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Imagine you are a young mother in Uganda who has been forced into sex work because you have no other options to provide for your four children. Or a woman in Haiti studying to be a midwife after a devastating earthquake destroyed your country’s hospitals and its cadre of skilled birth attendants. Imagine you are a pregnant Syrian refugee, looking for a safe place to give birth, or an adolescent girl in Guatemala, going in secret to receive contraception because your husband expects a child every year but you want to pursue an education, a job, a future.

I have seen the challenges these women and so many more around the world have faced — girls, women, and families who are in need of the same sexual and reproductive health services, including family planning, that many of us reading and writing this toolkit have been so privileged to enjoy.

I’ve also seen what women and communities can accomplish when their rights are realized. The sex worker in Uganda acts as a peer educator to other sex workers in her area, offering much-needed services to women who are traditionally stigmatized in their community. The midwives in Haiti now serve their community by providing a full range of prenatal, safe birth and antenatal care, including family planning. The pregnant Syrian refugee gave birth safely to a healthy baby, one of more than 7,000 infants delivered safely in the Zaataari refugee camp in Jordan. And the adolescent girl in Guatemala works as a community health promoter, distributing the same contraceptives she once sought in secret to dozens of women in her rural community.

Sexual and reproductive health and rights are fundamental to the health, dignity, and well-being of individuals around the world. They are also a critical — and proven — intervention for global development issues ranging from education to climate to economic development to security and stability. There is no question that women’s sexual and reproductive health and rights are essential for sustainable development. In fact, despite current political debates around these issues, there has long been global, bipartisan consensus on this matter, from explicit inclusion in the United Nations’ Sustainable Development Goals to bipartisan support for the creation of the UN Population Fund (UNFPA), the primary UN agency that works on reproductive health and family planning, as far back as 1969 under the Nixon administration.
But today, the health and rights of women and families all over the world are jeopardized. The administration and Congress have already begun cutting U.S. support to women’s health programs, from the reinstatement and expansion of the Global Gag Rule to the elimination of funding to UNFPA to slashing bilateral — or government-to-government — aid for these programs around the world. Because the U.S. is one of the largest supporters of international sexual and reproductive health and rights efforts, these unprecedented cuts pose the greatest threat to women’s health and rights in decades.

The truth is, we know how to make comprehensive sexual and reproductive health and rights a reality for girls and women around the world. We have the information. We have the tools. What we are missing is the political will from our world leaders to make this a reality, and we need to urge them to prioritize girls’ and women’s lives — for the individuals and for the world.

On behalf of the Universal Access Project — and of the girls, women and families around the world whose stories are waiting to be told — thank you for your interest in these important issues. I hope that this guide will help open pathways to deeper understanding and dynamic conversation at this critical time.
INTRODUCTION
Universal access to sexual and reproductive health and rights (SRHR) means that every individual has the opportunity for a safe and satisfying sex life and the freedom to decide if, when and how often they reproduce. To realize SRHR, an individual needs:

- To be informed about and have access to a safe, effective, affordable and acceptable contraception method of their choice;
- To be informed about and empowered to protect themselves from sexually transmitted infections;
- To be able to decide if and when to reproduce, and to have access to services for a healthy pregnancy, a safe delivery and a healthy baby; and
- To have the right to make their own choices about their sexual and reproductive health.¹

**CHALLENGE**

Today, 214 million girls and women in developing regions want to avoid or delay pregnancy but are not using modern forms of contraception. These women with an unmet need for modern contraception account for 84% of unintended pregnancies in developing regions.² Further, roughly 300,000 women around the world die every year — more than 800 each day³ — from preventable pregnancy-related complications, and complications from pregnancy and childbirth are the leading cause of death for adolescent girls in developing regions.⁴ Lack of access to sexual and reproductive health and rights has widespread consequences for women, families and communities. It means more unintended pregnancies and unsafe abortions, more maternal and newborn deaths and more childhood malnutrition, and can perpetuate the cycle of poverty to future generations. If a woman cannot plan her family, she cannot plan her future.

**OPPORTUNITY**

Evidence shows that realizing SRHR is life-saving in that it both reduces maternal and child mortality and morbidity and is a powerful tool to combat poverty and help societies thrive, as it empowers women to make reproductive decisions on their own timeline, therefore boosting their educational and economic prospects. Fulfilling the unmet need for family planning and providing quality maternal and newborn care would cost just $8.39 per person per year and would decrease maternal deaths to a quarter of current levels and newborn deaths to less than one-fifth of current levels.⁵ Further, every $1 invested in family planning saves between $4 and $31 across other sectors, including education, food, health, housing and sanitation.⁶

This toolkit provides background, context and resources for journalists writing about global SRHR and related topics. It includes an overview of key challenges and opportunities in ensuring comprehensive SRHR; a snapshot of the current U.S. political landscape with regards to SRHR; a summary of global commitments to SRHR and progress against those commitments; and in-depth information and additional resources on a variety of SRHR-relevant topics.

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The Universal Access Project, a project of the United Nations Foundation since 2008, empowers girls and women around the world by improving their access to sexual and reproductive health and rights globally. The Universal Access Project convenes leading donors, influencers and civil society advocates to strengthen U.S. government leadership on and support for sexual and reproductive health and rights, including access to family planning, around the world.

This collective effort helped protect more than $600 million in U.S. funding for international reproductive health and family planning in 2017, which is estimated to provide 26 million women and couples who want them with access to contraceptive services and supplies.7

Our NGO partners include:

- CARE
- Christian Connections for International Health (CCIH)
- Management Sciences for Health (MSH)
- The Guttmacher Institute
- United Methodist Church
- The International Center for Research on Women
- Planned Parenthood Federation of America
- PAI
- Wilson Center

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Access to quality reproductive health care and family planning services is often treated as a controversial issue – but in fact there has been long-standing global, bipartisan support for these issues. For decades, policymakers on both sides of the aisle have invested in women’s sexual and reproductive health and rights and the ripple effect these rights have on education, economic opportunity, human rights, and more. SRHR efforts have been included in UN and U.S. programming and policies for more than 50 years, a reflection of our global values of prosperity, security, and goodwill.

UN LEADERSHIP ON GLOBAL SRHR

The UN plays three key roles in global SRHR efforts:

1. **The UN implements.** UN agencies, such as the UN Population Fund, implement SRHR programs on the ground in more than 150 countries around the world, directly reaching people who are most in need.

2. **The UN sets standards.** The UN sets global standards by which countries and programs can measure development progress; for example, the World Health Organization sets standards for maternal and newborn health that are used to guide programs worldwide.

3. **The UN creates global consensus.** The UN has the unique role of convening the world to discuss, find areas of agreement and determine plans of action for important development issues on SRHR and beyond. The inclusion of sexual and reproductive health and gender equality in the Sustainable Development Goals, adopted by all 193 UN member states, is a prominent example of the UN facilitating global consensus on women’s rights and empowerment.

Key agencies, programs and initiatives related to SRHR under the UN umbrella include:

- The **UN Population Fund (UNFPA)** is the primary UN agency focused on SRHR. UNFPA works in more than 150 countries and territories that have requested help to ensure that every pregnancy is wanted, every childbirth is safe, and every young person’s potential is fulfilled. UNFPA works in approximately three times as many countries as USAID. Because of UNFPA’s global reach, U.S. investments in family planning and maternal health that are channeled through the organization reach far more women and girls in far more countries.

UNFPA is the largest multilateral provider of voluntary family planning information and services (excluding abortion). UNFPA supports the training and deployment of skilled birth attendants and midwives, prevents gender-based violence, and works to end the harmful practices of child marriage and female genital mutilation. UNFPA also delivers life-saving services to women and girls in war zones and refugee camps. For instance, previously supported with U.S. funds, UNFPA runs the maternal health clinic in the Zaatari Syrian refugee camp in Jordan, where it has delivered more than 7,000 babies without a single mother dying. In Iraq, a UNFPA clinic supports survivors of physical and sexual violence inflicted by ISIS. The clinic was 100% funded by U.S. contributions to UNFPA. For more information on UNFPA’s frontline humanitarian work, please see: “UNFPA Humanitarian Action: 2017 Overview.”

UNFPA does not fund or perform abortions anywhere in the world. Instead, it promotes voluntary family planning to prevent unintended pregnancies and recourse to abortion. UNFPA does not promote coercion or
birth quotas of any kind anywhere in the world and has publicly condemned human rights abuses in population policy — including sex-selective abortion, forced sterilization or abortion and birth quotas.

The U.S. government played a central role in the creation and launch of UNFPA in 1969. The U.S. has been an active member of UNFPA’s Executive Board, which vets and approves all UNFPA programs, for more than 45 years. As part of its global investments, the U.S. has for years been one of the largest contributors to UNFPA. In 2016, the U.S. was the fourth-largest supporter of UNFPA and contributed a total of $69 million to the agency, which included $32.5 million in core funding and approximately $36 million in targeted humanitarian funding. Last year, U.S. contributions to UNFPA core resources prevented an estimated 320,000 unintended pregnancies, 100,000 unsafe abortions and 10,000 maternal deaths.

• **Family Planning 2020 (FP2020)** is an international partnership that was born out of the 2012 London Summit on Family Planning, a major convening of governments, foundations, NGOs and civil society to accelerate progress on the Sustainable Development Goals related to SRHR. The Summit, hosted by the United Kingdom and the Bill & Melinda Gates Foundation, was considered to have put family planning “back on the agenda.” FP2020 works with governments, civil society, multilateral organizations, donors, the private sector and the research and development community to enable 120 million more women and girls to use contraceptives by 2020. In 2017, FP2020 will convene a follow-up to the 2012 London Summit, marking just past the halfway point of the initiative and looking ahead to achieving the 2020 goal.

• **Every Woman Every Child**, launched by then-UN Secretary-General Ban Ki-moon in 2010, is a global movement that mobilizes action by governments, NGOs, civil society and the private sector to address major health challenges facing women, children and adolescents around the world. The movement puts into action the Global Strategy for Women’s, Children’s and Adolescents’ Health, created in 2015, which presents a roadmap to ending all preventable deaths of women, children and adolescents within a generation and ensuring their well-being.

• **The World Health Organization (WHO)** creates global health care guidelines and standards as well as leads disease response; for example, WHO led the global response to the Zika outbreak, which included outreach to women of child-bearing age, pregnant women and their families and communities.

• **The International Conference on Population and Development (ICPD)** took place in 1994 in Cairo, Egypt, and outlined a new vision about the interconnection of population, development and individual rights. At the ICPD, 179 countries adopted a 20-year Programme of Action that signaled a shift in the conversation from population to sexual and reproductive health and rights. The Programme to this day serves as a roadmap for people-centered development.

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• The Beijing Platform for Action was born of the Fourth World Conference on Women in Beijing in 1995 and is considered the “most progressive blueprint ever for advancing women’s rights.”\(^9\) The Platform for Action envisions gender equality in all dimensions of life and outlines women’s rights, including SRHR, as human rights.

• Because SRHR is inextricably tied to global issues from poverty to child health to economic growth and more, other UN agencies and programs incorporate aspects of SRHR priorities into their work, including the Educational, Scientific and Cultural Organization (UNESCO); the World Bank; the Development Programme (UNDP); and the Children’s Fund (UNICEF).

SRHR IN THE GLOBAL GOALS\(^10\)

Adopted in 2000, the Millennium Development Goals (MDGs) were critical in raising awareness of and mobilizing resources for progress against poverty eradication by 2015. While the MDGs recognized good health and gender equality as key parts of the development agenda, explicit reference to sexual and reproductive health and rights was omitted by the MDGs and their related benchmarks until 2007, when advocates helped ensure that “Universal Access to Reproductive Health” became a necessary component and target (target 5B) of MDG5, “Improving Maternal Health”. But many critics viewed this inclusion as too narrow and not reflective of the overall rights-based SRHR approach that had developed since the ICPD Programme of Action. Additionally, MDG5 realized the least progress of all eight MDGs, and vast disparities between and within countries continue in this regard.

In 2015, 193 member nations of the UN adopted a new set of global goals: the Sustainable Development Goals (SDGs). The SDGs outline the post-2015 development plan and official agenda for sustainable development by 2030, and sexual and reproductive health and reproductive rights (SRH/RR) were included as a central tenant — both as a human right and a key component of health and well-being. Two SDGs include an explicit focus on SRH/RR:

SDG3: Ensure healthy lives and promote well-being for all at all ages

SRH/RR-related targets in SDG3:

• 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.

• 3.2 By 2030, end preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-five mortality to at least as low as 25 per 1,000 live births.

• 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.


• **3.7** By 2030, ensure universal access to sexual and reproductive health care services, including family planning, information and education and the integration of reproductive health into national strategies and programs.\(^{11}\)

### SDG5: Achieve gender equality and empower all women and girls

**SRH/RR-related targets in SDG5:**

- **5.2** Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.
- **5.3** Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.
- **5.6** Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.\(^{12}\)

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U.S. LEADERSHIP ON GLOBAL SRHR

Historically, the United States has been a leader on global SRHR, providing almost 50% of all global assistance to reproductive health and family planning. In FY 2017, the U.S. invested US$607.5 million in global SRHR efforts, including its contribution to UNFPA. This support is estimated to result in:

- Providing 26 million women and couples with contraceptive services and supplies.
- Preventing 8 million unintended pregnancies, including 3 million unplanned births.
- Averting 3.3 million induced abortions (most of them unsafe).
- Averting 15,000 maternal deaths.

In addition, the U.S. provides 36% of all family planning commodities purchased using public or donor monies in low-income countries.

The U.S. Agency for International Development (USAID) is the leading implementer of U.S. SRHR efforts and supports SRHR programs in more than 30 countries with the goal of providing more than 120 million more women and girls with access to voluntary family planning information and services by 2020. Other U.S. government efforts include the Centers for Disease Control and Prevention, which offers research, surveillance, technical assistance and collaborates with the WHO on SRHR issues; the State Department, which leads on diplomatic and humanitarian efforts related to SRHR; the National Institutes of Health, which conducts research on SRHR; and the Peace Corps, which incorporates SRHR issues into its volunteer activities.

Kaiser Family Foundation: Donor Governments as a Share of Total Bilateral Disbursements for Family Planning, 2014

NOTES: Represents donor government disbursements for family planning activities.

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HISTORY OF U.S. AND UN LEADERSHIP ON SRHR

• 1946: UN Population Commission founded (later renamed to the Commission on Population and Development); the UNCPD monitors and advises on population issues, trends, strategies, policies and programs.

• 1961: U.S. Congress first authorizes research on reproductive health and family planning under the Foreign Assistance Act.

• 1965: USAID launches its first family planning program and adopts a plan to reduce birth rates in developing countries through its War on Hunger program.

• 1967: Then-UN Secretary-General U Thant creates a trust fund for population activities (later to become UNFPA).

• 1968: USAID begins purchasing contraceptives to distribute in developing countries; UN declares “the ability to determine the number and spacing of one’s children” a basic right.

• 1969: With the U.S. playing a lead role, UNFPA becomes operational to provide women's health care, including voluntary family planning, in low-income countries.

• 1973: Abortion is legalized in the U.S.; Helms Amendment to the 1961 Foreign Assistance Act prohibits use of foreign assistance to pay for abortion services as a method of family planning.

• 1980s: USAID programs expand to address maternal, newborn and child health.

• 1984: President Reagan first institutes Mexico City Policy or Global Gag Rule (which was later rescinded by President Clinton, reinstated by President Bush, rescinded by President Obama and reinstated and expanded by President Trump).

• 1987: World population passes five billion; UN establishes World Population Day (July 11).

• 1990: USAID establishes the Central Contraceptive Procurement Project to provide contraceptives to USAID-supported family planning programs.

• 1994: The International Conference on Population and Development (ICPD) takes place in Cairo, Egypt; 179 countries adopt a 20-year Programme of Action which recognized that SRHR are cornerstones of population and development and continues to serve as a guide to people-centered and rights-focused development.

• 1995: USAID expands programs to address adolescent reproductive health; Beijing World Conference on Women launches the Beijing Platform for Action, a progressive blueprint for advancing women’s rights and establishing women’s rights as human rights.

• 2000: Millennium Development Goals are adopted.


• **2007**: “Universal Access to Reproductive Health” becomes a target of MDG5, “Improving Maternal Health.”

• **2010**: Then-UN Secretary-General Ban Ki-moon launches Every Woman Every Child with the goal of saving the lives of 16 million women and children by 2015; the Alliance for Reproductive, Maternal and Newborn Health is established by USAID, DFID, AusAID and the Bill & Melinda Gates Foundation.

• **2011**: World population reaches seven billion.

• **2012**: London Summit on Family Planning convenes governments, NGOs and civil society and launches FP2020.

• **2015**: Sustainable Development Goals are adopted; Every Woman Every Child launches the Global Strategy for Women’s, Children’s and Adolescent’s Health as a roadmap to ensure every newborn, mother and child not only survives, but thrives.

• **2017**: Trump Administration reinstates and expands Global Gag Rule and defunds UNFPA; She Decides global fundraising initiative launches; 2017 London Summit on Family Planning convenes.
CURRENT POLITICAL LANDSCAPE
2017: GLOBAL SRHR UNDER THREAT

Historically, U.S. political support for funding international SRHR programs has fluctuated with changes in administration and Congressional makeup. Statutory requirements and policies have restricted how, where and through which organizations funds are spent, starting with the Helms Amendment in 1973, which bars the use of U.S. foreign aid for abortion information or services as a method of family planning. But unprecedented efforts are currently under way to roll back gains in women’s sexual and reproductive health and rights. Recent policy and funding changes under the new administration and Congress threaten or cut off U.S. support for SRHR programs and put the health and rights of the world’s most vulnerable girls and women on the line. These three recent actions pose the greatest threat to international SRHR aid seen in decades and will have a devastating impact on girls, women, families, communities and the world:

- **Global Gag Rule:** On January 23, 2017, the U.S. administration instated a more harmful version of the Mexico City Policy, otherwise known as the Global Gag Rule. The Global Gag Rule prohibits international NGOs that receive U.S. funds from providing, referring to, or sharing information about abortion, even where it is legal, and even with their own, private funds — effectively forcing them to choose between receiving U.S. funds and providing comprehensive health care services (with some exceptions). Discussion of the Global Gag Rule has at times been oversimplified and portrayed as “cutting off funding for abortion.” But, it’s not that simple: Since 1973, current U.S. law under the Helms Amendment already prevents U.S. funds from paying for abortion as a method of family planning. The Gag Rule cuts off funding for any foreign NGO that discusses abortion, including where it is legal, even if they do so with their own money. This will impact NGOs providing crucial services such as maternal and child health care, comprehensive sex education and contraceptive services for the people who need it most.

In the past, the policy applied only to U.S. international reproductive health and family planning funds. However, the Global Gag Rule enacted in January 2017 expands the scope to all U.S. global health funding. In May 2017, the administration issued guidance on the implementation of the Global Gag Rule on global health funding under a new name: “Protecting Life in Global Health Assistance.” But this policy does the opposite of what its new name suggests: it expands the rule to apply to other aspects of global health assistance, impacting U.S. funding not only for reproductive health and family planning, but also for maternal and child health, nutrition, HIV/AIDS, malaria, tuberculosis, infectious diseases and neglected tropical diseases. Life-saving services will now be out of reach for women and communities who already have limited access to affordable, high-quality health care. This means that some of the most effective foreign NGOs in 60 low- and middle-income countries that provide prevention and lifesaving treatment for SRHR and broader global health issues will risk losing funding and could possibly be forced to shut down if they or their partners use non-U.S. government funds to provide, refer someone to, or even discuss abortion services. The Global Gag Rule now

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impacts 15 times more funding than its previous iteration, affecting nearly US$9 billion of global health assistance provided by the Department of State, USAID and the Department of Defense.

The reinstated and dramatically expanded Global Gag Rule will have a tragic impact on the world’s poorest families, particularly women and girls. Many organizations provide comprehensive health care, especially in rural areas where there may only be one clinic serving as a one-stop-shop providing everything from immunization to contraceptives to maternal and child care services to HIV and malaria treatment. The implications of the Global Gag Rule on these clinics and organizations will be devastating. When the policy was last enacted, health care clinics in many countries were forced to close and outreach services for the hardest-to-reach populations were eliminated, leaving many of the world’s poorest people without access to basic health care. Women and infants died from pregnancy-related complications, and in some countries, abortion rates (particularly unsafe abortions) went up — not down — as women were unable to access contraceptives and had more unintended pregnancies.

The Global Gag Rule is already having a very real impact in the lives of women and girls. For example: Marie Stopes International (MSI) and the International Planned Parenthood Federation, two of the largest SRHR organizations worldwide, have already said they will not comply with the Global Gag Rule — and will lose U.S. funding as a result. MSI estimates that, without alternative funding, it will be forced to scale back its services, which it estimates could result in upwards of 6.5 million unintended pregnancies, 2.2 million abortions, of which 2.1 million would be unsafe abortions, and 21,700 maternal deaths, from 2017 to 2020.22

Read more on the Global Gag Rule: Statement from UN Foundation President & CEO Kathy Calvin On New Restrictions Of U.S. Foreign Assistance To Limit Women’s Access To Health Care Globally

- **Cuts to UNFPA Funding:** On April 3, 2017, the administration issued a determination cutting off all U.S. funds to UNFPA. The State Department invoked the Kemp-Kasten Amendment, which prohibits aid to any organizations that the president determines is supporting or participating in the management of a program of coercive abortion or involuntary sterilization. Because of UNFPA’s programs in China, it has been subject to a longstanding false claim that it is complicit in coercive reproductive practices in keeping with China’s one-child policy. The reality is quite the opposite: UNFPA does not fund or perform abortions or forced sterilizations anywhere in the world, and it does not provide a single dollar to the Chinese government or the Chinese family planning agency. In fact, UNFPA’s advocacy for rights-based, voluntary family planning in China was key to moving China one step away from its one-child policy.

Because the U.S. was the fourth-largest contributor to UNFPA — and was the second-largest donor to UNFPA’s humanitarian work specifically — eliminating U.S. funds severely

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damages the agency’s ability to serve millions of girls and women globally. UNFPA estimates the loss of U.S. funding for even one year would prevent the delivery of services such as domestic violence counseling, pregnancy checkups and other vital services to 9 million people in humanitarian settings. For instance, previously with U.S. funds, UNFPA runs the biggest maternal health clinic in the Zaatari Syrian refugee camp in Jordan and has delivered 7,000 babies safely without a single mother dying in childbirth.\textsuperscript{23}

Read more on cuts to UNFPA:

- Statement from UN Foundation President & CEO Kathy Calvin On Elimination of U.S. Funds for UNFPA
- Statement by UNFPA on U.S. Decision to Withhold Funding
- Statement by the Spokesman of the Secretary-General on UNFPA

• **Cuts to Bilateral Funding:** The president’s fiscal year 2018 budget request proposes a complete elimination of all U.S. international aid for reproductive health and family planning, of which the U.S. is the largest global funder and major donor of contraceptive supplies. Even as one of the largest funders of global health and development programs, the entirety of foreign aid makes up less than 1\% of the U.S. budget. Cuts to this aid would have a devastating effect on people around the world while helping very little at home. It’s now in the hands of Congress to make the ultimate decision on FY18 funding.

These policy changes and funding cuts represent a loss of U.S. leadership as one of the largest global funders of sexual and reproductive health and rights and are in stark contrast to the American values of prosperity, security and goodwill. According to the latest analysis by the Guttmacher Institute, each cut of US$10 million of U.S. SRHR funding means:

- 433,000 fewer women and couples receiving contraceptive services and supplies.
- 128,000 more unintended pregnancies, including 57,000 more unplanned births.
- 55,000 more induced abortions (most of them unsafe).
- 250 more maternal deaths.\textsuperscript{24}

### GLOBAL AND DOMESTIC RESPONSE

The administration’s posture has triggered unprecedented domestic and international concern. In the U.S.:

- As of June 2017, 192 Members of Congress have now sponsored the **Global Health, Empowerment and Rights (HER) Act** to permanently repeal the Global Gag Rule; and
- 95 Members of Congress wrote to Secretary Tillerson urging the Administration to reverse its decision to eliminate funding for UNFPA.

Globally, in the days immediately following the Global Gag Rule announcement, the Netherlands Minister for Foreign Trade and Development Cooperation, Lilianne Ploumen, launched a global campaign — “**She Decides**” — to raise compensatory funds and galvanize political

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\textsuperscript{23} Goldberg, M. L. (2017, May 9). Thanks to the USA, 7,400 babies were born in this refugee camp without a single death. Now, the White House is pulling its support. UN Dispatch. Retrieved from https://www.undispatch.com/thanks-usa-7400-babies-born-refugee-camp-without-single-death-now-white-house-pulling-support/

commitments, including through a ministerial conference held in Brussels in March.

FP2020 and its core partners, UNFPA, the Bill & Melinda Gates Foundation and DFID, are convening the UN, governments, foundations, the private sector and civil society in London in July 2017 to redouble efforts for universal access to sexual and reproductive health, including family planning. The Summit will focus on four areas: (i) innovative financing, especially for commodities; (ii) strengthened supply chains that expand the range of contraceptives available to women, including through private-sector expertise in logistics; (iii) empowerment of young people, including through policy shifts that increase voluntary contraceptive access and uptake; and (iv) targeting those hardest to reach, especially women in humanitarian crises or facing other socio-cultural barriers. The Summit will complement the African Union’s Year of the Demographic Dividend, which has made access to modern contraception a key development objective for the continent.

Longer-term, FP2020 has already been focusing on the critical issue of domestic resource mobilization and the provision of a more complete spectrum of options for women and their families, which is the ultimate long-term solution. In 2016, FP2020 reported that in Eastern and Southern Africa, the region that has experienced the fastest growth in modern method use and the steepest decline in unmet need, for the first time more than 30% of women are using a modern method. And in West Africa, where contraceptive use has been persistently low, the nine Francophone countries of the Ouagadougou Partnership have achieved their collective goal of one million additional users between 2011 and 2015, and have now set a more ambitious goal of 2.2 million additional users between 2015 and 2020.

U.S. support for international SRHR over the past 50 years has embodied what remains true today: investing in the health and rights of girls and women — and empowering them to plan their families and their futures — is the right thing to do and the smart thing to do. Now is the time to build on progress, not reverse it. We have the opportunity to empower millions of girls, women, families and communities — but only if the U.S. protects and restores critical investments in international reproductive health and family planning.
EMERGING ISSUES

Following are emerging issues or unique angles in the broader conversation on SRHR:

• The impact of the new administration and Congress on global SRHR.
  Explore more: PAI’s analysis of the Global Gag Rule; Vox’s outlook on the defunding of UNFPA; and PAI’s overview of proposed cuts to bilateral funding for SRHR.

• The connection between access to SRHR and global security and stability.

• The economic payoff of investing in SRHR on individuals and the global economy.
  Explore more: Guttmacher’s analysis of the ROI of investing in SRHR, and McKinsey’s study on the ripple effect healthy women can have on global GDP.

• The multi-faceted impact of women on the environment and what it means for achieving climate sustainability.
  Explore more: Wilson Center’s Environmental Change and Security Program.

• Challenges of SRHR in humanitarian situations.

• Showcasing the real faces of SRHR around the world:
  Explore more: Universal Access Project’s “Global Voices for Family Planning.”
  - Get to know Perpetua and how access changed her life.
  - Get to know Margaret and understand what second chances can do.
  - Get to know Sherley and see how family planning allows her to be a successful entrepreneur.
  - Get to know Jerry, who works with HERproject to provide basic health care curricula and peer educator training to the employees of his apparel production company.
  - Get to know baby Rima and the doctor she was named after.
  - Get to know Butet and her passion for serving as a health educator in Jakarta.
COVERING SRHR: SENSITIVITIES & CONSIDERATIONS
COVERING SRHR: SENSITIVITIES & CONSIDERATIONS

Reporting on sexual and reproductive health and rights around the world offers incredible opportunities to tell the real stories of girls, women and families who are empowered by access to — or impacted by lack of access to — their full rights. Alongside these opportunities come sensitivities, particularly when it comes to the intersection of SRHR issues and underserved or at-risk populations, youth and adolescents, victims of violence, or specific religious and cultural norms. Remember that SRHR are fundamental human rights and that the individuals who are impacted by these issues are just that: humans.

Following are recommended considerations when covering global SRHR issues:

• **Be aware of religious and cultural norms.**
  Every community has its own religious and cultural norms. Being aware of these norms, particularly as they relate to SRHR, is critical in respectful coverage of SRHR issues at a community level. For example, understand how a community’s religious beliefs interact with its approach to or outlook on SRHR; or how cultural beliefs and traditions, such as traditional gender roles, impact realization of those rights.

• **Ensure fully informed consent.**
  Ensuring fully informed consent for interviews and photos is especially important when covering sensitive issues that often come alongside SRHR reporting. Take care to fully explain to a potential interview subject — either directly or through a translator in his or her native language — exactly what they are consenting to with regards to an interview or photo, including how it will be used. Confirm that you have their express permission to use their comments, photo and/or name or identifying information. Interviewing can be personal or feel intrusive at times, so consider if a subject has little (or no) experience with media and spend careful time with that individual to ensure they understand what is about to take place in an interview and what could be the resulting coverage.

  This is especially true for minors. When interviewing a minor on sensitive subjects and anything that could have personal or legal ramifications, ensure you have explicit minor and parental or guardian consent for the interview and that the minor and their parent or guardian fully understand what they are consenting to. Even with full consent, consider using a pseudonym and omitting any identifiable information such as photo, hometown, or anything that could be used in their community to identify them.

• **Protect sensitive issues and identities.**
  Take precautions to protect identities and ensure sensitivity when interviewing victims of sexual assault or gender-based violence; individuals with sensitive health status like HIV/AIDS; or subjects with a story that may be sensitive in their community, such as sex work, contraceptive use, or abortion. Always consider whether a resulting story with identifiable information for an individual — minor or not — could put them in danger or cause them to be ostracized in their community.
THE PROBLEM

Lack of access to sexual and reproductive health and rights has widespread consequences for women, families, communities and the world:

- **214 million** girls and women in developing regions want to avoid or delay pregnancy but are not using modern forms of contraception.\(^{25}\) This means more unintended pregnancies and more abortions, many of which are unsafe.

- An estimated **22 million** unsafe abortions are performed each year, mostly in developing countries.\(^ {26}\) Each year, approximately **47,000** women die due to unsafe abortion and around **6.9 million women** in developing regions seek medical care for complications from unsafe abortion.\(^ {27}\)

- Around the world, **300,000** girls and women die every year – that’s more than **800 every day** – from preventable pregnancy-related causes.\(^ {28}\) Complications from pregnancy and childbirth are the **leading cause of death** for girls aged 15–19.\(^ {29}\)

- An estimated **23 million** girls aged 15–19 living in developing areas are sexually active and want to delay pregnancy but are not using modern contraceptives.\(^ {30}\)

- Every year, more than **15 million** girls under age 19 give birth. That means **every day, 41,000** girls become mothers.\(^ {31}\)

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THE SOLUTION

When sexual and reproductive health and rights are realized, we spark a ripple effect. Empowering women to plan their families and their futures achieves progress on all our global development goals and puts families, communities and countries on a stronger, more prosperous and sustainable path:

- Fulfilling the unmet need for family planning and providing quality maternal and newborn care would reduce maternal deaths by 73% and newborn deaths by 80%.

- Every $1 invested in family planning saves between $4 and $31 across other sectors, including education, food, health, housing and sanitation.

- 62% of comprehensive sexuality education programs had a positive effect on at least one behavioral or biological outcome, such as increased condom use or reduced unplanned pregnancies.

- Girls and women who can plan their families are better able to pursue their education and become economically empowered, lifting themselves and their families out of poverty. Each additional year of education improves a girl’s employment prospects, increasing her future income potential by 10–20%.

- If women participated in the economy at the same level as men, $28 trillion — or 26% — could be added to the global annual GDP by 2025. That’s the annual GDP of the U.S. and China combined.

- Women play a key role in global security: when healthy, empowered women have a voice at the table in decisions about war and peace, peace agreements are 20% more likely to last at least two years and 35% more likely to last 15 years.

- Lowering the rate of unintended pregnancy through access to voluntary family planning leads to slower population growth, which could provide 16–29% of the emissions reductions suggested as necessary by 2050 to avoid dangerous climate disruptions.

- Empowering women to have the number of children they desire can improve environmental sustainability by allowing women to better manage natural resources such as firewood, water and homegrown food for their families.

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CONTRACEPTION

Contraception is defined as the deliberate prevention of conception or impregnation. Access to contraception is a cornerstone of rights-based family planning and allows women and girls to determine the number and spacing of their children. Ensuring access to and accurate information about a variety of contraceptive methods is central to good reproductive health and, by extension, the empowerment and well-being of women, their families and their communities. As defined by the ICPD Programme of Action, all people have the right to be informed about and have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility that are not against the law.39 As part of this right, all women should be offered all choices of contraceptive method and be able to make an informed choice that best serves her within the context of her physical, emotional and spiritual needs.

THE UNMET NEED

Today, 214 million women in developing countries want to delay or avoid pregnancy but are not using modern forms of contraception.\(^{40}\) According to the WHO, reasons for this include:

- limited choice of methods;
- limited access to contraception, particularly among young people, poorer segments of populations, or unmarried people;
- fear or experience of side effects;
- cultural or religious opposition;
- poor quality of available services;
- users and providers bias; and
- gender-based barriers.\(^{41}\)

This unmet need for contraception has broad implications on unplanned pregnancy, maternal health, infant mortality, infectious diseases, access to education and more. For instance: over 300,000 women around the world die each year from preventable pregnancy-related causes — that’s more than 800 women every day.\(^{42}\) By fulfilling the unmet need for family planning and providing quality maternal and newborn care, the Guttmacher Institute estimates we could reduce maternal deaths to a quarter of current levels and newborn deaths to less than one-fifth of current levels.\(^{43}\)

The unmet need is particularly dangerous for adolescent girls. Married or unmarried, an estimated 23 million girls 15–19 living in developing areas are sexually active and want to delay pregnancy but are not using modern contraceptives. With almost 50% of their pregnancies unintended, and more than half of those ending in abortion, girls in this age group are at increased risk. Meeting the need for modern contraception among adolescent girls could reduce unintended pregnancies among this age group by 6 million annually — that includes, 2.1 million unplanned births, 3.2 million abortions and 5,600 maternal deaths.\(^{44}\)

COMMONLY USED CONTRACEPTIVES

Method-specific contraceptive use varies widely across the world. According to the United Nations, female sterilization and the intrauterine device (IUD) are the two most commonly used methods for women who are married or in-union worldwide — more than 19% use female sterilization and nearly 14% the IUD.\(^{45}\) Globally, short-term methods are less common, with 9% of women using the pill, 8% using male condoms and 5% using injectables. But there are regional differences: among women using contraception in the world’s least developed countries,\(^{46}\) injectables have the

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\(^{46}\) As defined by the United Nations, least developed countries (LDCs) are low-income countries confronting severe structural impediments to sustainable development. They are highly vulnerable to economic and environmental shocks and have low levels of human assets. More
highest prevalence (12.9%), followed closely by the pill (12.3%). In Africa, short-term and reversible methods, such as the pill (8.7%) and injectables (9.8%), are more common than other methods, whereas long-acting or permanent methods, such as sterilization (23.7%) and the IUD (17.4%), are more common in Asia.47

There are in-region differences, as well. In Eastern Asia and Central Asia, the IUD is the most commonly used method — in China alone, prevalence is almost 40% — but women in South-Eastern Asia rely more on injectables (almost 19%). Injectables are the most commonly used method in Sub-Saharan Africa, the developing sub-regions within Oceania and in some of the poorest countries in Latin America and the Caribbean. By contrast, oral contraceptives are the most prevalent method in Northern Africa.48

**TYPES OF CONTRACEPTIVES:**

**Combined oral contraceptives** (“the pill”) contain a combination of progestin and synthetic estrogen and are taken orally once a day.

**Progestin-only oral contraceptives** (“mini-pill”) contain only progestin and are taken orally once a day.

**Injectable contraceptives** are hormone-based shots that are given every one to three months.

A **contraceptive implant** is a hormonal method in which one or several matchstick-sized plastic rods are surgically inserted under the skin of a woman’s upper arm.

**IUDs** (intrauterine device) are small, flexible T-shaped devices that are inserted into the uterus and come in two types: hormonal and copper.

**LAM** (Lactational Amenorrhea Method) is a temporary method based on the natural impact of breastfeeding on fertility; can be used as long as monthly bleeding has not returned and the woman is fully or nearly fully breastfeeding.

The **patch** is a hormone-based contraceptive that adheres to the skin and is replaced once a week.

The **vaginal ring** is a flexible, hormone-based contraceptive device that is inserted into the vagina and must be replaced once per week.

**Male condoms** are disposable, single-use sheaths made of latex, plastic, or lambskin and worn on the penis to collect semen.

**Female condoms** (“internal condoms”) single-use pouches made from plastic that are worn inside the vagina or anus to capture semen.


**Spermicide** comes in many forms (cream, gel, foam, suppository, tablet and film) and is inserted into the vagina or used with contraceptive devices like diaphragms, cervical caps and sponges.

**Diaphragms** and **cervical caps** are flexible silicone or latex cups that are inserted into the vagina to cover the cervix, keeping semen from entering the uterus. They are often used with spermicide.

**Contraceptive sponges** are disposable foam sponges that are pre-filled with spermicide and inserted into the vagina before intercourse.

**Natural family planning** or **fertility awareness** are behavior-based methods that rely on tracking and understanding monthly fertility patterns through calendar tracking, basal body temperature, cervical mucus, or other cervical characteristics.

**Emergency contraception** is used to prevent pregnancy after unprotected intercourse, regular contraception failure or misuse, or forced or coerced unprotected sex. There are two types of emergency contraception: the pill ("morning-after pill") and the copper IUD. Emergency contraceptives do not cause miscarriage or abortion.

**Female sterilization** blocks the egg’s path from ovary to uterus and is intended to be permanent. There are two types: tubal ligation ("getting your tubes tied") and transcervical sterilization.

**Vasectomy** is surgery for men that blocks the path from testes to urethra by cutting, closing, or otherwise blocking the vas deferens. Vasectomy is intended to be permanent.
MATERNAL & NEWBORN HEALTH

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. Complications from pregnancy and childbirth are a leading cause of death and disability for women age 15–49 in most developing countries. While exact numbers of maternal and newborn deaths are often difficult to track, as many countries do not track causes of death or neonatal deaths (deaths within 28 days of birth), the WHO estimates that more than 300,000 women around the world die each year from preventable pregnancy-related causes — that’s more than 800 women every day. Seventy-five percent of these deaths are from postpartum hemorrhage, infection, pregnancy-related high blood pressure, complications of delivery, or unsafe abortion. Ninety-nine percent of these deaths occur in developing countries.\(^49\)

Newborn mortality is tied closely to maternal health and accounts for 44% of deaths of children under five annually.\(^50\)

Family planning is a key intervention to reduce maternal and newborn mortality. With modern contraception, women can choose if and when to have children and can space births safely. The Guttmacher Institute estimates that meeting the need for modern contraception in developing regions and ensuring that pregnant women and their newborns receive essential care would result in the following declines from 2017 levels:

- 67 million fewer unintended pregnancies (75% decline)
- 23 million fewer unplanned births (76% decline)
- 36 million fewer induced abortions (74% decline)
- 2.2 million fewer newborn deaths (80% decline)
- 224,000 fewer maternal deaths (73% decline)\(^51\)

SRHR AND INFECTIOUS DISEASES

When integrated with HIV/AIDS, tuberculosis and malaria services, comprehensive sexual and reproductive health services can also reduce the impact of these diseases. For example, according to the WHO, most HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding. Increased access to modern contraceptives, comprehensive sexuality education and the prevention, diagnosis and treatment of sexually transmissible infections plays a role in addressing the HIV/AIDS epidemic. Similarly, efforts to prevent and control malaria, which kills about 10,000 mothers and 75,000 to 200,000 infants in Africa each year, can reduce malaria-related maternal, neo-natal and infant deaths.\(^52,53\)


ADOLESCENTS AT RISK

With one-third of girls in the developing world marrying before age 18, and one-fifth becoming pregnant before age 18, access to comprehensive sexual, reproductive and maternal health services is especially important for adolescent women. The risk of maternal death for mothers under age 15 in low- and middle-income countries is double that of older women, and stillbirths and newborn deaths are 50% higher among infants of adolescent mothers than among infants of women age 20–29.\(^\text{54}\) Pregnancy complications, such as hemorrhage, sepsis, obstructed labor, and complications from unsafe abortions, are the leading cause of death among 15–19-year-old girls.\(^\text{55}\)

MEDICINAL INTERVENTIONS

Comprehensive SRHR also encompasses safe birth. Postpartum hemorrhage is one of the leading causes of maternal death, but it can be prevented and treated with drugs like oxytocin and misoprostol. While oxytocin is the current standard treatment, it must be administered by injection, usually within a hospital or health facility setting. Misoprostol may be taken orally or vaginally, making it easier to give during a home birth and to distribute to women with little access to health clinics. Distributing misoprostol in the community so that it is readily available when women need it, even if they are giving birth outside of the health care system, could drastically reduce maternal death; however, misoprostol can also be used for induced abortion, so the drug is not easily accessible in many countries where abortion is restricted or illegal.

SKILLED BIRTH ATTENDANTS

Traditional birth attendants such as midwives play an important role in maternity care in developing regions, particularly where access to health care systems is limited and/or where home birth is the preference or norm. Increasing the percentage of births attended by a skilled birth attendant is a critical progress indicator for the WHO’s Global Strategy for Women’s, Children’s and Adolescents’ Health, 2016–2030, highlighting how important the birth attendant’s abilities are to maternal and newborn health.\(^\text{56}\) Not only must they be educated and trained in the skills required to manage uncomplicated pregnancies, childbirth and the immediate postnatal period, they should also be able to identify and manage complications, including referring women and newborns to emergency services if necessary.


FOCUS AREA: CONTRACEPTION

ABORTION

Part of ensuring comprehensive sexual and reproductive health and rights is ensuring a woman’s access to a safe, legal abortion, should she choose one. According to the WHO, between 2010 and 2014, 56 million induced (safe and unsafe) abortions occurred worldwide each year — that’s about 35 per 1000 women age 15–44 years, and about 25% of all pregnancies. While induced abortion happens all over the world, the rate of abortion is higher in developing regions than developed regions.57

METHODS OF ABORTION

Induced abortion comprises the various methods of medical abortion and surgical abortion. There are three methods of medical abortion, two of which are recommended by the WHO: mifepristone followed by misoprostol or, where mifepristone is unavailable, misoprostol alone. A combination of methotrexate and misoprostol has also been used, but because methotrexate may cause birth defects in cases of unsuccessful abortion, the WHO recommends against this method. There are also several methods of surgical abortion, including vacuum aspiration, dilatation and evacuation (D&E), dilatation and curettage (D&C) and hysterectomy abortion. Only vacuum aspiration and D&E are recommended by the WHO.58

LEGAL STATUS

Not all methods of induced abortion are legal in every country or for every reason. An analysis by Pew Research Center shows that 96% of countries allow abortion to save the woman’s life, even if abortion in other circumstances is illegal. Forty-two percent of countries allow induced abortion in specific circumstances, such as rape or incest, fetal impairment, to save a woman’s health, or in certain socioeconomic circumstances. Almost 30% of countries allow induced abortion for any reason, though many of them restrict this at a certain gestational age.59 Restrictive laws do not stop women from having abortions; rather they make the procedure clandestine and often unsafe.60

UNSAFE ABORTION

Induced abortion performed by skilled health care providers using appropriate methods is generally considered medically safe. When girls and women do not have access to safe abortion services, they often resort to unsafe abortion, or abortion performed by a person without the necessary skills and/or using equipment or a facility that does not meet minimum medical standards. The WHO estimates that 22 million unsafe abortions are performed each year, mostly in developing countries.61 The health risks are staggering: incomplete abortion, hemorrhage, infection, uterine perforation, organ and genital tract damage and death. Each year, approximately 47,000 women die due to unsafe abortion62 and around 6.9 million


62 Department of Reproductive Health and Research, World Health Organization. (2011). Unsafe abortion: Global and regional estimates of the
women in developing regions seek medical care for complications from unsafe abortion.63 Almost all abortion deaths occur in developing countries, with the highest number occurring in Africa; an estimated 8–18% of maternal deaths worldwide are due to unsafe abortion.64 Researchers also estimate that 40% of women with complications never receive medical care. The cost of treating major complications resulting from unsafe abortion is estimated to be $680 million each year.65

The WHO outlines barriers to accessing safe abortion, which include:

• restrictive laws;
• poor availability of services;
• high cost;
• stigma;
• conscientious objection of health-care providers; and
• unnecessary requirements such as:
  – mandatory waiting periods.
  – mandatory counselling.
  – provision of misleading information
  – third-party authorization
  – medically unnecessary tests.66

Though rates of unsafe abortion are generally higher in developing regions, any woman with an unwanted pregnancy who cannot access a safe abortion for any reason is at risk of an unsafe abortion. Unsafe abortion can be prevented through the full realization of SRHR around the world, including comprehensive sexuality education, use of effective contraception and the provision of safe, legal abortion.


GIRLS & ADOLESCENTS

The world currently has the largest generation of young people — defined as 10–24 year olds — in human history. But more than 1.2 million adolescents die every year (more than 3,000 every day), mostly from preventable causes. Girls and adolescent women face particular risks in the absence of comprehensive sexual and reproductive health and rights. For example: 40% of the 60 million 10-year-old girls globally are not reached at all by our global health and development investments and are most at risk of being left behind. And an estimated 38 million girls in developing countries age 15–19 are at risk of pregnancy but would like to delay or avoid becoming pregnant in the next two years. Only 40% of them are using effective contraception. They often have less sexual and reproductive health knowledge, their bodies are more vulnerable to complications of pregnancy and childbirth, they are more physically vulnerable to infection and they face more barriers when accessing health services.

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COMPREHENSIVE SEXUALITY EDUCATION

Comprehensive sexuality education encompasses age-appropriate, scientifically accurate information about sexual and reproductive health and rights coupled with discussion and information about personal, family, cultural and societal contexts that affect their health. Based in human rights, comprehensive sexuality education also addresses gender equality and power issues, culture and gender roles, discrimination and abuse. Without accurate, complete information about their sexual and reproductive health and rights, young people are at risk for coercion, sexually transmitted infections and unintended pregnancy. While comprehensive sexuality education requires training and support for educators, researchers have seen positive outcomes, with about 60% of programs impacting at least one outcome, such as increased condom use.\(^\text{72}\)

PREGNANCY

Complications from pregnancy and childbirth are the leading cause of death for girls age 15–19, according to the WHO’s 2017 Global Accelerated Action for the Health Of Adolescents (AA-HA!) guidance, which outlines ways governments can respond to the health needs of adolescents in their countries.\(^\text{73}\) Every year, more than 15 million girls under age 19 give birth. That means every day, 41,000 girls become mothers.\(^\text{74}\) With almost 50% of their pregnancies unintended, and more than half of those ending in abortion (often unsafe), girls in this age group are at increased risk.\(^\text{75}\) Drivers of early pregnancies include a combination of individual, relational, community and societal factors. For example, girls can face barriers to accessing contraception due to national laws, community social norms and attitudes or both. In addition, poor or nonexistent comprehensive sexuality education in schools can lead adolescents to seek information from less reliable sources, such as peers. Adolescent girls are often less able to negotiate the terms under which they engage in sexual activities, both due to their age and pervasive gender inequalities, leading to riskier sexual behavior.\(^\text{76}\) Among adolescents in developing countries, first sex, marriage and the initiation of childbearing tend to happen within a relatively short timeframe. The vast majority of adolescent births in developing countries occur within the context of marriage; thus, adolescent births, like early marriages, are highest in Africa.\(^\text{77}\)

CHILD MARRIAGE

One-third of girls in developing regions are subject to child marriage, or marriage before age 18, the internationally recognized age of adulthood, and 7% of girls marry before age 15. Parents may arrange marriages for their young daughters for financial reasons or to try to protect the girls’ safety or honor, but child marriage violates girls’ human rights and can isolate them, curtail their schooling.


and prevent them from escaping poverty.\textsuperscript{78} Once married, the couple may feel significant societal pressure to have a baby.\textsuperscript{79} But when girls give birth before their bodies are ready, not only are they more likely to drop out of school and earn a lower income, they are at a much higher risk of dying and their babies face more health risks. Further, new research from Kenya and Zambia point to unintended early pregnancy as a pathway to early marriage as girls who become pregnant are expected to leave the home and get married.\textsuperscript{80}

**FEMALE GENITAL MUTILATION**

Girls in many developing countries are at risk for female genital mutilation (FGM). Widely considered to be a violation of human rights, FGM is almost always inflicted upon girls and has lifelong health implications. Though a culture may have a strong tradition of FGM, the practice has no health benefits and can cause serious long-term health problems, including pain, keloids, infection, increased risk of HIV and other sexually transmitted infections, sexual dysfunction, depression and anxiety, painful and prolonged menstrual periods, urinary problems and fistula. It also increases the risk of problems during and after childbirth, low birth weight and stillbirth.\textsuperscript{81}

**ADOLESCENTS AND HIV**

Adolescents (10–19 years) and young adults (20–24 years) are at particular risk for HIV, especially girls who live in areas with a generalized HIV epidemic or who are at risk of transmission through sex or drug use.\textsuperscript{82} In 2015 alone, 670,000 people 15–24 were newly infected with HIV. About 37\% of them were 19 or younger.\textsuperscript{83} With approximately one out of every seven new HIV infections happening during adolescence, and over two million adolescents currently living with HIV,\textsuperscript{84} there is a significant need for comprehensive sexuality education and access to prevention services, supplies and medications.

**ADOLESCENTS AND MENTAL HEALTH**

Various inequities, including those linked to gender, shape all aspects of adolescent health and well-being, including mental health.\textsuperscript{85} Economic and gender inequality, sexual behavior, family dynamics and violence against women can all impact mental health. Even without external stressors, many mental disorders that emerge during adolescent years persist into adulthood with consequences for mental health across the life


Adolescents who are socially and economically marginalized have the highest risks for suicide, and adolescent girls have the least power to overcome these barriers. Child brides — socially isolated, subject to early and unwanted sex, lacking the skills or power to succeed in a relationship — are at particular risk. Research from Southeast Asia shows a link between violence and self-immolation and suicidal thoughts among married adolescents.

Unwanted pregnancy and suicide may also be linked for unmarried girls, particularly in contexts where they have little or no access to sexuality education, contraception, or safe abortion. Global strategies such as the Sustainable Development Goals and the WHO’s Global Strategy for Women’s, Children’s and Adolescents’ Health, which aim to extend education, reduce gender inequalities and empower women, improve food security and nutrition and promote vocational skills and opportunities for employment, are likely to benefit adolescents and young adults. Among its other objectives and targets, the Global Strategy explicitly includes mental illness in its causes of preventable deaths and recommends psychosocial support and related services for adolescent mental health and well-being as an essential intervention.

Likewise, the expansion of secondary education in many countries, particularly for girls, can improve health and wellbeing, including mental health. Participation in quality secondary education enhances cognitive abilities and improves mental health and sexual and reproductive health.

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SECURITY & STABILITY

Sexual and reproductive health and rights allow women to plan their families and their future, helping them receive an education, participate in the labor force, raise their standards of living and climb out of poverty. This impact extends to their families, their communities and their nations and contributes to stability and security around the world.

Women’s empowerment and gender equality are closely associated with peace and stability. When women have a voice at the table in decisions about war and peace, peace agreements are 20% more likely to last at least two years and 35% more likely to last 15 years.92 And, as the percentage of women in parliament increases by 5%, a state is five times less likely to use violence when faced with an international crisis.93 In 2000, the UN Security Council adopted Resolution 1325, which first recognized women’s role in making and keeping peace as well as the disproportionate and unique impact of conflict on women. The Resolution called on UN member states to ensure women’s full participation in peace and security talks and, after multiple follow-up resolutions on the topic, most recently adopted Resolution 2122 in 2013 which “puts the onus on the Security Council, the United Nations, regional organizations and Member States to dismantle the barriers, create the space and provide seats at the table for women.”94,95 Despite the clear evidence for women’s involvement, they are consistently excluded from peace and security talks: between 1992 and 2011, 4% of signatories to peace agreements and fewer than 10% of negotiators at peace tables were women.96

On the flip side, threats to international SRHR — including the impact of U.S. policy and funding changes like the Global Gag Rule, the defunding of UNFPA and cuts to bilateral funding — prevent women from taking control of their own bodies and lead to increased gender inequality. Gender inequality is connected to global problems like food insecurity, famine, poverty, disease, demographic problems, poor governance and conflict. Fourteen out of the 17 countries in the OECD’s index for gender discrimination have also experienced conflict in the last two decades.97

Demographic challenges are also gaining attention as having a role in instability and violence around the globe. For additional reading on this perspective, we recommend:

- Richard P. Cincotta, Robert Engelman, and Daniele Anastasion, The Security Demographic: Population and Civil Conflict After the Cold War

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FOCUS AREA: SECURITY & STABILITY

- Elizabeth Leahy, Robert Engelman, Carolyn Gibb Vogel, Sarah Haddock, and Todd Preston, *The Shape of Things to Come: Why Age Structure Matters to a Safer, More Equitable World*
- Richard Cincotta, *How Demography Foretold the Arab Spring*
- UNFPA, *The State of the World Population 2012*
EDUCATION & ECONOMIC EMPOWERMENT

Ensuring sexual and reproductive health and rights and empowering women to reach their full potential can also lead to significant economic gains for individuals, families and nations. It has been shown to reduce health care costs, improve productivity and increase rates of education, leading in turn to greater economic growth.

SRHR AND EDUCATION

When girls are healthy and their rights are fulfilled, they can go to school, learn and gain the skills and resources they need to be healthy, productive and empowered adults. Sexual and reproductive health and rights issues, especially gender-based violence and adolescent girls’ vulnerability to early and/or forced marriage, unintended pregnancy and HIV and other sexually transmitted infections, impact the educational aspirations of girls and women around the world, especially in the poorest and most marginalized regions.

To start, early pregnancies and child marriage contribute to school dropout. UNFPA approximates one in three girls in the developing world is married by age 18.98 Early marriage in these regions is often followed by an early pregnancy, and a significant proportion of girls become pregnant during the time that they should be in school: about 19% of girls in the developing world become pregnant before age 18, and about 3% become pregnant before age 15.99 According to the Guttmacher Institute, an estimated 38 million adolescents age 15–19 living in developing regions are sexually active but do not want a child in the next two years; 23 million of these have an unmet need for contraception and are at risk for unintended pregnancy.100 Further, more than half of the reduction in child deaths in the past 40 years is due to increased education among women.101

Early marriage is not the only factor: gender-based violence is another major deterrent to education. Violence undermines access to school as well as learning; it can occur in and around schools and on the way to or from schools. Additionally, girls and boys often lack access to information and services that would improve their sexual and reproductive health and educational status. Comprehensive sexuality education around the world plays a significant role: about 62% of programs had a positive effect on at least one behavioral or biological outcome, such as increased condom use or reduced unplanned pregnancies. However, in many countries, such programs are unavailable or are limited in scope.102

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SRHR AND ECONOMIC EMPOWERMENT

SRHR can empower adolescent girls and women to avoid early marriage and pregnancy and stay in school longer, directly impacting their economic power. Each additional year of education improves a girl’s employment prospects, increasing her future income potential by 10–20%.103 This all allows women to take control of their future. In Columbia, family planning programs introduced in the 1960s empowered young girls to work toward a career and invest in their futures, and as a result they stayed in school longer and took more formal jobs in the labor market; similarly, Indonesian family planning programs allowed women to stay in school, postpone marriage and have smaller families. This impact has a ripple effect: in Bangladesh, access to family planning trickled down to extend a woman’s children’s education by 12–15%.104

At a macro level, access to SRHR promotes gender equality and leads to economic gains. In fact, if women participated in the economy at the same level as men, $28 trillion — or 26% — could be added to the global annual GDP by 2025. That’s the annual GDP of the U.S. and China combined.105 But to realize this full participation, women need to be healthy, well and empowered — and that starts with the basic right and ability to plan a family.

DEMOGRAPHIC DIVIDEND

Realizing the unmet need for SRHR impacts not just individuals and communities but ladders up to global prosperity. In short: it pays dividends.

Investing in voluntary family planning services can lead to a demographic dividend — the accelerated growth of a country’s economy. This occurs when fertility rates decline due to investments in SRHR, changing the population’s age structure. When declining fertility rates are coupled with investments in education and other social policies, the next generation of highly educated youth contributes more to the workforce and becomes the next generation of consumers.106 The so-called “Asian Tiger” economies—including Korea, Taiwan, and Singapore—all reaped the demographic dividend because their governments invested in voluntary family planning and education for their large cohorts of young people allowing them to plan their families, invest in the education of their children, and contribute more to the labor force. Other countries, such as Thailand and the Philippines, are following a similar path, providing voluntary family planning coupled with investments in education and employment to reap the economic and security gains. As Bill and Melinda Gates noted in their 2017 Annual Letter, “No country in the last 50 years has emerged from poverty without expanding access to contraceptives.”107

Comprehensive SRHR also reduces health care costs across the board: investments in contraceptive and family planning services have been shown to

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save anywhere from $4 for every dollar invested in Zambia to $31 for every dollar invested in Egypt across other sectors, including education, food, health, housing and sanitation.\textsuperscript{108}

THE ROLE OF MEN

Though family planning programs traditionally focus primarily on women, gender equality and comprehensive SRHR cannot be achieved without the meaningful participation of men. But men remain largely on the sidelines of reproductive health policies and programs. The ICPD Programme of Action calls specifically for men’s equal participation in SRHR, prevention of unwanted pregnancies, and prenatal, maternal, and child health.109

Educating and engaging men in addition to women in decisions about sexual and reproductive health and family planning leads to more effective interventions,110 better family health,111,112 better intra-spousal communication, and higher and more continued use of family planning methods.113

MEN AS DECISION MAKERS

In many countries around the world, men play a significant role in decision-making around women’s reproductive choices, including family size, contraception and access to health services. Men who are opposed to or misinformed about family planning and reproductive health may prevent their wives or daughters from accessing contraception.

Including men in SRHR efforts with the goal of creating more equitable, supportive relationships between men and women can lead to greater respect for women’s autonomy and decision-making when it comes to her reproductive health.

MEN & SOCIAL NORMS

In many countries, men adhere to gender norms surrounding “masculinity” and see reproduction and fertility as a woman’s role and responsibility. They are often less likely to support use of contraception, more likely to have multiple partners and more likely to want a large number of children. The power inequalities between men and women, particularly men with more rigid views on masculinity, can also perpetuate cycles of violence. For instance: a recent survey of men in the Middle East and North Africa showed that traditional attitudes about gender equality are dominant, and only one-quarter of men hold more open views of women’s empowerment; the survey also found evidence for inter-generational cycles of violence in which men who witnessed their fathers being violent against their mothers were more likely to perpetrate intimate partner violence. (On the positive side, the survey also found evidence for inter-generational cycles of care).114

PROGRAMS ENGAGING MEN

Because of progress against the ICPD Programme of Action, men are now being engaged in various ways.115

- **Men as clients.** Men have their own sexual and reproductive health needs; their access to information and services, and the full realization of their own SRHR, have an impact on the health, rights and well-being of their sexual partners and families. In this approach, programs are designed to encourage men to use reproductive health services to meet their own needs and to reduce the reproductive health burden on women, reflecting the reality that improving men’s health has positive effects for their partners. For example, the Asociación Dominicana de Planificación Familiar reached almost half a million men by training barbers on proper condom use and providing informational materials about preventing HIV/AIDS and other sexually transmitted diseases for their customers. These services increased the number of customers for the barbers, and even after the project ended, they continued to provide referrals and information and sold subsidized condoms.116

- **Men as supportive partners.** In this approach, men are acknowledged as key allies toward better reproductive health for their partners. This approach works within the context of men as primary health decision-makers, recognizes men’s greater access to information and resources, and often addresses reproductive health needs within the context of the couple’s relationship.117 These programs have worked with men and women together to develop emergency plans for labor and delivery and encouraging men to accompany their partners for post-abortion services and counseling. Research in India has shown that the more information men have, the more likely they are to participate in routine care and during the antenatal, delivery and postnatal periods.118

- **Men as agents of change.** In this approach, programs reflect the idea that gender roles and norms can hurt both men’s and women’s reproductive health. These programs challenge attitudes and behaviors that compromise not only men’s health and safety, but that of women and children, and require recognition that male involvement programming must motivate men to actively address gender inequities. For instance, the Centre for development and Population Activities used an empowerment model in its work with young men in India and Egypt. The program challenged gender inequities and expanded life options to address reproductive health issues, unemployment, legal rights and relationship issues.119

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THE ENVIRONMENT

Realizing sexual and reproductive health and rights around the world is essential to promoting healthy families, healthy communities and a healthy planet. As the primary resource managers for households around the world, women are disproportionately affected by environmental degradation, water scarcity and natural disasters — challenges that are compounded when women have larger families than they want. Ensuring access to sexual and reproductive health and rights leads to increased investments in education, economic and social gains and improvements in health, helping women and their families become more resilient to climate disruption and get more involved in environmental conservation and community resource management initiatives. Protecting the health and rights of individuals and protecting our planet go hand in hand.

WOMEN’S HEALTH AND THE ENVIRONMENT

Just as women impact the environment, the environment impacts them: women bear the brunt of negative environmental changes. Women are 14 times more likely to die in natural disasters than men, and women and girls suffer more from shortages of food and economic resources in the aftermath of disasters. Climate disruption is having a profound effect on water availability, access and quality. As women and children bear the primary responsibility for water collection in 76% of households in the developing world, the ability to have one’s desired family size helps ease this burden.

Environmental toxins also have detrimental consequences on women’s sexual and reproductive health. Industrial chemicals, air pollution, pesticides and other toxins in the environment are linked to numerous health problems, including infertility, reproductive cancers and birth defects. Forty-one percent of the world’s energy is generated from coal, which generates toxins that disproportionately affect women and have been linked to fertility problems, fetal abnormalities and asthma in children. Likewise, female agricultural workers are at increased risk for sexual and reproductive health problems, especially while pregnant and breastfeeding.

THE ENVIRONMENTAL BENEFITS OF SRHR

Improving access to SRHR improves the environment. The economic and educational gains associated with access to SRHR help equip women with the necessary knowledge and skills to own property and more effectively manage resources. Women have been found to be more responsive than men to changing their behaviors toward more

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environmentally friendly practices, and a study of 130 countries found that countries with higher female parliamentary representation are more prone to ratify international environmental treaties.\textsuperscript{125} Community water and sanitation projects designed and run with the full participation of women are more sustainable and effective than those that do not.\textsuperscript{126} Access to SRHR fosters a woman’s ability to participate in these projects by improving her health, freeing up time for education and income-generating activities and empowering her to make decisions about her own future and that of her community.

Realizing SRHR could also help mitigate climate issues. More than 40\% of pregnancies worldwide are unintended.\textsuperscript{127} Lowering the rate of unintended pregnancy through access to voluntary family planning leads to slower population growth, which could provide 16–29\% of the emissions reductions suggested as necessary by 2050 to avoid dangerous climate disruptions.\textsuperscript{128} A team of several dozen researchers recently ranked the top 100 solutions to climate change and found that a combination of educating girls and family planning could reduce 120 gigatons of CO\textsubscript{2}-equivalent by 2050 — more than on- and offshore wind power combined.\textsuperscript{129}

Finally, SRHR access also contributes to improved food security.\textsuperscript{130} If women had the same access to productive resources as men, they could increase yields on their farms by 20–30\%, which could raise total agricultural output in developing countries by 2.5–4\%, which could in turn reduce the number of hungry people in the world by 12–17\%.\textsuperscript{131} Investments in voluntary family planning and the resulting decreases in fertility — especially in countries with the highest per capita resource consumption — will help to slow the growth in greenhouse gas emissions and reduce pressure on already scarce food and water resources.\textsuperscript{132}

\begin{thebibliography}{99}
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THE ROLE OF FAITH

Of the girls and women who want to avoid or delay pregnancy but do not use effective contraceptives, few report religious beliefs or traditions as a reason. However, religion plays an integral part in many people’s life choices, and when engaged, faith leaders can have significant influence. With faith-based organizations (FBOs) actively engaged in health and development efforts around the world, and religious leaders respected in their communities, faith actors have a unique opportunity to promote and advocate for women’s sexual and reproductive health.

SRHR is not antithetical to religion, and the concept of healthy timing and spacing of pregnancy is acceptable in almost all faith traditions. The United Methodist Church (UMC), for instance, explicitly “supports the right for men and women worldwide to choose when, or if, to have children” and affirms “the right of women to access comprehensive health care services, including reproductive health.” UMC implements these beliefs through United Methodist Women, which works with women worldwide on a wide range of family, maternal and child health issues and provides maternal and newborn care, among other services.

Many FBOs provide reproductive health services around the world, though some do place limitations on acceptable methods. Where community or organizational values may exclude abortion or other reproductive services, FBOs provide other diverse offerings, including contraceptive options and counseling. Faith actors tend to maintain their commitments to women’s and family health, adapting to individuals’ and community needs as possible. FBOs and other faith actors tend to integrate family planning efforts into greater poverty reduction and health endeavors with an understanding of the implications of SRHR on maternal, child and family health and survival, though some FBOs avoid addressing gender equality issues and the SRHR needs of unmarried youths. Family planning and SRHR aligns with many FBOs’ efforts toward poverty reduction and improving health in families.

A survey by Christian Connections for International Health (CCIH) found that its member organizations were active in 151 countries, all supporting family planning — not including abortion — when understood as enabling individuals to achieve their desired number and spacing of children in the context of comprehensive


health care. More than half currently provide family planning methods or information, and of those that provide comprehensive health services, 70–85% want to integrate family planning into their services.
The Universal Access Project is committed to advancing understanding of how access to reproductive health information and services can impact girls, women and communities around the world. We encourage you to read the reports and factsheets on our Resources page and explore this additional recommended literature:

**GENERAL**

United Nations Population Fund, *Universal Access to Reproductive Health: Progress and Challenges*. Report profiling existing data around the main MDG5b indicators to identify progress achieved and old and new challenges that could be addressed under the SDGs, particularly the nine targets under SDG3. The report highlights the most vulnerable and disadvantaged population groups and their access to and use of reproductive health services.

Guttmacher Institute, *Adding It Up: Investing in Contraception and Maternal and Newborn Health, 2017*. Report estimating the need for and the use, costs and impacts of various sexual and reproductive health services for women in developing countries.

Population Reference Bureau, *2015 World Population Data Focus on Women’s Empowerment*. Annual demographic data. The 2015 data collection includes a focus on indicators on the status of women in key areas such as education, employment and government and provides analysis on women’s progress towards equity.

Family Planning 2020, Performance Monitoring and Accountability 2020, *Family Planning Briefs*. Two-page snapshots of key indicators at the country level (modern contraceptive prevalence rate, total fertility rate, unmet need for family planning, and new measures for family planning access, equity, quality and choice).

United Nations Population Fund, *Humanitarian Action: 2017 Overview*. Overview of UNFP humanitarian actions, including 2016 funding and results, a breakdown of current funding needs by country, results planned for 2017. The overview also focuses on three thematic areas: sexual and reproductive health in emergencies; women, adolescent girls and young people; and preventing and responding to gender-based violence in emergencies.

**HEALTH**


Population Institute, *Double Trouble*. Report outlining the intersection of SRHR and Zika.

**ADOLESCENT HEALTH**


World Health Organization, *Global accelerated action for the health of adolescents (AA-HA!)*. Outlines guidance to support country implementation for adolescent health.

Family Planning 2020, *Global Youth Family Planning Index*. Index that assesses a country’s policy framework (constitutions, laws,
reproductive health acts, etc.) and programmatic guidelines (family planning costed implementation plans, adolescent health strategies, youth development plans, etc.) that impact youth family planning.

Guttmacher Institute, *Adding It Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents*. Report estimating the need for and the use, costs and impacts of various sexual and reproductive health services for adolescents in developing countries.

Guttmacher Institute, *Adding It Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents in Developing Regions*. Fact sheet focused on the need for and the use, costs and impacts of various sexual and reproductive health services for adolescents in developing countries.

Guttmacher Institute, *Adding It Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents in Asia*. Fact sheet focused on the need for and the use, costs and impacts of various sexual and reproductive health services for adolescents in Asia.

Guttmacher Institute, *Adding It Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents in Latin America and the Caribbean*. Fact sheet focused on the need for and the use, costs and impacts of various sexual and reproductive health services for adolescents in Latin America and the Caribbean.

Guttmacher Institute, *Adding It Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents in Sub-Saharan Africa*. Fact sheet focused on the need for and the use, costs and impacts of various sexual and reproductive health services for adolescents in Sub-Saharan Africa.


Planned Parenthood Global, the O’Neill Institute for National and Global Health Law at Georgetown University and Ibis Reproductive Health. *Stolen Lives: A Multi-Country Study on the Health Effects of Forced Motherhood on Girls 9–14 Years Old*. Study report examining forced pregnancy among girls under 15 as both a public health problem and human rights violation, outlining the consequences of the lack of access to comprehensive sexual and reproductive health faced by victims of sexual violence; the criminalization of abortion on the grounds of rape in Guatemala and Peru, the total criminalization of abortion in Nicaragua and the partial decriminalization of abortion for rape in Ecuador, where only mentally disabled women have access; and the biomedical focus on the physical health of girls and adolescents facing unwanted pregnancies, particularly as a result of rape, ignoring the impact on mental and social health.


International Center for Research on Women. *She Cannot Just Sit Around Waiting to Turn Twenty: Understanding Why Child Marriage Persists in Kenya and Zambia*. Report documenting key findings from a qualitative study on the pathways that lead to child marriage in Kenya and Zambia. The authors also identify
recommendations to dismantle some of those pathways.

World Health Organization. *Health for the World’s Adolescents: A Second Chance in the Second Decade*. Report bringing together all the WHO guidance concerning adolescents across the full spectrum of health issues. It offers a state-of-the-art overview of four core areas for health sector action: providing health services; collecting and using the data needed to advocate, plan and monitor health sector interventions; developing and implementing health-promoting and health-protecting policies; and mobilizing and supporting other sectors. The report concludes with key actions for strengthening national health sector responses to adolescent health.

**ECONOMIC BENEFITS**


**GOVERNMENT & POLICY**

Guttmacher Institute, Just the Numbers: The Impact of U.S. International Family Planning Assistance. Policy analysis detailing the impact of USAID foreign aid.

Kaiser Family Foundation, UNFPA Funding & Kemp-Kasten: An Explainer. A policy explainer outlining issues surrounding the Kemp-Kasten amendment and UNFPA funding.


Population Action International. Global Gag Rule. Website outlining the history, impact and dangers of the re-institution and expansion of the Global Gag Rule, which threatens the lives of millions of women around the world.


**ENVIRONMENT**


Worldwatch Institute, *Family Planning and Environmental Sustainability Assessment*. A project surveying the field of health and environmental research for well-documented and evaluated data shedding light on how the use of family planning might relate to climate change mitigation and adaptation, sustainable water supply and food production, the maintenance of biological diversity, the future of forests and fisheries and more.
Science. The interaction of human population, food production and biodiversity protection. Research article examining an approach to sustaining biodiversity and human well-being through actions that can slow and eventually reverse population growth: investing in universal access to reproductive health services and contraceptive technologies, advancing women’s education and achieving gender equality.

FAITH


General Board of Church & Society of The United Methodist Church. Family Planning and Reproductive Health. Web page outlining the UMC’s commitment to supporting the right of men and women worldwide to choose when, or if, to have children and affirming the right of women to access comprehensive health care services, including reproductive health.

United Methodist Women. Maternal and Child Health. Overview of United Methodist Women’s work to support the health and family needs of women and children around the world.

Christian Connections for International Health. Family Planning & Reproductive Health. Information and publications from CCIH’s networks promoting family planning, reproductive health and global health from a Christian perspective.

Christian Connections for International Health. Faith Matters: International Family Planning From a Christian Perspective. Report from a 2014 meeting with CCIH, USAID’s Advancing Partners and Communities, and the Universal Access Project. This report was developed to help faith communities discuss family planning among their congregations and includes biblical analysis, discussion of why family planning saves lives and improves maternal and child health and lists of helpful resources.

GENDER EQUALITY

Institute for Reproductive Health. Ethnographic Research Findings From the Gender Roles, Equality and Transformations (GREAT) Project. An ethnographic study focusing on the impact that influencing individuals have on adolescents and their perspectives and attitudes on gender norms and identifying opportunities promote gender equitable norms and to improve sexual and reproductive health knowledge.

International Center for Research on Women. Advancing Gender Equality. Interview with Mayra Buvinic, ICRW’s Director of Gender, Economic Empowerment, and Livelihoods, outlining the motivation behind founding ICRW and the organization’s role in advancing gender equality worldwide.

International Center for Research on Women. Revising the Script: Taking Community Mobilization to Scale for Gender Equality: Intimate Partner Violence, Violence Against Women and Girls. Study exploring the nascent conversation around the challenges of applying the “innovate, evaluate, scale up” script to community mobilization approaches to address socially and politically sensitive issues, particularly but not exclusively intimate partner violence.
# ACRONYMS TO KNOW

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>EC</strong></td>
<td>Emergency contraception</td>
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<tr>
<td><strong>FGM/C</strong></td>
<td>Female genital mutilation/cutting</td>
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<tr>
<td><strong>FP</strong></td>
<td>Family planning</td>
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<tr>
<td><strong>GGR</strong></td>
<td>Global Gag Rule</td>
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<tr>
<td><strong>HTSP</strong></td>
<td>Healthy timing and spacing of pregnancies</td>
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<tr>
<td><strong>ICPD</strong></td>
<td>International Conference on Population and Development</td>
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<td><strong>IRH</strong></td>
<td>International reproductive health</td>
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<tr>
<td><strong>IUD</strong></td>
<td>Intra-uterine device</td>
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<tr>
<td><strong>LARC</strong></td>
<td>Long-acting reversible contraception</td>
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<tr>
<td><strong>MDGs</strong></td>
<td>Millennium Development Goals</td>
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<tr>
<td><strong>MNCH</strong></td>
<td>Maternal, newborn and child health</td>
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<tr>
<td><strong>SDGs</strong></td>
<td>Sustainable Development Goals</td>
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<td><strong>SRHR</strong></td>
<td>Sexual and reproductive health and rights</td>
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<td><strong>UNFPA</strong></td>
<td>United Nations Population Fund</td>
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<td><strong>USAID</strong></td>
<td>U.S. Agency for International Development</td>
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GLOSSARY

Abortion: the termination of a pregnancy.

**Induced:** An abortion that is purposefully caused, usually by use of medication or surgery.

**Medical:** An induced abortion by use of medication.

**Spontaneous (miscarriage):** The natural ending of a nonviable pregnancy before 20 weeks of gestation. After 20 weeks, this is called fetal demise or stillbirth.

**Surgical:** An induced abortion by surgery.

**Unsafe:** An abortion performed by a person without the necessary skills and/or using equipment or a facility that does not meet minimum medical standards.

**Adolescence:** The period between childhood and adulthood.

**Child marriage:** Marriage or union before age 18.

**Childbearing years:** Ages 15 to 49, also called reproductive age.

**Contraception/Contraceptives:** Contraception is the deliberate prevention of conception or impregnation. Contraceptives are methods serving to prevent pregnancy. For other contraceptive methods, see Contraception.

**Emergency:** Contraception used to prevent pregnancy after unprotected intercourse, regular contraception failure or misuse, or forced or coerced unprotected sex. There are two types of emergency contraception: the pill (“morning-after pill”) and the copper IUD. Emergency contraceptives do not cause miscarriage or abortion.

**Implant:** A hormonal contraceptive method in which one or several matchstick-sized plastic rods are surgically inserted under the skin of a woman’s upper arm.

**Injectable:** Hormone-based shots that are given every one to three months.

**IUD:** Small, flexible T-shaped devices that are inserted into the uterus and come in two types: hormonal and copper.

**Oral:** Pills taken once a day that contain either only progestin (“mini-pill”) or a combination of progestin and synthetic estrogen (“the pill”).

**Ectopic pregnancy:** A pregnancy that occurs outside the uterus, often in the fallopian tube.

**Family planning:** Defined in ICPD Programme of Action paragraph 7.5 as actions recommended to help couples and individuals meet their reproductive goals; to prevent unwanted pregnancies and reduce the incidence of high-risk pregnancies and morbidity and mortality; to make quality services affordable, acceptable and accessible to all who need and want them; to improve the quality of advice, information, education, communication, counseling and services; to increase the participation and sharing of responsibility of men in the actual practice of family planning; and to promote breastfeeding to enhance birth spacing.

**Female genital mutilation/cutting:** Piercing, cutting, removing, or sewing closed all or part of a girl’s or woman’s external genitalia for non-medical reasons.

**Fertility / Fertility rate:**

**Fertility:** The natural capacity of an individual, couple, or population to bear children.

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**Total fertility rate:** The average number of children a hypothetical cohort of women would have at the end of their reproductive period if they were subject during their whole lives to the fertility rates of a given period and if they were not subject to mortality.

**Global Gag Rule:** Also known as the Mexico City Policy. Prohibits international NGOs that receive U.S. funds from providing, referring for, or discussing abortions, even with their own, private funds. See more in Current Political Landscape.

**Helms Amendment:** Prohibits foreign assistance funds from being used to pay for abortion or to motivate or coerce any person to practice abortion. After-abortion care is allowed. Per the Leahy Amendment (1994), “motivate” shall not be construed to prohibit provision, where legal, of information or counseling about all pregnancy options.

**Hyde Amendment:** Prohibits federal funds from being used to pay for abortion, except in cases of incest or rape or if the life of the woman is in jeopardy.

**ICPD:** The International Conference on Population and Development, convened by the United Nations September 5–13, 1994. The resulting Programme of Action, adopted by 179 member states, outlines four goals: universal education, reduction of infant and child mortality, reduction of maternal mortality, and access to reproductive and sexual health services including family planning. The Universal Access Project works to implement the ICPD Programme of Action, which serves as a comprehensive guide to people-centered development progress.

**Kemp-Kasten Amendment:** Prohibits aid to any organizations that support or participate in the management of a program of coercive abortion or involuntary sterilization. See more in Current Political Landscape.

**Maternal morbidity:** Any health condition caused by and/or made worse by pregnancy and childbirth that has a negative effect on the woman’s wellbeing.

**Maternal mortality:** The death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the duration and site of the pregnancy, from any cause related to or made worse by the pregnancy or its management. Maternal mortality does not include accidental or incidental causes.

**Maternal and newborn health:** The health of women during pregnancy, childbirth and the postpartum period, coupled with the health of babies during the first 28 days of life. Maternal health and newborn health are inextricably linked.

**Miscarriage/spontaneous abortion:** The natural ending of a nonviable pregnancy before 20 weeks of gestation. After 20 weeks, this is called fetal demise or stillbirth.

**Obstetric fistula:** An opening between the urinary or gastrointestinal tract and the vagina that results in chronic leakage of urine or feces. Obstetric fistula is associated with severe stigma in communities.

**Prenatal:** During pregnancy but before childbirth.

**Postpartum:** After childbirth.

**Postpartum hemorrhage:** Blood loss of 500 ml or more within 24 hours of giving birth.

**Reproductive age:** Ages 15 to 49, also called childbearing years.

**Reproductive health:** 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 its functions and processes. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of
fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.¹⁴¹

**Reproductive rights:** 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. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.¹⁴²

**Sex selection:** The practice of choosing the sex of offspring either before birth via medical techniques such as selective abortion, embryo selection during in vitro fertilization and sperm separation or after birth via infanticide or neglect. Generally, sex selection favors boys over girls.

**Sexual health:** A person’s physical, mental and social well-being in relation to sexuality and sexual relationships. Good sexual health includes the possibility of pleasurable and safe sexual experiences, free from assault or discrimination.¹⁴³

**Sexual rights:** Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- The highest attainable standard of sexual health, including access to sexual and reproductive health care services.
- Seek, receive and impart information related to sexuality.
- Sexuality education.
- Respect for bodily integrity.
- Choose their partner.
- Decide to be sexually active or not.
- Consensual sexual relations.
- Consensual marriage.
- Decide whether or not, and when, to have children.
- Pursue a satisfying, safe and pleasurable sexual life.¹⁴⁴

**Skilled birth attendant:** An accredited health professional who has been educated and trained in the skills required to manage uncomplicated pregnancies, childbirth and the immediate postnatal period. They should also be able to identify and manage complications in women and newborns, including referring them to emergency services if necessary. Skilled birth attendants may be doctors, nurses, or midwives.¹⁴⁵

**Unmet need for family planning:** The percentage of girls and women of reproductive age who want to avoid or delay pregnancy but do not use a method of contraception.¹⁴⁶


