leading to loss of bladder or bowel control and often to severe health consequences and social ostracism.

Most maternal deaths occur to women who live in sub-Saharan Africa and South Asia. The number of maternal deaths in sub-Saharan Africa has increased as the number of women in the childbearing ages has grown.



Source: PRB analysis of estimates from the United Nations Population Fund (UNFPA), World Health Organization (WHO), UNICEF and World Bank.

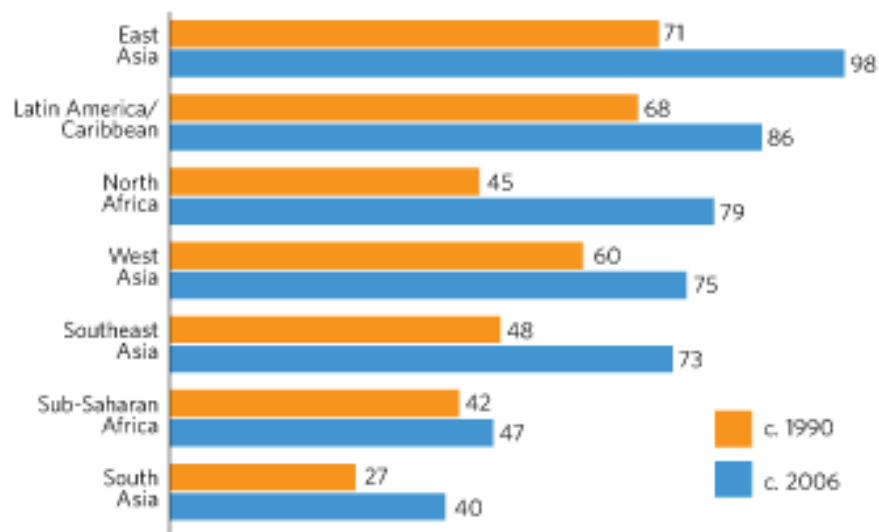
The challenge of reducing maternal deaths can be met through securing:

- Comprehensive family planning — counselling, services, supplies
- Safe abortion services (where abortion is legal)*
- Skilled birth attendance
- Emergency obstetric care
- Prenatal and postnatal care

Family planning alone can reduce maternal mortality by 25 to 40 per cent.

Although progress in reducing maternal deaths has stalled, more births are now attended by skilled health personnel. But this is less likely in countries where women give birth at home. There are hopeful signs: In East Asia, nearly every birth is now assisted by skilled health personnel.

Percentage of infants delivered with assistance from skilled health personnel.



Source: United Nations. 2008. *Millennium Development Goals Report 2008*.

In addition, the challenge of reducing child deaths can be met through securing:

- Adequate medical and nursing intervention at the time of birth
- Improved nutrition of the mother
- Availability of safe water and hand-washing³
- Access to child and maternal health services
- Availability of antibiotics, vaccines and essential medicines

Simple and cost-effective strategies such as cleaning, drying and warming the newborn, skin-to-skin contact with the mother and exclusive breastfeeding for the first six months can save the lives of millions of infants.⁴

Child spacing saves lives. When a woman becomes pregnant less than six months after a previous birth, her baby is 2.5 times more likely to die in the first month of life than a child conceived three years after the previous birth.

Relative risk of dying in first month of life by birth interval.

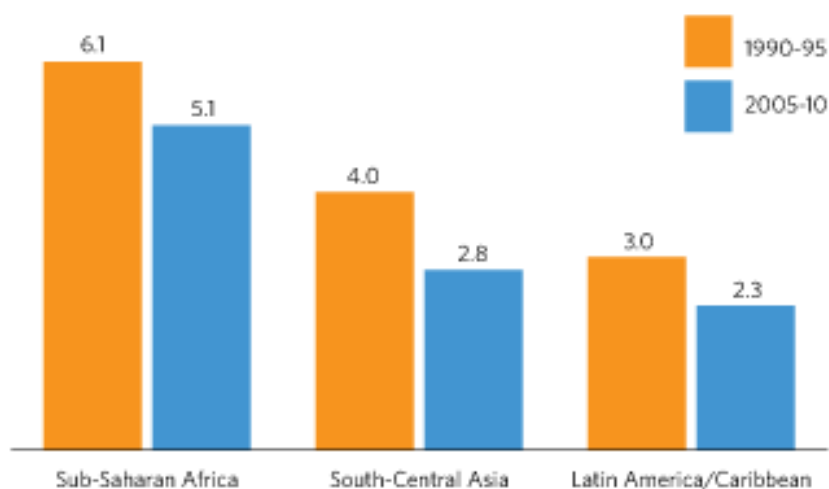


Source: Rutstein, S. 2000. "Effect of birth-spacing on mortality and health".

*At the International Conference on Population and Development, governments agreed that abortion should not be promoted as a method of family planning, unsafe abortion should be dealt with as a major public health concern, and family planning services should be expanded and improved to prevent unwanted pregnancies and reduce recourse to abortion.

More women and couples are choosing to plan their families, space their pregnancies and limit the number of their children. The average number of children born per woman has declined in every major region since the early 1990s. A general decline in fertility — possible with increased access to modern contraceptives — shows that couples want fewer children. Among other factors, desire for smaller families reflects increases in women’s education and labour force participation, improvements in child survival and changing social expectations.

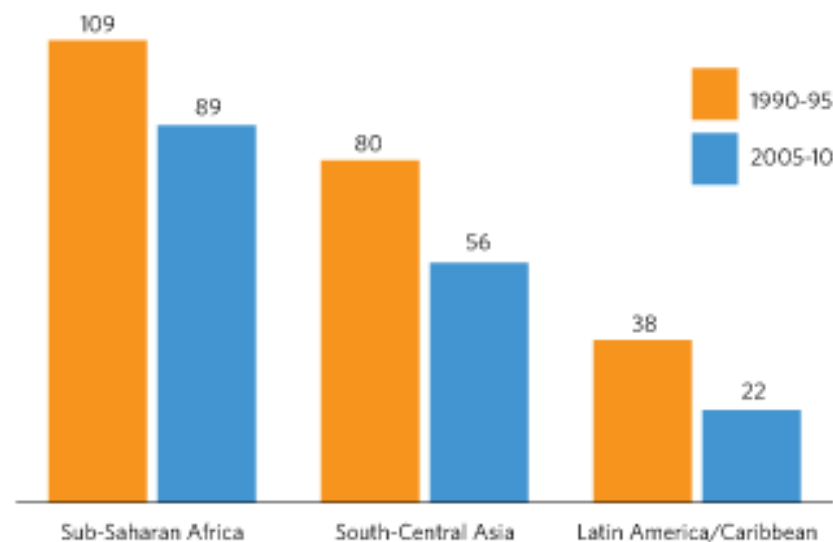
Average number of children per woman.



Source: UN Population Division. *World Population Prospects: The 2008 Revision*.

Infants and children are healthier. Although infant mortality has declined in every region in the past 15 years, it remains very high in sub-Saharan Africa, where nearly 90 of every 1,000 infants die before the age of 1 year. Most infant and child deaths are preventable if mothers have skilled medical care during childbirth and families have access to clean water, proper sanitation, childhood immunizations and adequate nutrition. Many infant deaths can also be prevented if women are able to space births by two or more years.

Deaths under age 1 per 1,000 live births.



Source: UN Population Division. *World Population Prospects: The 2008 Revision*.

REDUCING EXTREME POVERTY IS INTERTWINED WITH ALL OF CAIRO'S GOALS.

Worldwide, the number and percentage of people living in extreme poverty (less than US\$1.25 per day) has declined, but much of this improvement is due to the remarkable economic gains made in China, where the poverty rate fell from 80 per cent in 1980 to 17 per cent in 2005. Poverty reductions in other developing countries were partly or fully offset by continued population growth.

“Persistent widespread poverty and serious social and gender inequities have significant influences on, and in turn are influenced by, demographic factors such as population growth, structure and distribution.”

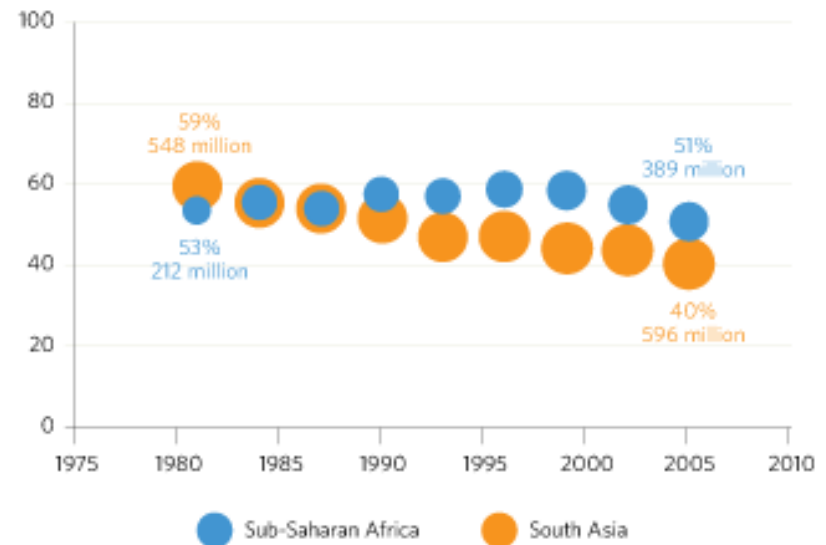
International Conference on Population and Development (ICPD) Programme of Action, Chapter III

Whether poverty is further reduced — or increases — in the future will reflect the combined effect of global economic trends, international aid, government policies, resources and population dynamics. The current financial crisis threatens to undo years of progress.

Poverty is associated with large family sizes, low use of family planning services, low educational attainment and poor nutrition — all factors that work against the goals of Cairo.

Rapid population growth keeps large numbers of people in extreme poverty in South Asia and sub-Saharan Africa. In sub-Saharan Africa, the percentage of people in extreme poverty began to decline around the year 2000, but, because of rapid population growth, the number of people in extreme poverty nearly doubled, from 212 million to 389 million. In South Asia, the percentage in poverty declined more rapidly, from 59 to 40 per cent, but the number increased from 548 million to 596 million.

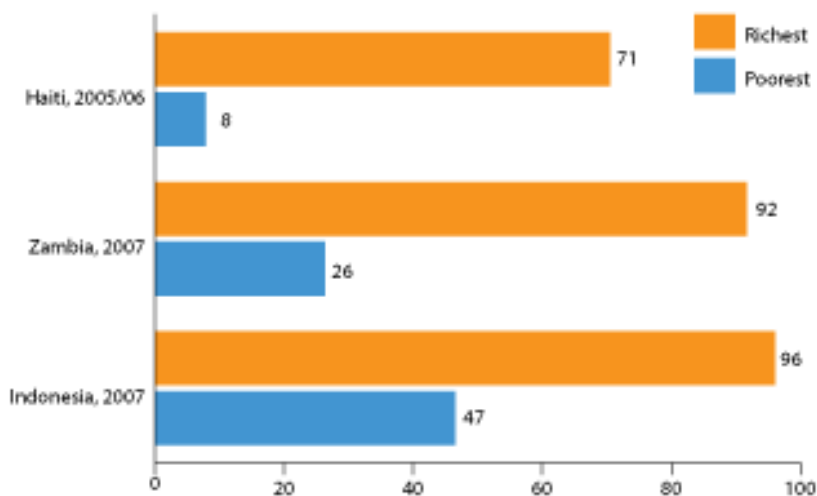
Percentage of the population living in extreme poverty (less than US\$1.25/day) in sub-Saharan Africa and South Asia. (circle size represents the number of people)



Source: World Bank. 2008. *Poverty Data: A Supplement to the 2008 World Development Indicators*.

Inequality within countries also hinders progress on the Cairo goals. In low-income countries throughout the world, wealthier women are far more likely than poorer women to have skilled personnel assisting at childbirth — important for saving the lives of both mothers and infants.

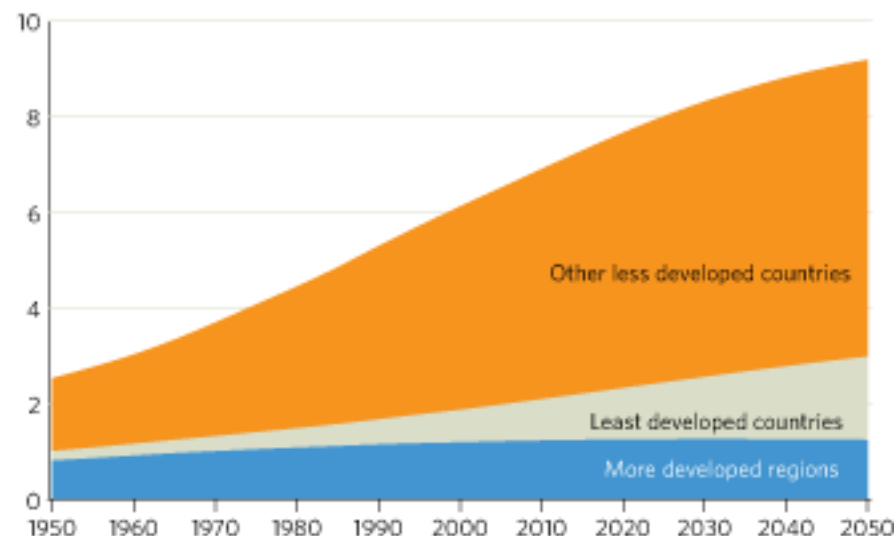
Percentage of mothers attended by skilled personnel at childbirth by wealth, 2005-2007.



Source: Recent Demographic and Health Surveys accessed at STATCompiler. www.measuredhs.com.

Most of the growth in the world's population is taking place in developing countries, especially in the 49 least developed countries where most of the population lives in extreme poverty. With large percentages of their populations in young and reproductive ages, the developing and least developed countries will continue to grow well into the future, and their share of total global population will increase. The population of the least developed countries is projected to grow faster than that of more developed countries, from 679 million in 2000 to 1.7 billion in 2050. Rapid growth in poor countries thwarts efforts to reduce poverty, expand access to education and health and attain other development goals.

Population growth by region, 1950 to 2050. (in billions)



Source: UN Population Division. *World Population Prospects: The 2008 Revision*.

The Cairo goals of ensuring access to family planning and health care during pregnancy and childbirth are key to saving the lives of women and newborns.

A woman's risk of injury or death as a result of pregnancy or death is much greater when:

- She becomes pregnant before age 18
- She has another pregnancy less than two years after giving birth
- She does not obtain prenatal care
- She does not have access to skilled health personnel or emergency care during childbirth

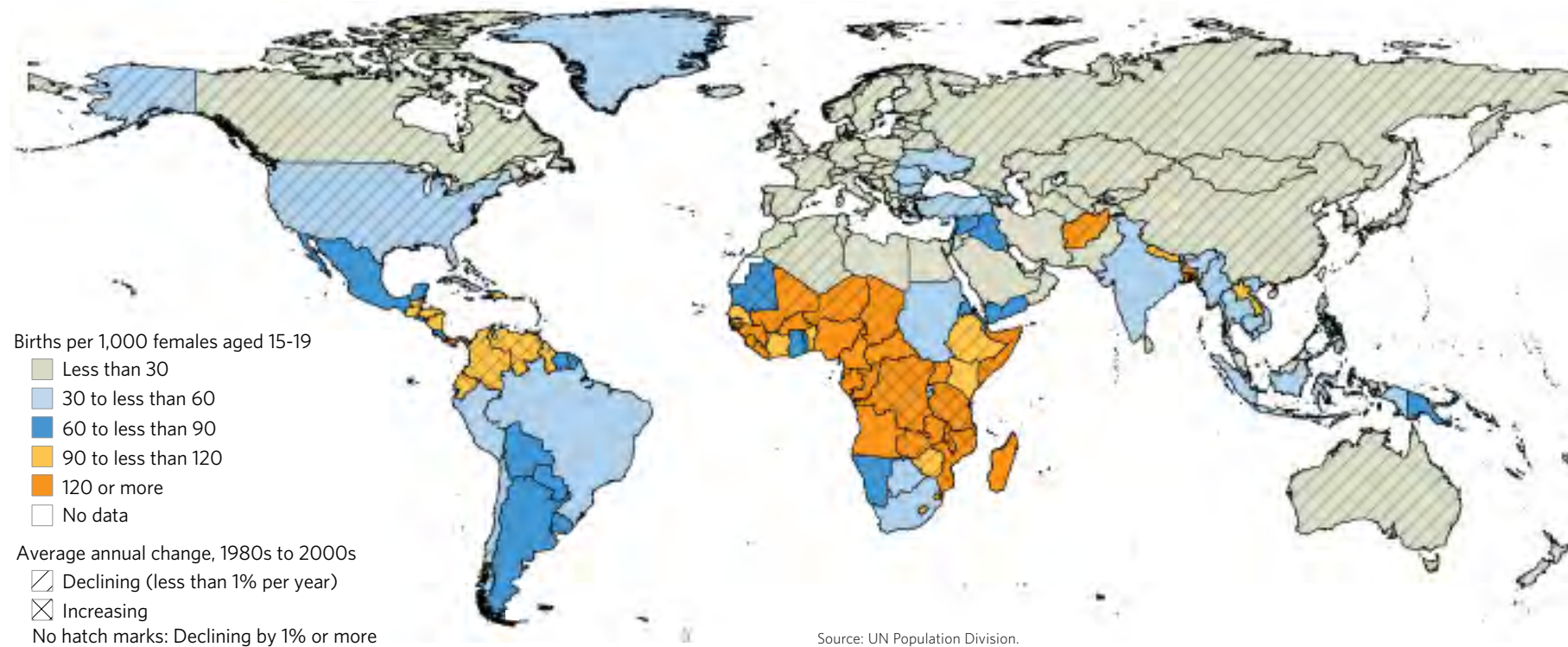
These same factors also put infants at a higher risk of death or serious health problems.

Pregnancy-related complications, including unsafe abortions, are the leading cause of death for young women aged 15 to 19 worldwide.

In numerous countries, 30 per cent or more girls are married and become pregnant before age 18. For both physiological and social reasons, girls aged 15 to 19 are twice as likely to die in childbirth as are women in their twenties. Girls under age 15 are five times as likely to die of pregnancy-related causes as those in their twenties.⁵

The birth rates of teenage women vary widely around the world. In many countries where teen birth rates are high, rates are actually increasing or are falling very slowly.

Teen birth rates, c. 2005.



ENSURING ACCESS TO FAMILY PLANNING IS KEY TO SAVING LIVES AND IMPROVING HEALTH.

Globally, 56 per cent of all women who are married or in union use a modern method of family planning. Enabling women to have children if and when they want them promotes maternal and child health and helps parents provide better lives and opportunities for their children.



A 16-year-old pregnant girl in Guatuso, Costa Rica. She decided to continue with her studies, so she's wearing her high school uniform.

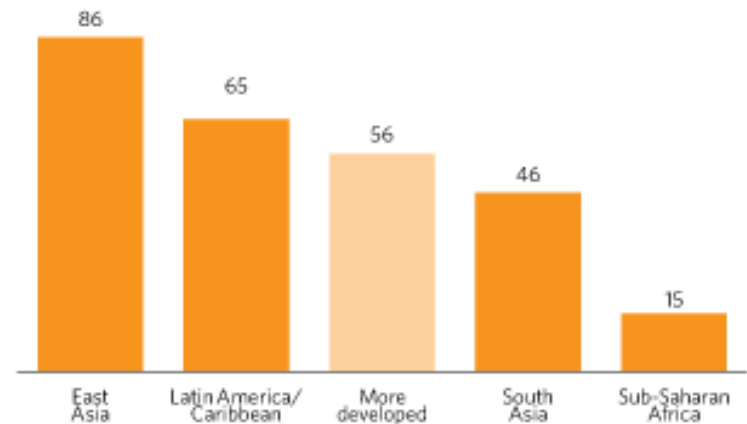
Rising demand for family planning contributes to the growing number of women with an unmet need for effective contraceptives as more women want smaller families. Globally, more than 200 million women have an unmet need for contraception: They want to delay their next pregnancy by at least two years or stop having children, but are not using a modern method of contraception. The most common reasons women do not use contraception when they want to delay a pregnancy are inadequate knowledge about contraceptive methods; fear of social disapproval; concern about potential side effects; and a belief that their husbands would oppose it.⁶

While at a global level unmet need declined slightly between the 1990s and 2005 (from 17 per cent to 15 per cent), in some countries, more than 40 per cent of women have unmet need.

And because of continued rapid population growth in countries with the greatest unmet need, the number of women facing unintended pregnancies has steadily increased since Cairo.

Use of modern contraceptives has increased worldwide, from about 47 per cent of women of reproductive age in 1990, to 56 per cent in 2007. But the rate varies widely by region, and less than one quarter of married or in-union women in sub-Saharan Africa use any form of contraception.

Percentage of married or in-union women, aged 15-49, using a modern contraceptive in 2007.

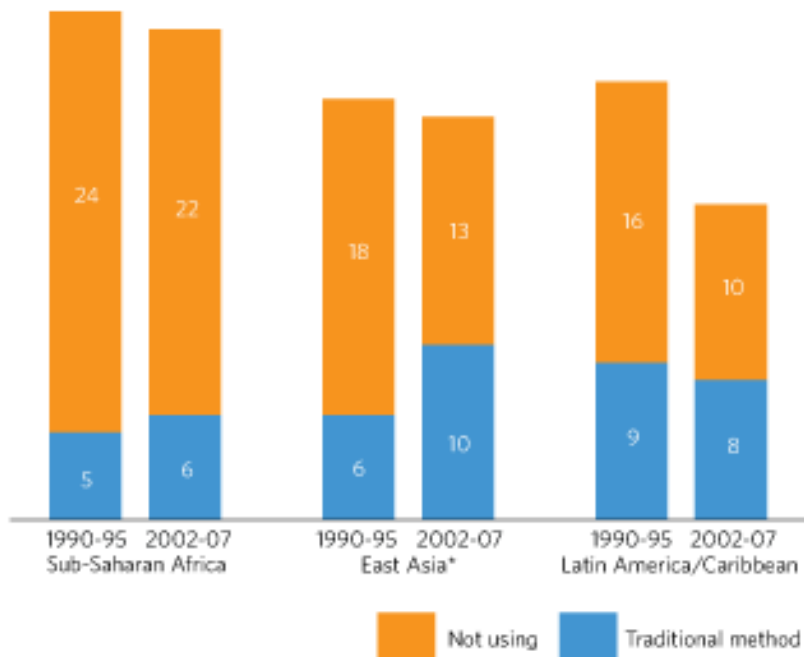


Source: UN Population Division. 2008. *Contraceptive Use 2007*.

The Cairo Consensus called for universal access to modern methods of contraception. Traditional methods, including withdrawal and periodic abstinence, have higher failure rates than do modern methods, and result in more unintended pregnancies and more unsafe abortions. Preventing unintended pregnancies by using effective contraceptive methods would reduce the need for maternal and neonatal care and post-abortion care.

Unmet need has remained high in less developed regions and has declined significantly only in Latin America since the early 1990s.

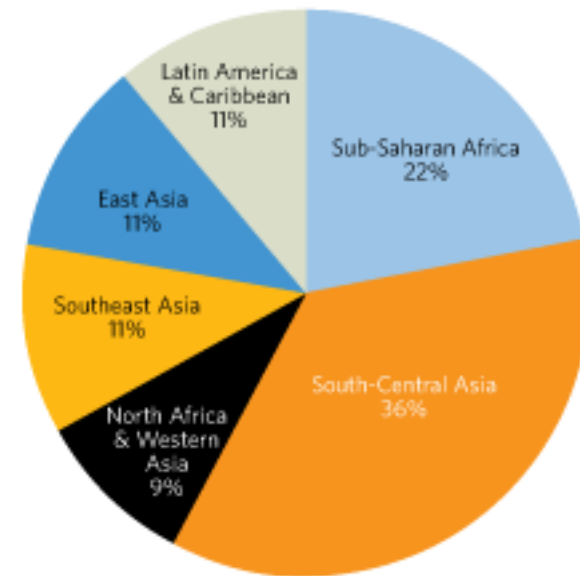
Percentage of married or in-union women, aged 15-49, who do not want to have a(nother) child within the next two years, but are not using a modern contraceptive method.



*excluding Japan.
Source: Guttmacher Institute. 2009.

Women in sub-Saharan Africa and South-Central Asia account for 58 per cent of women with unmet need for modern contraception. Unmet need is higher among women who are younger, have less education and who live in rural areas. These women are the most at risk of unintended pregnancy and unsafe abortion, and are the most likely to suffer maternal death or illness.

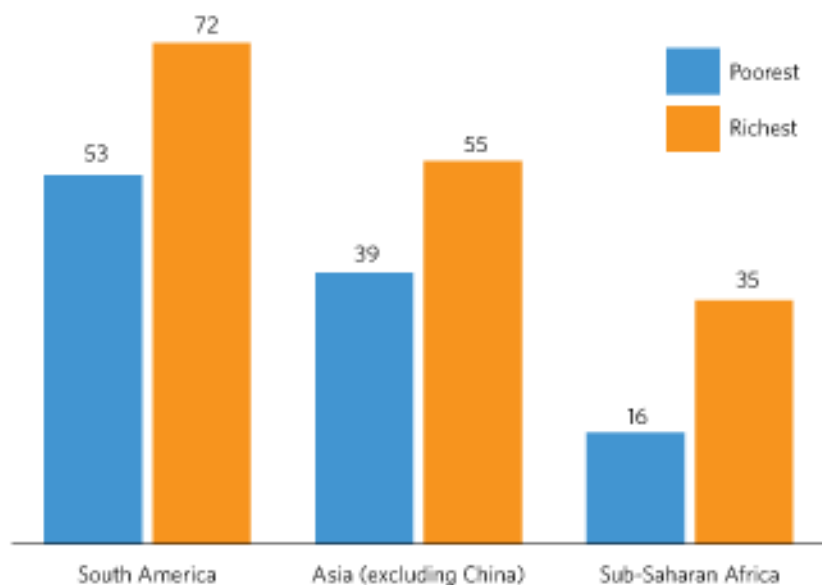
Distribution of women who have an unmet need for contraception by region, 2008.



Source: Guttmacher Institute. 2009.

Poorer women are much less likely than wealthier women to use contraception. The disparity in contraceptive use between the wealthy and the poor is only partly due to differences in their desires to limit or space births. Desired family size is influenced by education and access to knowledge about family planning. Poorer and rural populations tend to have less accurate and complete information about methods of family planning, and may be more influenced by myths and rumors about contraception. Those who are less well off may not be able to access contraceptives even if they want to use a method. Providers may also discriminate against poor clients and give better services to wealthier clients.

Percentage of married or in-union women, aged 15-49, using modern contraception by household wealth, c. 2006.



Source: Clifton, D., T. Kaneda, and L. Ashford. 2008. *Family Planning Worldwide 2008*. Population Reference Bureau.

Even with declining fertility, the number of women of reproductive age — the mothers of the present and future — will continue to increase. Recent demographic trends suggest that the number of women of reproductive age will rise from 1.3 billion in 1990 to 2.1 billion by 2050. Over that period, the number in more developed countries will stabilize and begin to fall, and all of the growth will occur in Africa and other less developed areas where fertility — and maternal and child mortality — remain high.



© Marc Westhof / UNFPA

Young children in Mardan, Pakistan.

PROMOTING GENDER EQUITY IS CRUCIAL FOR DEVELOPMENT.

The Cairo Consensus envisioned development from a gender perspective. It called for improvements in women’s health, education and empowerment that would lead to women’s increased ability to contribute to economic and social growth and development.

“It is essential to improve communication between men and women on issues of sexuality and reproductive health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private life.”

ICPD Programme of Action 4.24

Cairo recognized not only that gender equity was essential to development, but also that it could only be achieved with the constructive engagement of men.

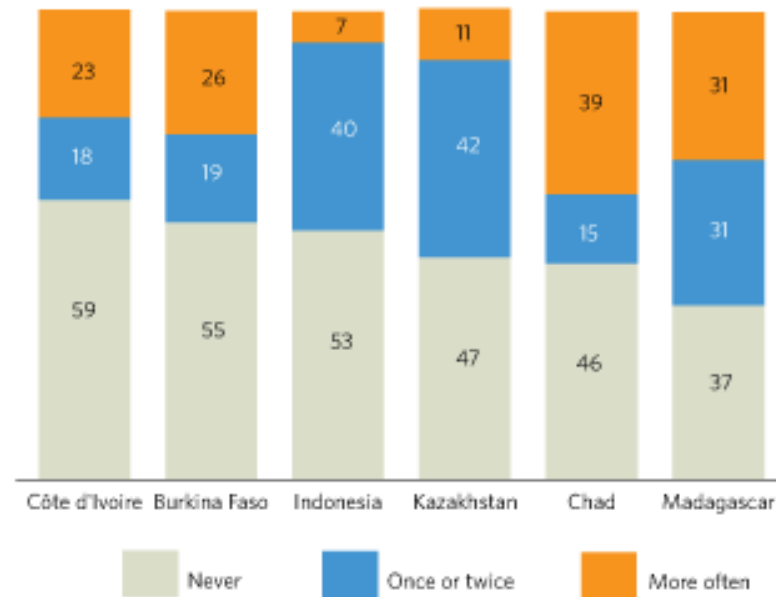
Conversations between partners increase family planning acceptance. While progress to engage men in support of family planning and reproductive health has occurred, communication about such issues remains difficult in many societies.

Men may therefore be unaware of the importance of family planning and birth spacing for maternal and child health. Women may mistakenly assume that their

husbands oppose family planning. Alternatively, family planning may be seen only as a woman’s concern — even as she may not be able to access it.

Cairo called upon men to share responsibility with women, but family planning remains largely the responsibility of women. Globally, vasectomy accounts for less than 20 per cent of all sterilization, and condom use represents about 10 per cent of total contraceptive method use.

Percentage of husbands who know of a method of contraception and have discussed family planning with their wives in selected countries, c. 2000-2007.



Source: Recent Demographic and Health Surveys accessed at STATCompiler. www.measuredhs.com.

Income Disparity and Gender Inequality Go Hand in Hand

Women are half of the world's population but make up 60 per cent of the world's poorest, and two thirds of the world's illiterate.

A woman's ability to earn income is tied to her education, the number of children she has, her ability to prevent unintended pregnancies and her access to labour markets and to credit. Seventy-five per cent of women lack access

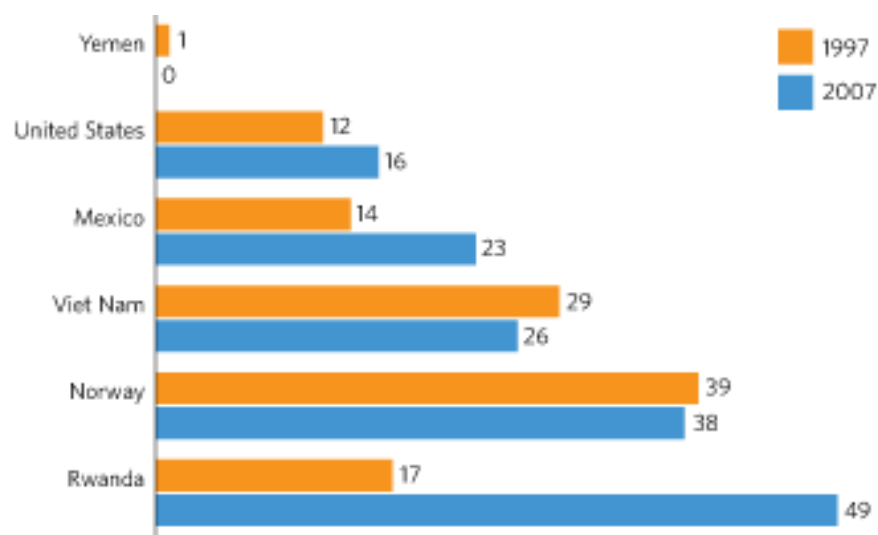
to credit. Where women are able to get small (micro-credit) loans, they have successfully built businesses and improved the lives of their children and families.

Access to comprehensive reproductive health services in combination with girl's secondary education enable women to participate in the paid labour market and to have earnings closer to those of men.

While the percentage of women in non-agricultural employment is growing, it remains small in some communities, especially where women's freedom of movement is limited.

Women cannot achieve equal rights within society if they are shut out of political decision-making. Women have raised their profile in political bodies in many — but not all — countries around the world. In 2007, they are under-represented nearly everywhere.

Women's percentage of seats in national parliament.



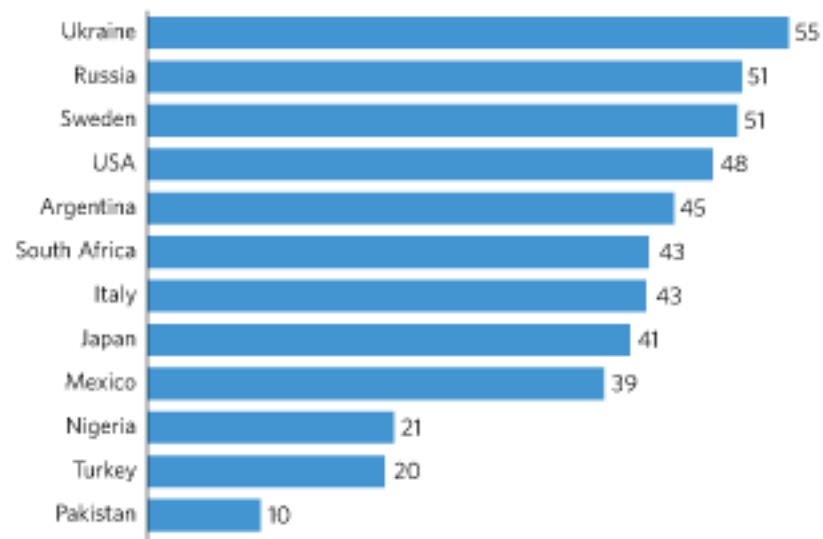
Note: Refers to the lower or single house of parliament.

Source: UN Statistics Division. "Gender Info 2007". <http://data.un.org>.

Women's participation in the wage labour force varies widely, influenced by child-rearing, educational and employment opportunities and mobility.

The range of women's participation in the non-agricultural labour force is quite wide. Pakistan at 10 per cent is among the lowest, while in Russia and Ukraine, women comprise more than half. Women's access to prestigious sectors and positions is still limited in many countries. Women are also in the majority of those working in the informal labour sector, where risk of exploitation and abuse are higher.

Women as a percentage of the non-agricultural labour force, 2005.



Source: UN Statistical Division. "Gender Info 2007". <http://data.un.org>.

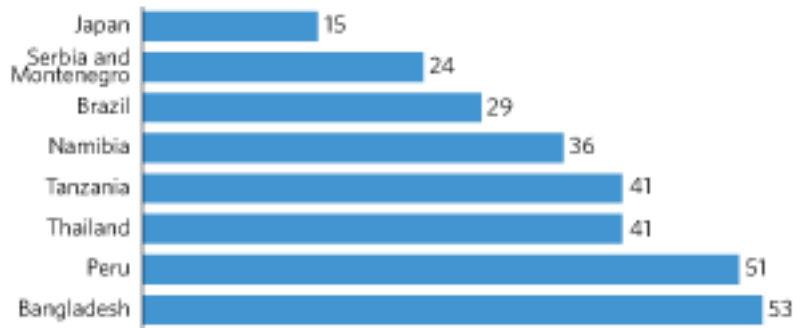
ENDING VIOLENCE AGAINST WOMEN IS ESSENTIAL TO HEALTH AND HUMAN RIGHTS.

According to a recent World Health Organization (WHO) survey in 10 countries representing very different geographic regions and cultural traditions, between one eighth and two thirds of women experienced physical or sexual violence, or both, at some time in their lives. Results from eight of these countries are shown below.⁷

Younger women are more likely than older women to be victims of gender-based violence. As many as 48 per cent of young women reported in recent surveys that their first sexual experience was forced.⁸

Violence against women violates their human rights, and is a significant factor in poor health experienced by women, infants and children.

Percentage of women who reported having experienced physical or sexual violence or both at least once in their lifetimes, cities in eight countries, 2005.



Source: Moreno-Garcia, C., et al. 2005. WHO multi-country study on women's health and domestic violence against women.



A young Nepalese woman bears the marks of domestic violence. Safebagar, Nepal.

HELPING GIRLS STAY IN SCHOOL IS ONE OF THE BEST INVESTMENTS POSSIBLE.

Like family planning, the education of girls is a “best buy” for development. Better educated girls are less at risk of death and disease; have fewer, healthier children; and higher earnings. For each year of schooling she completes, a girl’s income increases by 10 to 20 per cent.⁹

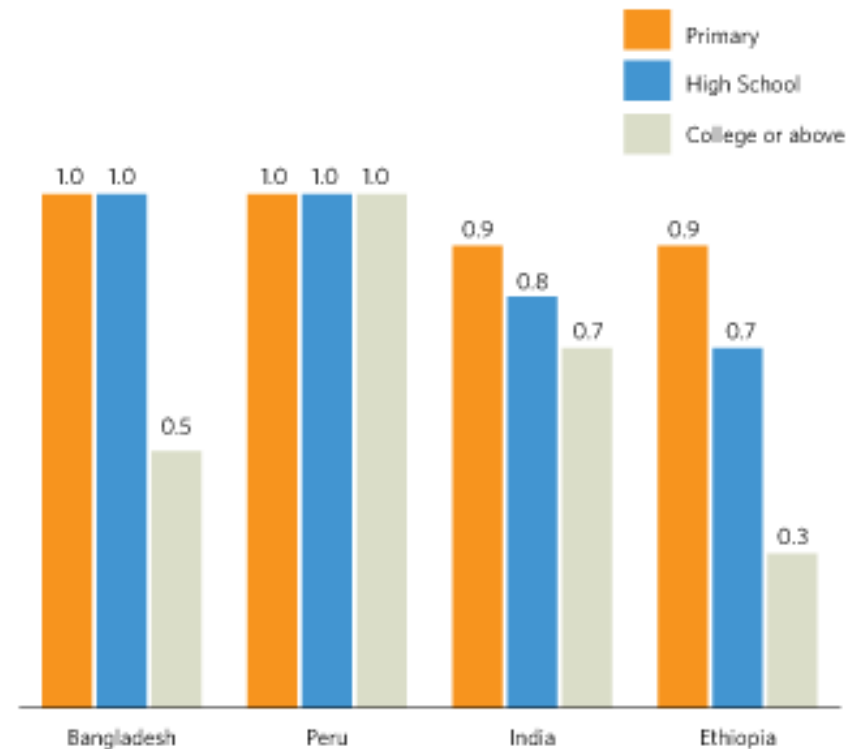
Globally, 122 girls are out of school for every 100 boys. The gender gap among out-of-school youth is much wider in some countries such as Yemen (230 girls for every 100 boys), and India (181 girls for each 100 boys). Girls in many countries are much less likely than boys to attend high school and college or university.¹⁰

Significant progress has been made in educating girls, at least through the primary grades. Nevertheless, 58 out of 86 countries that lacked universal primary education are not expected to reach this goal by 2015.

Adolescence is also a period of vulnerability to life-changing events, from child marriage or coerced sex to unintended pregnancies and HIV/AIDS. Keeping girls enrolled in school through the secondary level reduces vulnerability and furthers their economic and social development.

Progress is being made in achieving gender parity in education in most countries, particularly at the primary level. While the gender gap has disappeared at all levels in some countries, such as Peru, it surfaces in secondary or high school and especially at the college level in many countries.

Ratio of girls to boys, 2005-2007 (1.0 = equal number of girls and boys).



Source: UN Statistics Division. "Gender Info 2007". <http://data.un.org>.

Many Factors Influence Girls to Leave School Early

Even where education is free, parents expect daughters rather than sons to perform household tasks, fetch water and firewood, care for younger siblings and contribute to family income.

Distance to the school and lack of transportation also present greater disadvantages for girls, as parents fear for their daughters' safety in walking to and from school, especially since gender-based violence and sexual assault are not uncommon.

Lack of sanitary facilities and teachers who discriminate against or sexually harass female students also contribute to girls leaving school early. Poor parents may also withdraw a daughter from school for an arranged marriage.

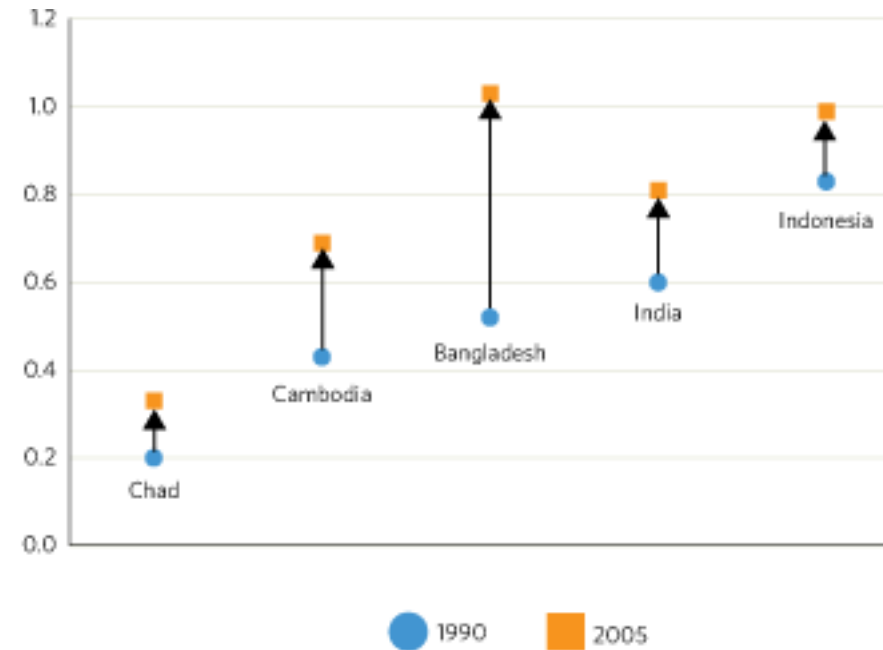


Girls and boys attend primary school together at a village school in Sierra Norte, Oaxaca, Mexico.

The ratio of girls to boys in secondary school has improved in most countries, but remains quite low, especially in the least developed countries.

In Chad, less than 4 girls attended high school for every 10 boys in 2005 — still it was an improvement over 1990. In Bangladesh, girls gained equality with boys at the high school level between 1990 and 2005.

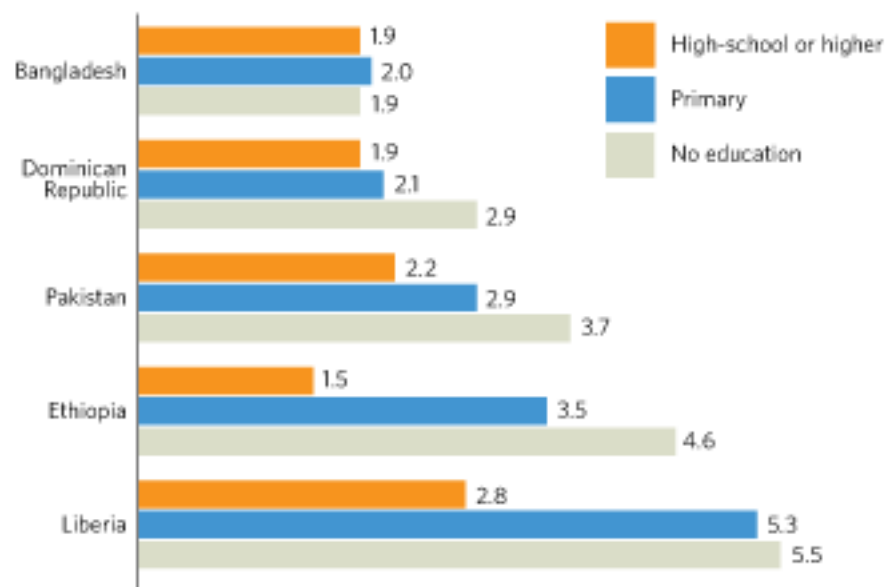
Ratio of girls to boys enrolled in secondary school. (1.0 = equal number of girls and boys)



Source: UNESCO Database. Public Reports: Education. <http://stats.uis.unesco.org>.

Except in a few countries such as Bangladesh, women with no education want more children than women with primary or higher education. The difference is especially great in Ethiopia, where women with a high-school or higher education want just 1.5 children, while Ethiopian women with no education want an average of 4.6 children.

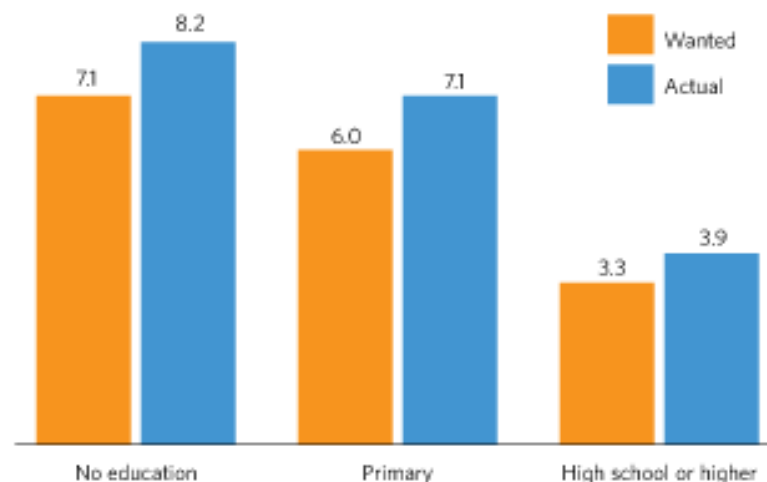
Number of children women want by woman's level of education, 2005-2007.



Source: Recent Demographic and Health Surveys accessed at STATCompiler. www.measuredhs.com.

Women who have more children than they would like represent a large potential demand for family planning services to help them avoid unwanted pregnancies. Education is strongly linked with the number of children women want and actually have. This difference is stark in Zambia, where women with no education wanted 7.1 children and had, on average, 8.2 children. Women with at least a high school education wanted just 3.3 children, but had an average of nearly four children.

Percentage of women by number of children they want and actually have by education level, Zambia, 2007.



Source: Zambia Demographic and Health Survey, 2007. www.measuredhs.com.

PROTECTING THE HEALTH OF INFANTS AND CHILDREN IS AN IMPORTANT GOAL OF CAIRO.

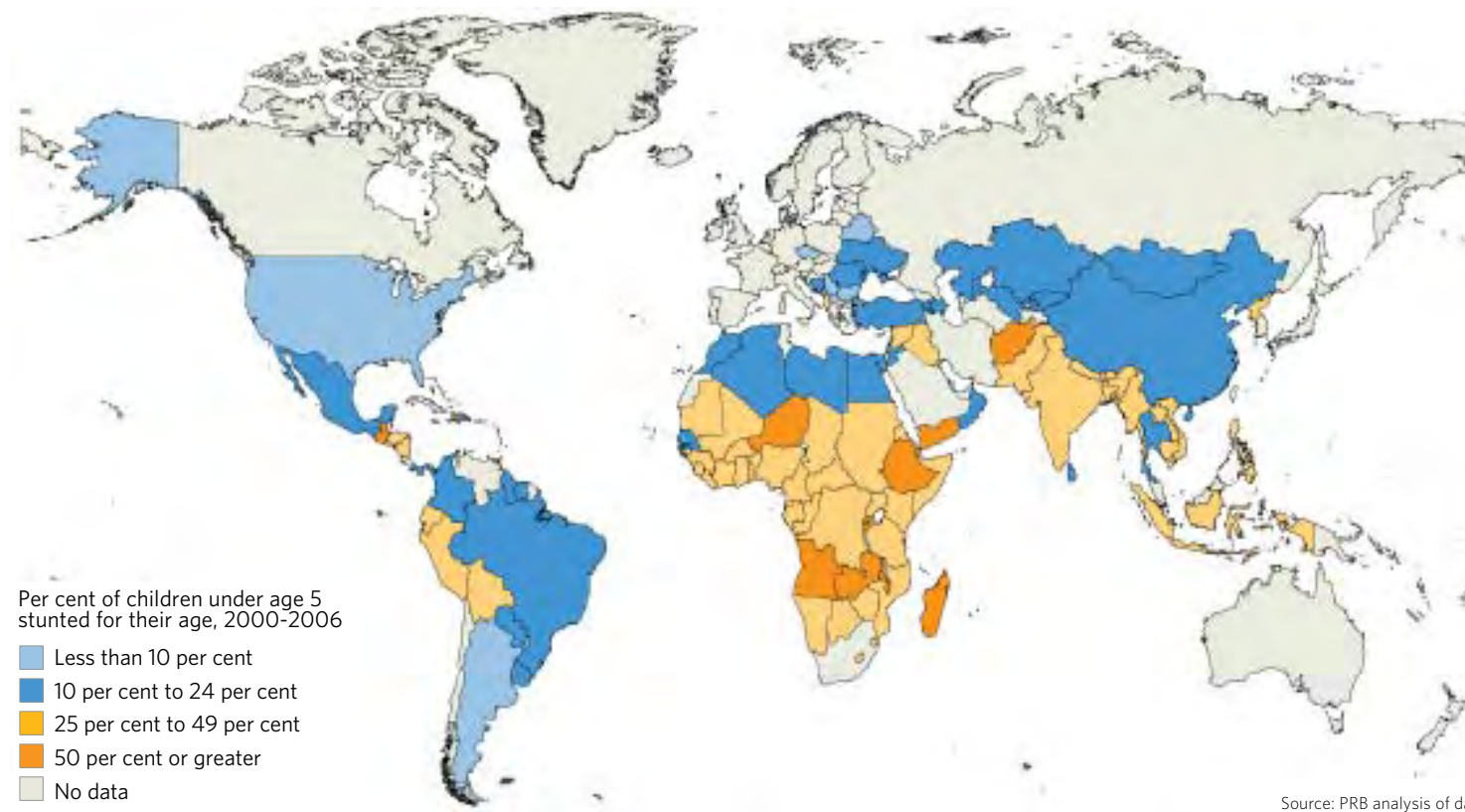
The significant reductions in infant and child mortality by 2015 called for in the Cairo Consensus are now measured as Millennium Development Goals. While infant and child health has improved, millions of children die each year of easily preventable causes, particularly in Africa.

The principal remaining causes of death to young children are pneumonia, diarrhea, malaria, measles and HIV/AIDS.

Undernutrition is an underlying factor in more than half of deaths to children under age 5 and is directly linked with poverty and mother's age, education and nutritional status. Infants born to adolescent girls are more likely to be premature and have a low birthweight — and they are at higher risk of dying before age 5.

Undernutrition in some societies reflects gender discrimination: When there is not enough food for all, girls receive less than boys.

Percentage of children under age 5 who are shorter than normal for their age, 2000-2006.



Source: PRB analysis of data from UNICEF, accessed at <http://data.un.org>.

Good Nutrition Prevents Child Deaths and Is Essential For Children to Reach Their Full Potential

Nutritional status of children is measured by height for age (stunting) or weight for age (underweight). Thirty per cent of children in low and middle income countries are stunted or underweight, with significant variations within regions. Measurements of height and weight for age are therefore important markers of child health and vulnerability.

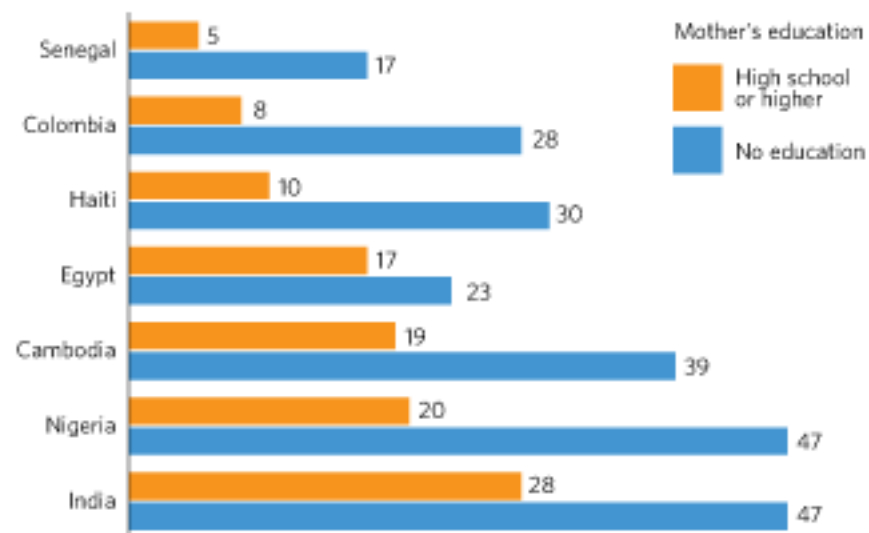
Stunted and underweight children do not reach their biological potential for growth, and do not achieve their full potential to learn. They do less well in school and are more likely than well-nourished children to leave school early.



A young mother and child from Mozambique. UNFPA-supported programmes in Mozambique include a focus on maternal health, HIV/AIDS, family planning and young people.

Mother's education is linked to her children's nutritional status. As an underlying factor in a majority of deaths to children under age 5, eliminating undernutrition is an essential strategy for keeping children alive and enabling them to live full lives and contribute to development. Mothers with more education generally have higher "health literacy" — they know the importance of basic hygiene and nutrition for their families' health. Educated mothers are far less likely to have undernourished children.

Percentage of children under age 3 who are shorter than normal for their age, 2005-2006, by mother's education level.



Source: Recent Demographic and Health Surveys accessed at STATCompiler. www.measuredhs.com.

INVESTING IN YOUNG PEOPLE TO HELP THEM SUCCEED ADVANCES THE CAIRO CONSENSUS.

In most countries in the developing world, 30 to 49 per cent of the population is under the age of 15, as compared to about 17 per cent in the more developed

“The reproductive health needs of adolescents as a group have been largely ignored by existing reproductive health services ... information and services should be made available ... to help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility. This should be combined with the education of young men to respect women’s self-determination and to share responsibility with women in matters of sexuality and reproduction.”

ICPD Programme of Action 7.41

countries. As these youthful populations become sexually active and vulnerable to unintended pregnancies, HIV and other sexually transmitted infections, the youth-friendly services called for in the Cairo Consensus become a priority. Young women and men often do not have access to reproductive health services, especially if they are not married.

Women, especially young women, are more vulnerable to HIV and other sexually transmitted infections in cultures in which they lack the power and skills to negotiate for safe sex with their partners.

Regional rates of HIV-infection vary strongly by sex. In North America, South and Southeast Asia and the Caribbean, the majority of youth aged 15 to 24 living with HIV are young men, while in sub-Saharan Africa, where most people with HIV live, young women are three times more likely than young men to be infected.

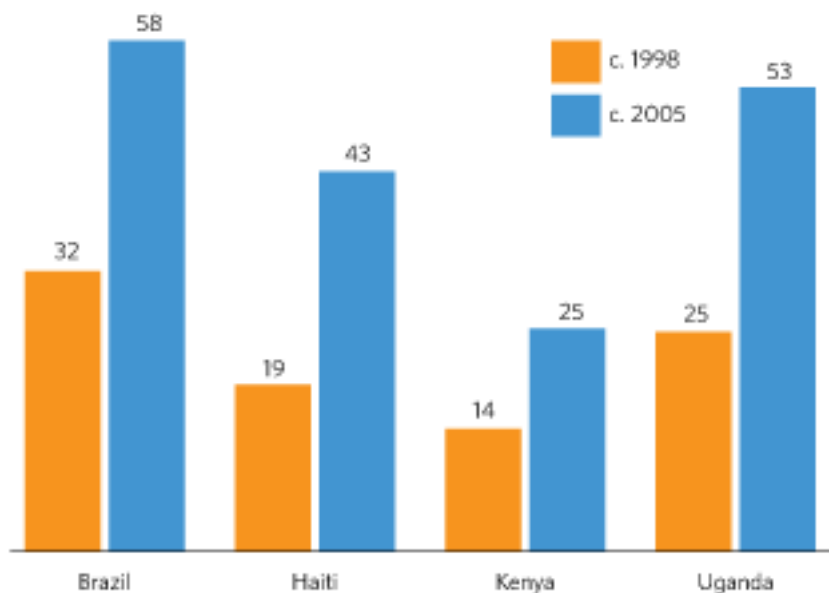


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The stigma of being HIV positive runs high in many societies and often prevents young people from getting tested for HIV. Voluntary counselling and testing programmes are crucial for controlling the spread of HIV/AIDS.

Young women and men are learning to protect themselves against sexually transmitted infections though the use of condoms. Although condom use is low in all regions of the world, both male condoms and the female condoms are being used more frequently. Between 1998 and 2005, the percentage of women aged 15 to 24 who used a condom at their last high-risk sex rose from 19 to 43 per cent in Haiti, and from 25 to 53 per cent in Uganda, both high HIV-prevalence countries. Yet, in Brazil, with a higher overall rate of contraceptive use, more than 40 per cent of young women did not use a condom the last time they had high-risk sex. In Kenya, 75 per cent did not protect themselves by using a condom.

Percentage of women, aged 15-24, who used a condom at last high-risk sex.*



*Sex within the last 12 months with someone who is not a spouse or regular partner.

Source: UN Statistics Division, "Gender Info 2007". <http://data.un.org>.

Young people are usually two to three times more likely to be unemployed than older adults. In 2006, about one quarter of North African youth aged 15 to 24 were unemployed, among the world's highest rates. Even in East Asia, which has seen record economic growth, youth unemployment was above 7 per cent. Young people need education, skills and job opportunities to succeed, and they need to stay healthy and be empowered to exercise their rights. These include reproductive rights, by which they are able to avoid unintended pregnancies and sexually transmitted infections and delay family formation.

Percentage of youths, aged 15-24, unemployed, 2006.



Source: ILO, "Youth Indicators", Key Indicators of the Labour Market (KILM), accessed at www.ilo.org.

Investing in Youth — Capturing The Demographic Dividend

People of working age generally support those who are too young or too old to work, either directly or through taxes. If fertility declines rapidly, relatively fewer children are born, and those in the working ages have fewer people who depend on them for support. Under the right conditions, this favorable ratio of workers to the economically dependent population can create the opportunity for a time-limited but substantial boost in economic growth, called a “demographic dividend” or “bonus”.

With fewer dependents to support, a country can invest more of the economic output of its workforce and spend more to improve health care and education, develop technology and skills to strengthen the economy, and protect the environment.

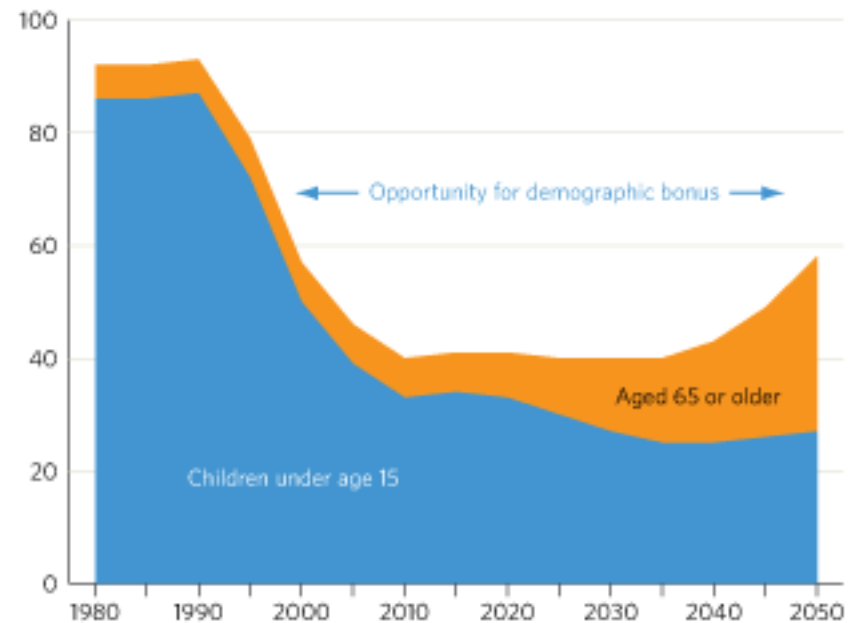
The demographic dividend can only be realized when there has been investment in the health, education and skills of youth and in creating job opportunities for them to fill as they enter the working ages. The demographic bonus provides a one-time window of opportunity that closes as the population ages.



Woman vendor at Pasar Rumput market. Jakarta, Indonesia.

As the ratio of dependent-age to working-age population falls, there is an opportunity for a demographic bonus, because a larger workforce is supporting relatively fewer people. Iran's age profile provides an example. Between 1980 and 2005, Iran's ratio of working-age to dependent-age population fell by half, from 92 dependents to 46 dependents. This favorable ratio will remain for several decades because of rapid and sustained fertility decline, which was assisted by a successful family planning programme.

Number of dependents per 100 working-age persons, Iran, 1980 to 2050.



UN Population Division. *World Population Prospects: The 2008 Revision*.

HEALTHIER LIVES DEPEND ON A HEALTHY ENVIRONMENT.

Population, poverty and the environment are closely intertwined. Rapid population growth contributes to environmental degradation, increased air pollution, soil depletion and deforestation and to global climate change. These factors have a direct effect on the poor, especially women.

More than a billion people lack access to safe water and 2.6 billion are without access to proper sanitation. Rapid population growth in the poorest countries has made progress difficult: While a 50 per cent increase occurred in the number of people with access to basic sanitation services between 1990 and 2004, the number lacking sanitation remained unchanged due to population growth.¹¹

Each year, lack of safe water contributes directly to the death of nearly two million children from diarrheal disease. Ninety per cent of diarrheal disease is linked to poor sanitation and hygiene, and unsafe water supply.

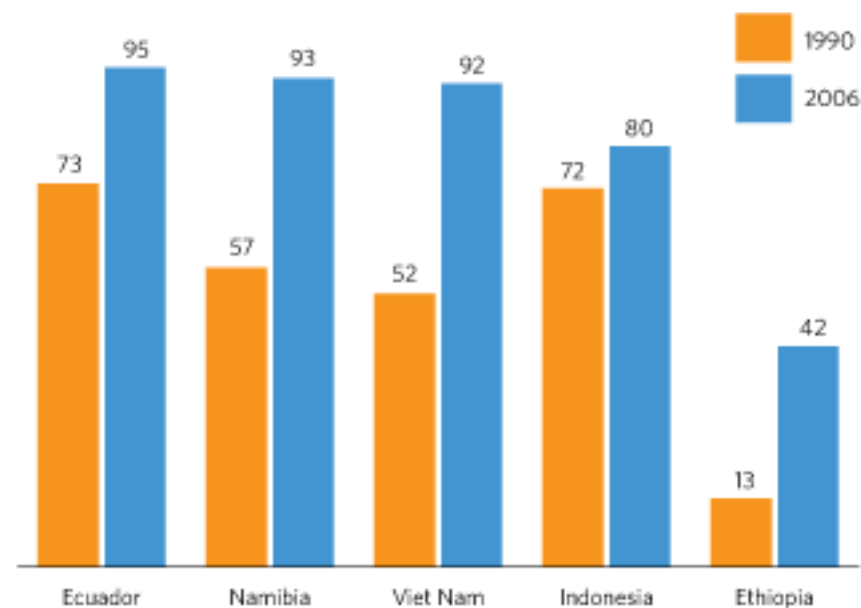
The lack of safe water and sanitation facilities has a disproportionate impact on women's lives. In many developing countries, women and girls are responsible for fetching water and firewood for the entire family. Women in many less developed countries walk several kilometers a day to collect water, carrying up to 20 kilograms of water on their heads.¹²



A woman carrying bread shares a dirt road with children on their way to school in a poor neighborhood of Cairo, Egypt.

A greater share of the global population has access to a safe water source. Ethiopia, Namibia, Viet Nam and several other countries achieved impressive gains between 1990 and 2006. Access to safe water and an improved water source are essential for maintaining health and preventing infant and childhood deaths.

The percentage of the population with access to an improved water source in selected countries, 1990 and 2006.

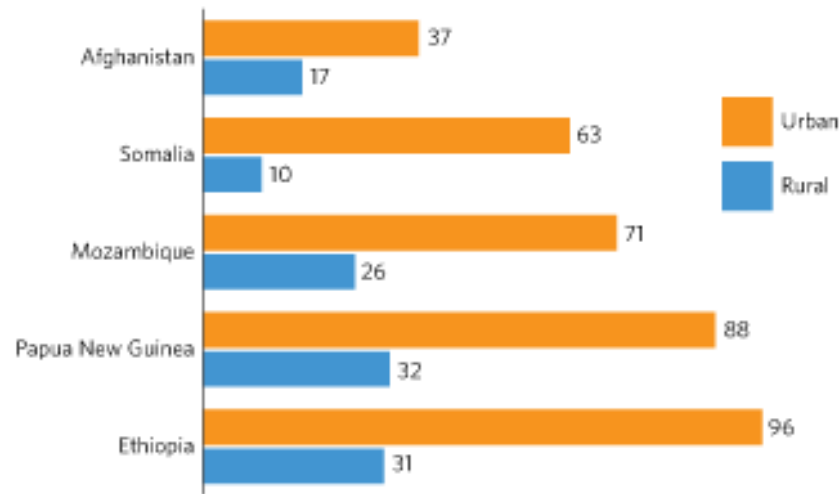


Source: UN Statistics Division. "Millennium Development Goals". <http://data.un.org>.

Population growth is concentrated in urban areas, accelerating the growth of urban slums. Lack of access to clean water, sanitation and other services contributes to poor health outcomes.

Urban residents are at least twice as likely as rural residents to have access to an improved water source in many low-income countries.

Per cent of urban and rural population with access to an improved water source in selected countries, 2006.



Source: UN Statistics Division. "Millennium Development Goals". <http://data.un.org>.

The majority of the rural poor and a substantial proportion of the urban poor rely on firewood for fuel and heating. As deforestation has made finding wood more difficult, women and girls spend as much as four hours per day collecting firewood, leaving less time for schooling or homework, child care, or especially, leisure.



A young Bolivian girl of African descent from Chicaloma, South Yungas.

WHERE DO WE STAND ON THE PROMISES OF CAIRO?

“Much has been achieved in the years since Cairo: concepts have been clarified, indicators selected; data compiled; programmes designed and evaluated; population-based analyses undertaken and priorities set; technologies expanded and improved; best practices identified and adopted; international and government agencies and NGOs activated; and evidence compiled ... on the cost-benefit ratios of investing in key aspects of sexual and reproductive health education and services. Nevertheless, much remains to be done if the vision of Cairo is to be realized”.¹³

What Is Needed to Meet the Goals of Cairo?

- Ensuring public health must be a priority for national political leaders
- Making health services for women and children easily accessible for all
- Skilled and motivated health workers at the right place at the right time
- Universal education
- Accountability for results with robust monitoring and evaluation
- Adequate financing and effective delivery
- Streamlined and harmonized aid operations

What Is Limiting Success?

Persistent inequities are key factors in limiting progress. Access to health information and services remains difficult among the poor and among rural and marginalized populations, including adolescents, refugees and people living with HIV. These vulnerable groups have:

- Higher unmet need for contraception and greater burden of unintended pregnancies and unsafe abortions
- Less access to HIV and STI prevention information and to antiretroviral and other treatment drugs
- A disproportionate share of maternal, infant and child deaths

Success is also limited by the:

- Difficulty of making strategic decisions with limited financial, human and infrastructural resources at national level
- Ineffective use of resources and corruption
- Lack of access to microcredit and lending to empower women
- Wars, political unrest, violence and forced migration
- Financial crisis threatening the health, well-being, livelihoods and education of millions
- Climate change and natural disasters

What Has Worked?

- Empowering women and providing them with economic and educational opportunity and equal rights
- Investing in youth
- Promoting positive behaviour change
- Microcredit to enable the vulnerable to develop their own means of support
- Bottom-up approach, enabling communities to identify their needs and to be involved in the solutions
- Involving the private sector and building public-private partnerships

GREATER POLITICAL COMMITMENT TO POPULATION, HEALTH, AND THE ENVIRONMENT IS REQUIRED.

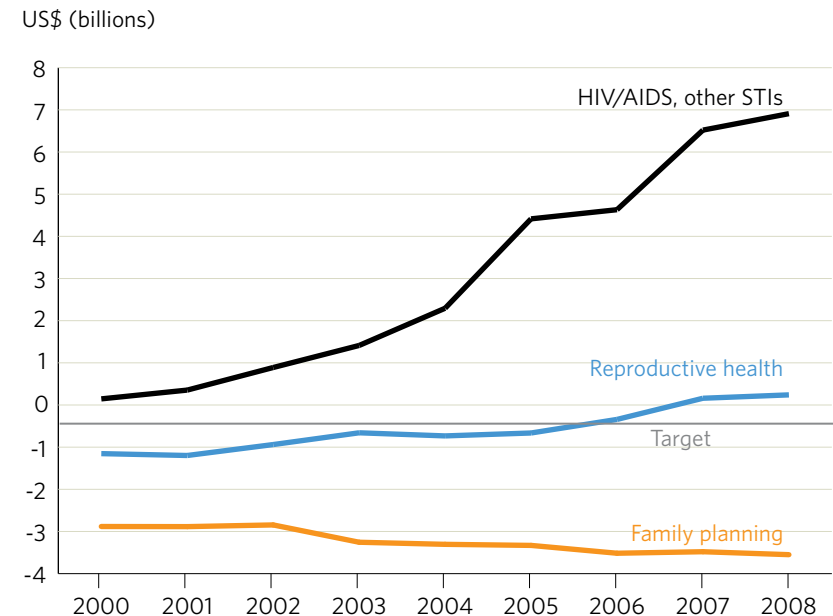
The Cairo Consensus reminds us of the importance of:

- Social determinants of health and health outcomes, particularly related to sexual and reproductive health
- Equity concerns and health disparities according to age, gender, wealth and location
- Civil society partnerships
- Rights-based and participatory approaches to development, stressing accountability mechanisms
- Long-term determinants of development, including demographic dynamics and climate change

Clearly, greater investment is needed if the vision of Cairo is to be achieved. As global aid for development increased nearly fivefold (from US\$2.9 billion in 1995 to US\$14.1 billion in 2007), aid for population and reproductive health, excluding funding for HIV programs, only doubled (from US\$901 million to US\$1.9 billion).¹⁴

Support for population and reproductive health fell from 30 per cent to 12 per cent of overall aid to health. The costs and benefits of family planning and maternal health care are synergistic and should be assessed jointly. While support for HIV/AIDS and other sexually transmitted infections has outpaced the targets set in Cairo, support for family planning (orange line) has fallen further from these targets since 2000. Spending on reproductive health (blue line) rose to target levels by 2007.

Actual spending above or below the 1994 Cairo targets by category, 2000 to 2008. (billions of U.S. dollars)



Source: UNFPA. 2009. *Report of the Secretary General on the Flow of Financial Resources for Assisting in the Implementation of the Programme of Action of the International Conference on Population and Development*, 42nd Session of the Commission on Population and Development.

FAMILY PLANNING IS COST-EFFECTIVE.

For each additional US\$10 million received for family planning, we can avert 114,000 unintended pregnancies, 50,000 unplanned births, 48,000 abortions, 15,000 miscarriages and more than 3,000 infant deaths.

The estimated global need for family planning and maternal and neonatal health in 2009 is US\$23.5 billion. This represents a gap of US\$10.1 billion for maternal health and US\$3.2 billion for family planning over current expenditures.



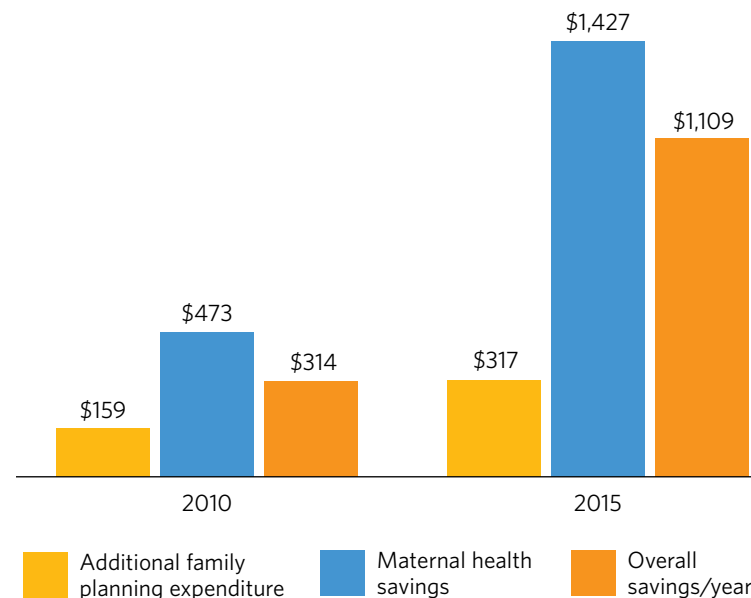
A woman makes tea in her tent on the grounds of the Saudi Maternity Hospital in El Fasher, Darfur, Sudan. It is the only maternal health care facility in the region. Women suffering from obstetric fistula are treated here through a programme supported by UNFPA. Some, whose home villages are far away, stay for many months until they are completely cured.

The resource requirements for the Cairo Program of Action have been updated in 2009. New funding estimates recognize increased costs of direct delivery of quality services, and added new components of maternal and newborn health, estimating associated programme and health system costs and including the reproductive health needs of people living in emergency situations. Family planning and maternal health services and programme costs are now estimated to rise to US\$33 billion by 2015, comprehensive HIV/AIDS programmes will then require US\$36 billion and basic data and research needs average US\$2 billion per year over the 2009-2015 period.

Satisfying Unmet Need Has Enormous Payoffs

If unmet need were completely satisfied, the accumulated savings in maternal health of US\$4.2 billion would be 2.3 times as great as the additional cumulative expenditures on family planning over a 10-year period — US\$1.8 billion. These are the direct savings from averting unintended pregnancies and do not include the other savings, for example, in education and health, that can be expected.

Overall savings and savings in maternal health from investing in family planning. (in millions of US dollars)



Source: UNFPA. Forthcoming. *Revised Cost Estimates: Methodological Report*.

References

1. World Health Organization (WHO). *2006 Neonatal and Perinatal Mortality: Country, Regional and Global Estimates*. Geneva: WHO.
2. Lawn, J.E., 2007. *A Price Tag for Newborn and Child Survival*. Accessed at www.countdown2015mnch.org/2005conference/alldocs/40%20Joy%20Lawn.ppt, August 2009.
3. Luby, S.P., et al. 2005. "Effects of Handwashing on Child Health: A Randomized Controlled Trial". *The Lancet* 366: 225-233.
4. Darmstadt, G.L., et al. 2005. "Evidence-Based, Cost-Effective Interventions: How Many Newborn Babies Can We Save"? *The Lancet* 365: 977-988.
5. World Bank, Maternal Mortality. Accessed at <http://go.worldbank.org/UQXMKI6L30>, August 2009.
6. Cleland, J., et al. 2006. "Family Planning: The Unfinished Agenda". *The Lancet* 368: 1810-1827.
7. Moreno-Garcia, C., et al. 2005. *WHO Multi-Country Study on Women's Health and Domestic Violence Against Women*. Accessed at www.who.int/gender/violence/who_multicountry_study, August 2009.
8. Lloyd, C., ed. 2005. *Growing Up Global: The Changing Transitions to Adulthood in Developing Countries*, Panel on Transitions to Adulthood in Developing Countries. Washington, D.C.: National Research Council.
9. Psacharopoulos, G., and H.A. Patrinos. 2004. "Returns to Investment in Education: A Further Update". *Education Economics* 12 (2): 111-134.
10. UNESCO, *Education for All, EFA Global Monitoring Report 2009* (GMR). Accessed at <http://www.unesco.org/en/efareport>, August 2009.
11. World Bank, *Water Supply and Sanitation*. Accessed at <http://www.worldbank.org/water>, July 2009.
12. IAEA, 2007. *Women and Water*. Accessed at <http://www.iaea.org/NewsCenter/News/2007/womeday2007.html>, August 2009.
13. de Francisco, A., R. Dixon-Mueller, and C. d'Arcangues. 2007. *Research Issues in Sexual and Reproductive Health for Low and Middle-Income Countries*. Geneva: Global Forum for Health Research and WHO.
14. World Bank. Press Release 2009/450/HD. Preliminary figures from a forthcoming 2009 report.

Resources

Adding It Up. The Guttmacher Institute and UNFPA. Available December 2009 at <http://www.guttmacher.org> and <http://www.unfpa.org>.

Beijing at Ten, UNFPA's Commitment to the Platform of Action. UNFPA. 2005. <http://www.unfpa.org/public/global/pid/348>.

Conversations for a Better World (website) <http://www.conversationsforabetterworld.com>.

Death and Denial: Unsafe Abortion and Poverty. International Planned Parenthood Federation. 2006. <http://www.ippf.org/en/Resources/Reports-reviews/Death+and+Denial.htm>.

Facts on Induced Abortion Worldwide. 2008. Guttmacher Institute. http://www.guttmacher.org/pubs/fb_IAW.html.

Facts on Young Men's Sexual and Reproductive Health. Guttmacher Institute. 2008. http://www.guttmacher.org/pubs/fb_YMSRH.html.

Family Planning Saves Lives. by R. Smith et al. 2009. Population Reference Bureau. <http://www.prb.org/Reports/2009/fpsl.aspx>.

"Family Planning: The Unfinished Agenda", by J. Cleland et al. 2006. *The Lancet* 368 (9549): 1810-1827. [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(06\)69480-4/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)69480-4/abstract).

Female Genital Mutilation (FGM). IPPF Briefing Paper. International Planned Parenthood Federation. 2008. <http://www.ippf.org>.

Female Genital Mutilation/Cutting: Data and Trends. by C. Feldman-Jacobs and D. Clifton. Population Reference Bureau. 2008. <http://www.prb.org/Publications/Datasheets/2008/fgm2008.aspx>.

For Women's Lives and Health: Report of the Global Safe Abortion Conference. Whose Right? Whose Choice? Who Cares? 23-24 October, 2007. Marie Stopes International and IPAS. 2009. http://www.ipas.org/Publications/For_womens_lives_health_Report_of_the_Global_Safe_Abortion_Conference_Whose_right_Whose_choice_Who_cares_23-24_October_2007.aspx.

Framework for Action on Adolescents and Youth. 2007. UNFPA. <http://www.unfpa.org/public/op/edit/cache/offonce/publications/pid/396>.

ICPD: International Conference on Population and Development (website). <http://www.unfpa.org/icpd/icpd.cfm>.

Population Ageing: A Larger and Older Population. Linking Population, Poverty and Development. UNFPA. 2009. <http://www.unfpa.org/pds/ageing.html>.

Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals. UN Millennium Project. 2006. http://www.unmillenniumproject.org/documents/MP_Sexual_Health_screen-final.pdf.

"Reducing Unmet Need for Family Planning: Evidence-Based Strategies and Approaches". UNFPA. 2008. *Outlook* 25(1). http://www.unfpa.org/webdav/site/global/shared/documents/publications/2008/EOL_nov08.pdf.

Revised Cost Estimates for the Implementation of the Programme of Action of the International Conference on Population and Development: A Methodological Report. UNFPA. forthcoming. <http://www.unfpa.org>.

State of World Population (annual). UNFPA. <http://www.unfpa.org/swp>.

"Unsafe Abortion: The Preventable Pandemic". by D. Grimes et al. 2006. *The Lancet* 368 (9550): 1908-1919. [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(06\)69481-6/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)69481-6/abstract).

Who's Got the Power? Transforming Health Systems for Women and Children. UN Millennium Project. 2005. <http://www.unmillenniumproject.org/documents/TF4Childandmaternalhealth.pdf>.



This report was produced by United Nations Population Fund (UNFPA) in partnership with the Population Reference Bureau (PRB). Contributors at UNFPA included Stan Bernstein, Zuzana Boehmova and Linda Demers. Contributors at PRB included Mary Mederios Kent and Karin Ringheim, with the help of Jay Gribble, Toshiko Kaneda and Erin Sines.

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ACKNOWLEDGEMENTS

The editorial team would like to acknowledge the assistance and inputs of many colleagues at UNFPA, including Ann Erb-Leoncavallo, Luc Debernis, Jose Miguel Guzman, Werner Haug, Katja Iversen, Mona Kaidbey, Richard Kollodge, Jacqueline Mahon and Saskia Schellekens.

Our thanks also go to Pat Donovan and Susheela Singh from the Guttmacher Institute for their technical input and support.



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ISBN 978-0-89714-963-1



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