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It takes two to tango

How investments in Reproductive health can reduce poverty

- emphasizing the male side of the gender equation

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Abstract

The aim of this thesis is to explore how Reproductive Health can contribute to development and poverty reduction, looking at non-medical and gender aspects. As poverty is both a cause and consequence of ill-health, investments in Reproductive Health are highly relevant for economic development and poverty alleviation in especially the developing countries. Investments save and improve lives, slow the spread of HIV/AIDS and promote gender equality, which stabilise population growth and reduce poverty. The male-dominated gender-relations affect especially the decision-making at the household level, which has serious consequences for the women who are least able to influence decisions. Due to the extent of market failures in the field, mainly caused by externalities, government intervention is argued for. The thesis focuses on social benefits that result from highly cost-effective strategies of prevention, exploring three key intervention areas: family planning, maternal health care and HIV/AIDS. Men and the male role are highlighted through strategies of Male involvement in the key interventions. This essay points out that Male involvement offers potential to improve the quality of investments and reach gender equality.

Key words: Reproductive Health, Poverty reduction, Gender, Male involvement and Government intervention

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List of abbreviations

ABC	Abstinence for younger adolescents, Being faithful within marriage and Condom promotion
AIDS	Acquired Immune Deficiency Syndrome
GAD	Gender and Development
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development, Cairo 1994
MDG	Millennium Development Goal
NGO	Nongovernmental organisation
RH	Reproductive Health
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
WHO	World Health Organization

1 Introduction

Poverty and health are intimately related and poverty is both a cause and consequence of ill-health. Reproductive Health encompasses health issues regarding reproduction and fertility and concerns everyone, everywhere, and at every stage of life. It constitutes a human right as well as means to sustainable development.

Health and Reproductive Health specifically is highly relevant for economic development and poverty alleviation all over the world, but especially in developing areas where the current situation is alarming. Investments in Reproductive Health save and improve lives, slow the spread of HIV/AIDS and promote gender equality, which in turn help stabilising population growth and reduce poverty. Therefore, investments in reproductive health clearly extend from the individual to the family, and from the family to the world. (UNFPA, 2005a)

Issues concerning reproductive health have often focused on the biological roles of men and women, but it is necessary to also consider gender - the socially constructed roles - in order to understand the field. Obviously, the issues concerning reproductive health encompass both women and men and hence, both need to be considered and their respective needs examined. Failing to involve men in policies aiming at gender equality, can hinder and delay many of the steps needed in order to reach true and sustainable development.

1.1 Problem and aim

The objective of this thesis is to highlight the link between good reproductive health and development and poverty reduction. Certainly this link is only one of many influencing the latter, but nonetheless it is one of the most important ones (The World Bank a). There are both medical and non-medical benefits involved, but to fully understand the wider individual, family and societal gains, one must look beyond the medical benefits. (Singh et al. 2004: 6) I have chosen to concentrate on the non-medical benefits primarily, but some of the medical aspects will be mentioned as well.

The intention is also to focus on the importance of stressing gender aspects within this topic, which at a first glance may seem to be only biological. Specifically, the male side of the gender equation within Reproductive Health will be concentrated on. This does not imply that there is less need of focusing on the female side, but should be understood as an argument for the need of a combined focus on women and men, the female and male role. Neither the essay claims that investments in reproductive health without involving men is meaningless.

However, it does argue that the strategy of reducing poverty and enhancing development through investment in Reproductive Health, can be improved by considering and involving men – the male role. The essay does not focus on a specific region or country, but aims to explore the subject from a more general perspective.

The need for and opportunities offered by mainstreaming gender aspects in order to improve development strategies has been acknowledged within the academic field of development economics. Yet the role of the male side of the gender equation has not been considered very much, although it may offer extensive opportunities to improve the quality of life for many people.

My personal interest in this subject comes from insights by spending time in South Africa, where the serious situation of HIV/AIDS (not recognised by the country's leadership) is obvious. Nor are the related gender issues and particularly the male role being questioned.

The questions I intend to answer in this thesis are:

- *Can investment in Reproductive Health reduce poverty, and if yes, how?*
 - *Why is government intervention necessary in Reproductive Health?*
 - *How can Male involvement make Reproductive Health investment more efficient?*

1.2 Method and material

As a base for the thesis I create a conceptual framework, including key concepts central in the essay and some theoretical perspectives I have understood to be important for the topic. This thesis is to be seen as a qualitative study since the issues dealt with often are not quantifiable in a just way and therefore one has to go beyond quantifiable factors. Qualitative studies are the most preferable when to answer questions such as *how* and *why*. (Merriam 2003: 22-23) With the underpinning conceptual framework I hope to be able to explain and answer the questions posed.

The material covering the topic is both extensive and scarce. A large number of studies have examined the linkages between poverty and health as well as how different forms of investments in Reproductive Health influence poverty and development. On the contrary there is still not much research regarding involving men in reproductive health strategies.

Due to the limited time and resources for this study I will use secondary sources. The majority of the material comes from the major international development agencies such as UNFPA, UNDP and the World Bank since they are the leading actors in the field. This

material is complemented by articles illustrating the subject from different angles. The lack of primary sources can certainly be criticised, but since the aim is not to cover any specific situation but instead investigate the general climate, secondary sources are suitable. This study can also be seen as an introduction to a possible future field work.

Since the subject is very broad, further delimitation is necessary due to the space and time of this study. I have chosen to focus at strategies of *prevention*, recognised to promote good Reproductive Health. Prevention is cost-efficient since it brings positive externalities both in the short and long run. The lack of prevention is likely to cause negative externalities.

Population issues such as Reproductive Health have been included in the field of development for a long time and my aim is not to cover this extensive process. The period I have chosen to focus at is 1994 – 2005, from the International Conference on Population and Development (ICPD) until now when we are halfway to 2015, which is when the Millennium Development Goals and universal access to Reproductive Health are set to be achieved.

1.3 Outline of thesis

In the first chapter the development of the international agenda and the current global situation of Reproductive Health is presented, followed by a conceptual framework where key concepts are explained and the general linkages between health and poverty are clarified. Thereafter main arguments for intervention and key intervention areas are focused at, making the need for and importance of investment in reproductive health clear. The following chapter is concentrated on Male involvement, which suggests that a combined strategy focusing on both women and men is needed in Reproductive Health. Finally summarising conclusions are presented.

2 International agenda and current situation

Understanding of the development of the international agenda and current situation regarding Reproductive Health (RH) is essential. This section illustrates the changes of priorities and the global recognition of these since 1994, promising opportunities for change. Yet the current global situation is severe, despite improved policies, and calls for attention.

2.1 International agenda

2.1.1 ICPD: The individual needs

At the United Nation's International Conference on Population and Development held in Cairo (1994), 179 governments agreed on new approaches to population and development. At the core was increased access to RH information and services, acknowledged essential for human well-being. The Programme of Action meant a new strategy emphasizing the many linkages between population and development, stressing the need for information, education and communication, as well as prevention and control of HIV/AIDS. The involvement of gender aspects addressed the importance of involving men in RH programmes. Rather than achieving demographic targets, which had been the tradition, its focus was targeting the individual needs of women and men. Central in the recommendations were women's health, empowerment and rights. Goals in regard to education, particularly for girls, and further reduction of infant, child and maternal mortality were set up. Universal access of family planning is to be reached by latest 2015. (UNFPAa)

2.1.2 The Fourth World Conference on Women: Gender and Development

The Fourth World Conference on Women in Beijing (1995) established that the lack of equality and rights for women are crucial obstacles to development. Studies from all over the world had shown the large gains for society due to improved equality, such as reduced child mortality and decreased population growth. The international community agreed on a Platform for Action to reduce inequalities between the sexes in all spheres of life by acknowledging a new perspective of gender – Gender and Development (GAD). This meant a move from solely focusing on women to emphasizing the relation between women and men. The different roles and positions of women and men in the private and public, as well as their different responsibilities, rights, opportunities and access to resources were highlighted. The

government in every country was acknowledged the main responsibility to promote gender equality. (SIDA 2005a)

2.1.3 The Millennium Development Goals

In 2000 the United Nations agreed on a broad set of goals for international development priorities - the MDGs - to improve the quality of life for all individuals.¹ To achieve the goals, governments, civil society, and international agencies must cooperate to address population issues as a development priority. Although not explicitly included, good RH is fundamental to achieve all of the MDGs. (UNFPA 2005a: 1, Singh et al. 2004: 6)

2.2 The current global situation

Of all human development indicators RH constitutes the most severe inequities between wealthy and poor, within and between countries. Reproductive ill-health represents one-third of all deaths and disabilities among women of reproductive age and one-fifth of the total global burden of disease. Among the leading causes of death and illness for women in reproductive age in the developing world, are complications during pregnancy and childbirth, which constitute a great tragedy and violation of human rights. Yearly about 529,000 women die from complications and more than 99 per cent of them live in developing countries. If all 201 million women with unmet need in the developing world would have access to modern contraceptive methods, unplanned births would be reduced by 72 per cent and 1.5 million lives of women and children would be saved yearly. RH investments therefore yield enormous benefits, especially for the poor who are least able to access services. (UNFPA 2005a: 8-9)

Stronger investments in quality RH services are also needed considering that each year, three million people are killed by AIDS. (ibid. 1) The disease remains incurable, ruining individuals, communities and nations and the infection rate continues to increase. Only in 2005 the newly infected were estimated 4.9 million. The total number of people infected also continues to grow and 40.3 million people are now living with HIV/AIDS. Trends are indicating that the pandemic will keep on spreading if left unchecked. Sub-Saharan Africa (SSA) is the region hardest hit where two thirds of all people with HIV are living. The epidemic's female face is clear there since 77% of all women with HIV reside in SSA. Estimations point out that 2.4 million people died of HIV-related illnesses in this region in 2005, while new infections were 3.2 million. (UNAIDS 2005a: 2, UNAIDS 2005b)

¹ UN 2000 The Millennium declaration <http://www.un.org/millenniumgoals>

3 Conceptual framework

In this section, the interlinked key concepts in this essay will be explained in order to clarify their significance. Some of the linkages between RH and poverty will also be presented, highlighting the need for investments in RH to reduce poverty.

3.1 Key concepts and theories

3.1.1 Development

Development is unfortunately often seen in the narrow aspect of economic growth. Economic growth as an end in itself cannot be equivalent with development, but economic growth is often a condition for development. (UNDP 1996: 1) The World Bank emphasized economic growth as the goal of development, but switched to the broader goal - improving *human quality of life* - in 1991. Means representing important ends in themselves are better education, higher standards of health and nutrition, cleaner environment, increased equality of opportunity, greater individual freedom and a richer cultural life. (The World Bank 1991: 4)

Development must therefore be conceived of as a multidimensional process involving major changes in social structures, popular attitudes, and national institutions, as well as the acceleration of economic growth, the reduction of inequality, and the eradication of poverty. (Todaro - Smith 2003: 17)

Sen's concept "development as freedom" acknowledges the freedoms of individuals as fundamental and thus the expansion of the "capabilities" of persons to lead the life they value and also have reason to value is crucial. The freedom-centered perspective thus focuses on quality of life instead of just emphasizing the resources a person commands. The expansion of freedom is both the primary end and the principal means to development. (Sen 2001: 18, 24, 36)

3.1.2 Poverty – The capability approach

Sen argues that the "capability to function" is what matters in the distinction between a poor and a non-poor person. Poverty then can be considered as the state when a person lacks capabilities – the choice of what a person is or can be, does or can do. (Todaro - Smith 2003: 17-20) Low income is one of the major causes of poverty since it can lead to capability deprivation, but reduction of income-poverty alone cannot be the crucial motivation of poverty-reduction policy. Not seeing poverty as the multidimensional concept of capabilities would neglect many aspects of inequality and inequity. High fertility rates can for example be

viewed as adverse to quality of life in many aspects, but especially for women who are responsible for bearing and rearing the children. (Sen 2001: 144). To analyse gender and understand the inequality of resources and opportunities, it is impossible to only focus on income shortfalls and poverty lines, and therefore the capability approach offers a better assessment, since capabilities of men and women differ. (ibid. 90-92, 107, 109, BRIDGE 2001: 4)

3.1.3 Reproductive health and rights

The concept of RH emerged out of the need to change the approach of population control, in which women were only seen as breeders of too many children whose fertility had to be curbed by any means. (Sen ed. 2002: 108) The key definitions of RH and rights of the ICPD Programme of Action are the following:

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 to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. (ICPD paragraph 7.2)

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. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. (ICPD paragraph 7.3) (UNFPA 1995: 40-41)

3.1.4 Sex and Gender

The concepts of sex and gender need to be distinguished since they are different. Sex refers to biological characteristics, while gender refers to the socially determined ideas and practices of what it is to be female or male. Separating the concepts make it possible to look beyond biological difference and challenge the social bases of power and inequality. Gender refers to structural inequalities characterised by unequal access to resources for women and men, which can change over time. (Reeves - Baden 2000: 24, Sen ed. 2002: 7-8)

Connected to gender are gender equality and gender equity. The meaning of gender equality is that all people have equal rights, obligations and opportunities in life, regardless of sex. Gender equality is a human right, which implies that women and men, girls and boys, are considered as equal in terms of dignity and rights. Attaining this goal would enrich the world.

(SIDA 2005b: 1) Gender equity refers to the fairness equivalence in life outcomes for women and men, recognising that they have different needs and interests, with the consequence of required redistribution of power and resources. (Reeves - Baden 2000: 3)

It has been widely recognised that gender and poverty combine. Because of gender discrimination, the impact of poverty is even greater on women and girls than on men and boys (Sen ed. 2002: 7-8). Gender bias in health can be seen through slow recognition of problems affecting women in particular. As the World Bank reports, gender inequality is inefficient and undermines development policies. Hence gender equality is an explicit element of the mission to reduce poverty. (The World Bank 2005) A gendered approach to health in general and RH in particular offers guidance for appropriate public policy.

3.1.5 Looking at both sides of the gender equation - Male involvement

If gender is about relations between men and women, then the male side of the equation must also be figured in. If women's gender identities are to be changed, then men's must change also. (Reeves - Baden 2000: 15)

Focus was for a long time on specific investment for women relating both to gender equality and RH. Investing in social sectors such as health and education was assumed to lead to improvement in equality, but the role of men and the relation between men and women was often neglected. To achieve sustainable positive changes for women and increased respect for women's human rights, changes in and understanding of the male role are necessary. Increased understanding and contribution of men is especially important in the work for gender equality in general and RH specifically. The concept of Male involvement thus refers to RH strategies including men and the male role. It means *adequate* involvement, not only *more* involvement. The same concept is often called partnership/partnering with men. (SIDA)

3.1.6 Decision making within the household – Cooperative conflict

Most of the basic choices in life are made within households – decisions regarding how to allocate time between work and leisure, saving and investment for the future and having children and how to raise them. The decisions depend on a combination of social and cultural norms, economic incentives and individual's power to influence the process. According to *the unitary model* the members of the household pool their resources according to a unified set of preferences in all decisions. The model does not address gender, implying that the power of men and women in negotiation is equivalent. Whether males or females are in control of the income and assets should therefore, not affect resource allocation in the household since its

members behave altruistically. Outcomes in reality are often inconsistent with the unitary model, appearing to reflect different preferences and unequal power to negotiate by gender among the household members.

Bargaining models address gender aspects and see decision making as cooperative conflict. They recognise that outcomes are the result of unequal power to negotiate, reflecting gender inequalities in the distribution and control of resources such as income, assets and education. Aspects affecting members' "fallback positions" and options to leave the household under bad circumstances also influence. These factors have implications for gender equality and especially women's capabilities. In most countries the gender division of labour is consistent where men, being the breadwinner of the household, work more in the market while women work more in the household. As a consequence of lower education and labour force participation, women generally have lower incomes limiting their power to influence resource allocation and investments. (The World Bank 2001: 148, 154-157, Sen 2001: 192-194)

Fertility

If preferences of women and men concerning fertility and investment in children differ, understanding of outcomes rely on understanding the household decision-making. The unitary household model obscures the potentially divergent preferences of women and men regarding the number and treatment of children. The model also neglects the social environment's strong influence on fertility preferences. However, the difference between men and women in the costs and benefits of bearing and raising children is severe. Women bear all the physical costs of childbirth and also most of the effort to raise the children. Empirical evidence shows that men and women often do not have the same preferences for total fertility. More than in any other context the invention of "household preferences" is therefore inappropriate. Fertility decisions are made in negotiation of unequal powers within households, influenced by the social context. When decisions concerning fertility are made or influenced by individuals not bearing the full cost of childbearing and raising, there is potential for an equilibrium in which fertility is too high. (Bardhan - Udry 1999: 23-24) The fundamental problem is not that women are bearing the full cost, but that they lack power to influence decisions.

Paid jobs for women lead to higher opportunity costs of children, which can decrease both preferred and actual fertility. Greater bargaining power within the household as a consequence of the income-contribution can bring fertility outcomes closer to women's preferences. When women's individual earning power and security is enhanced, households can benefit from a more stable income. Macroeconomic gains result from the growing labour force women's increased participation in formal work constitutes. (UNFPA 2005a: 9)

3.2 Linkages between Reproductive health and Poverty

..health is a fundamental right valued in and of itself, and improved health, including reproductive health, strengthens individuals' capacities to live more productive lives and break out of poverty traps. (UNFPA 2005a: 1)

The relation between health and poverty is mutual; Poverty contributes to ill-health which causes poverty because of the close connections between between ill-health, vulnerability and poverty. (Sachs 2005: 204) Many features of poverty affect health negatively and ill-health affects the productivity of individuals, households and communities, increasing their risk of falling into poverty or being unable to escape poverty for long periods. RH is a vital component of overall health and has both intrinsic and instrumental values in regard to poverty. Whether rich or poor, RH and rights are central in human life. If ensured RH and rights, individuals and couples can avoid unwanted pregnancies, have children safely, space births according to desires and prevent sexually-transmitted infections (STIs) including HIV/AIDS. The core is that RH contributes to people's overall health and well-being. (UNFPA 2005a: 2) The benefits of RH are both medical and non-medical but health in general is difficult to estimate by monetary values. Non-medical benefits stand for a large and important share of the gains from investments in RH, but since they are very difficult to quantify, they often remain unacknowledged. (Singh et al. 2004: 6)

The instrumental aspects are obvious when stressing human capital. Poor health puts burden on national budgets and the lost incomes and lower productivity, due to the reduced human capital, result in slower economic development. Human capital has been recognised essential to create economic growth. Good health can thus reduce poverty through improving the ability to break out of poverty by strengthening people's human capital. Investments in RH can hence via strengthening the human capital, which in turn enhances economic growth, lead to poverty reduction. Healthier and therefore more productive individuals, households and communities ultimately contribute to stronger and wealthier nations. (Sachs 2005: 194)

RH can also reduce poverty via economic growth made possible by demographic changes. Through the demographic transition the rapid population growth is curbed and the age structure of the population changes, and the share of productive individuals compared to dependents increases. Thereby opportunities to advance economic growth open through savings and investments, which can reduce poverty. The demographic changes are interlinked with the human capital in two ways. Strengthened human capital can reduce the rapid population growth and the reduced population growth rates can offer possibilities to invest in human capital. The instrumental aspects of RH are further explored in the following sections.

3.2.1 Reproductive Health strengthens all the MDGs

The goal of universal access to RH by 2015 was not included explicitly among the MDGs, but the achievement of good RH has been recognized to underpin all the goals, especially MDG 1: *Poverty*, MDG 3: *Gender equality*, MDG 4: *Child health*, MDG 5: *Maternal health*, and MDG 6: *Combating HIV/AIDS and other diseases*. This perspective clearly points out that good RH not only is an intrinsic goal, but also has an essential instrumental value. (UNFPA 2005a: 3) A closer description of how good RH underpins the MDGs is found in appendix I.

3.2.2 Demographic transition and dividend

The links among fertility, population growth and poverty have been discussed for a long time, and evidence of changing population age structure strengthens these links. RH can bring important economic benefits through changes of the population structure through the demographic transition and the demographic dividend. The demographic transition can be explained in two shifts. Initially there is a shift from high mortality and fertility to lower mortality with still relatively high fertility and thus rapid population growth. The second shift to low mortality and fertility results in stable growth again. In most poor countries this transition is still incomplete. (Bardhan - Udry 1999: 20)

The demographic dividend occurs when the age structure changes, so the proportion of productive individuals relative to dependents increases. This demographic window opens an opportunity to advance economic growth and thus reduce poverty through increased savings and investment in education and health of the population, while also creating a favourable macro-economic climate. The improved human capital improves the quality of the labour force by increasing the productivity of the population which in turn enhances the economic growth. The economic growth in turn can lead to poverty reduction if distributed and invested properly. Bearing in mind the exceptional numbers of young people entering their reproductive years now², investing in them is essential to reduce poverty. (The World Bank 2004: 3) By using their demographic dividends and distributing the growth in income to the poor, developing countries can reduce poverty by approximately 14 per cent between 2000 and 2015. In East Asia the demographic dividend has been credited one third of the exceptional economic growth between 1965 and 1990. (UNFPA 2005b: 13, UNFPA 2005a: 6-7)

The population growth rates are still very high in the poorest parts of the world. A demographic trap can cause a poverty trap when poor families continue to have large numbers of children, but are unable to invest in nutrition, health and education for each child. The high

² Of the more than 1.7 billion youth aged 10-24, 86 per cent were living in developing countries in 2004.

fertility rate thus leads to high fertility in the next generation as well. These conditions reduce the poor households' human capital and uphold the intergenerational cycle of poverty. (Sachs 2005: 65)

3.2.3 Women and children

The burden of poor RH which is largely preventable, affects most seriously the poorest women and their families who are least able to afford its consequences. The gaps between regions in the world and the rich and poor within countries, indicate that poverty increases risk of maternal mortality. (For a closer view of the estimates by region, please see Appendix II.) (UNFPA 2004a) The capability to make free and informed choices regarding one's sexual and RH and childbearing, underpins self-determination in all other areas of women's lives. Due to its profound impact on women, RH cannot be separated from the broader goal of gender equality. (UNFPA 2005b: 27-28)

By ensuring that mothers and children survive, RH plays an important role for the intergenerational transmission of human capital which is essential for economic growth and poverty reduction. Educated and healthier mothers tend to have healthier and more educated children, while mothers lacking education and health cannot transmit these benefits of human capital to their children. A mother's poor RH thus can undermine the health and well-being of her children, which undermines a large share of a country's future human capital and potential economic growth and development. Conversely, good RH can help ensure that every infant is wanted and has a chance to thrive, since unwanted children generally are more vulnerable to disease and premature death. Health care for pregnant women can boost child survival, because of improved knowledge and screening of potential problems, reducing the risk of complications due to lack of information. Infant mortality is drastically reduced by birth spacing and two to three years between births reduce the probability of premature birth and low birth weight. In India birth spacing has been credited reducing child mortality by about 20 per cent. There is a close link between maternal and infant mortality and when a mother dies during delivery, her infant often dies as well. Newborns lacking mothers are three to ten times more likely to pass away than those with surviving mothers. Since mothers most often are the primary care-takers of children's health, education and nutrition, surviving children without mothers also suffer. (ibid. 35, Bardhan - Udry 1999: 24).

The obvious linkages between poverty and RH demands active intervention for many reasons and will be explored in the next section.

4 Policy analysis

The aim of this section is to clarify why active policy is needed within RH. Firstly main arguments for intervention are introduced briefly, and then a closer examination of key intervention areas follows.

4.1 Arguments for intervention

Market failure

Market failure occurs when the market, operating without any government intervention, fails to deliver an efficient allocation of resources and tends to be the most severe in developing countries. If the provision of health care services is to be efficient and equitable, some specific conditions must be fulfilled. The basic conditions that will lead to markets failure are imperfect competition, public goods, externalities and imperfect information. (Stiglitz 2000: 88)

In order to function, markets demand perfect information since efficient choices rely on available information. The field of health in general is characterised by lack of information and information asymmetries which can result in ‘wrong’ choices by individuals. Market failures also involve issues of equity, meaning that denial of the poor’s access to essential goods and opportunities are considered unacceptable and demand government intervention. The extent of market failure in RH is very large due to the widespread lack of information and gender inequality. Especially the poor have limited information about and opportunities to control fertility and protect themselves from STIs including HIV/AIDS. Individuals’ choices do not coincide with neither individually nor socially optimal choices automatically and RH must be seen as a *merit good*³. If merit goods are underconsumed the external benefits are lost and instead imply severe costs. Hence intervention aimed at capturing positive externalities and preventing negative externalities is cost-efficient.

Externalities

The main reason for why intervention is needed in RH is *market failure* due to *externalities*. Positive externalities relate to situations where the social benefits of consumption exceed the private benefits as well as the social costs. Correspondingly, negative externalities are social

³ A merit good is ‘socially desirable’ and ‘better’ for a consumer than the consumer realises because of imperfect information.

costs moving beyond individual costs. Through RH prevention negative externalities can be avoided and instead bring positive externalities. Among the positive externalities from strengthened reproductive rights and services is reduced fertility, which extends from the individuals to society and can lead to lower and stable population growth. When women are allowed to have less children, the quality of each child can increase through more investment and hence the child mortality is likely to decrease. This in turn affects the role of women who would be more able to contribute in the labourmarket, thus increasing the female bargaining power in the household and expanding the labour force. Negative externalities can be exemplified by HIV/AIDS which results in the loss of lives and human capital, extending from individual costs to costs for the whole society. This lost productivity due to ill-health can be prevented by consumption of RH. (Stiglitz 2000)

When persistent market failures exist and the extent of externalities is large, government intervention is justified since its absence would be too costly. It is obvious that the extent of market failure due to externalities related to RH calls for intervention correcting such failures. The state is by definition the only agent that can represent the interests of the whole society (Chang 2003: 47, 54) and was recognized as responsible for leading the work for RH and gender equality at the ICPD as a consequence of the market failures at hand. That responsibility does not only mean providing health services, but creating an enabling environment for RH by laws and public policy, both directly and indirectly. (SIDA 2001)

4.2 Identifying and selecting key intervention areas

The challenge is to select the policies attaining the greatest social benefit for the resources committed, considering local and national gender differences and disparities, as well as the bottlenecks to progress. In order to identify interventions with the greatest impact, the costs and benefits of different methods need reflection. To be able to capture the full value of any health intervention and compare returns of investment, consideration must be given not only to policies' medical benefits, but also to their contributions to economic development. Unfortunately the wide-ranging benefits of RH are difficult to measure and relevant data for gender analysis is often missing. Policymakers should also mind cross-sectoral links offering opportunities of more effective interventions, when calculating full benefits and costs of different policy. The entry point needs attention, addressing the relative efficiency of different types of interventions, such as targeted versus untargeted methods. Active measures can speed up the progress toward correcting market failures by targeting specific groups such as the

poor, which is a great benefit since scarce resources then could reach the ones needing them the most. Providing RH services can help policymakers encourage gender equality, improve social equity, expand community and political participation and speed up productivity and economic growth. (The World Bank 2001: 249-250, 253-254, Singh et al. 2004: 22)

Prevention rather than treatment

Prevention is usually much cheaper than treatment of ill health. Problems arising from poor RH can be averted to a large extent by policies focusing on prevention. Stronger health systems and better access to services can avoid many costly consequences, implying extended savings for public health and other social services.

There are also further costs to consider in RH. The opportunity cost for potential clients is a cost rarely addressed yet essential. Visiting the health clinic can translate into high costs considering value of forgone time and cultural pressure in a developing country. The social stigma that delayed childbearing, being HIV-positive or using a condom can put on women and men also needs attention. (ibid. 15)

4.3 Key interventions

Among many studies showing that investment in RH is highly cost-effective is the World Bank's 1993 World Development Report. It recommended an "essential health package" making the most efficient use of scarce health resources for low- and middle-income countries, including family planning, maternal health care, and prevention and treatment of STIs - including HIV/AIDS. (ibid. 10) I have chosen to highlight these interlinked key interventions separately through strategies of family planning, maternal health care and HIV/AIDS. However, these only represent some of many potential RH measures and a few examples of each intervention. Firstly market failures and externalities will be emphasised and secondly, empirical evidence from policies reducing poverty will be mentioned.

4.3.1 Family planning

Family planning is services aiming at helping couples decide whether to have children, and if so, when and how many. It enables women and men to limit their family size. Couples have large families for present and future gains and to pool risk, exemplified by economic inputs and old age support. Fertility decisions are based on the probability of child mortality and the degree of risk aversion of the family. Poor families often desire many children since they are risk-averse, but according to studies they also have more children than they want. The main

reason for this is market failure due to incompleteness of information. The uncertainty of whether children will survive or not, will not disappear until the next generation. Had families had the right information, they could have revised their fertility choices. The risk-aversion will in turn pose risks to the children, since the already scarce resources have to be shared among the many children, which likely leads to high child mortality. (Ray 1998: 313, 318) As economic development proceeds, fertility rates tend to go down since more children actually survive. Families can take the “risk” of having fewer children, knowing that each child is more likely to survive. (Sachs 2005: 325)

When fertility decisions of couples have implications for other members of the household or other households and these effects are not internalised by the decision maker(s), fertility decisions being privately optimal may not be socially optimal, implying externalities. Externalities of fertility are typically negative and thus private fertility decisions result in large numbers of children in general. Public provision of for example education and health not priced at their marginal cost, reduce private costs below the social marginal costs, pushing fertility beyond the social optimum. (Ray 1998: 319, 321)

Costs of family planning programs can initially be high due to high infrastructure costs and few users, but when programs become established and attract more clients, the costs per user decrease. Potential savings in social expenditures depend on actual governmental spending on education and health services. The cost of preventing an unwanted birth by family planning has been estimated \$368 in a typical high-mortality and high-fertility African country, while the government savings were \$440. In a typical low-fertility country in Latin America, the cost to avert an unintended birth was estimated at \$133 and savings at \$1,600, meaning that each dollar invested in family planning saved the government \$12 in health and education costs alone. (Singh et al. 2004: 11)

Policies

Studies have highlighted complex relationships working together between socioeconomic development and family planning, but also that both independently have effects on reducing fertility rates. (ibid. 12) The poor and illiterate households often lack both information and services regarding effective contraceptives and therefore education and access to contraceptives are crucial. (Ray, 1998: 318)

Contraceptives supporting women empowerment

Use of contraceptive services to time births and avoid unintended pregnancies has been acknowledged by women of all ages to improve their individual well-being and status in the

household. If young women can delay childbearing until they have achieved education and training, their social position and their economic and political participation can improve, constituting essential ends in themselves, but also crucial means for the long-term success of population programs. (Sen ed. 2002: 84)

Expanding economic opportunities

Family Health International's Women's Studies Project in the mid- to late 1990s, concentrated on contraceptive use only, reported how effects such as delayed childbearing and smaller families allowed more educational and economic opportunities as well as leisure time for women. Among the benefits were better opportunities for employment. Bolivian and Indonesian women using modern contraceptives were more likely to have paid jobs than those not using contraceptives. The ability to contribute economically to the household leads to increased confidence and decision-making power within the household for women, which in turn improved partner relationships. Market incomes also raised the opportunity cost of fertility which was likely to decrease both preferred and actual fertility. Contraceptive users in the Philippines were found to have a larger probability in comparison to nonusers to join their husbands in taking household decisions. Costs such as side effects of contraceptive methods and family disapproval of contraceptive use were also documented. (Singh et al. 2004: 8)

Expanding community and political participation

Having fewer children can release time to spend in community activities and thus family planning can encourage especially women taking on a more active role in community and political life. In a survey of older married women in two urban areas of Indonesia, fifty percent answered that they were able to spend more time in community activities because of family planning. There were also cumulative effects of contraception and smaller families. When women had time and the choice to become involved in social and political issues, they took advantage of and promoted contraceptive services more and more to others. Thus the lack of information regarding contraceptives could be reduced even further. (ibid. 25)

Smaller families can also reduce gender discrimination in the short run. According to a study in Ghana, children in larger families, especially girls, have less probability to attend school. In comparison to those with fewer siblings, they experience greater inequality within the household. Contraception can therefore make a contribution to in the direction of equality by allowing smaller families. (ibid. 23-24)

Social norms matter

People are affected by the social environment and tend to do what other people do. The strength of social norms can become a weakness when once accepted suitable behaviour becomes inappropriate. Social practise often changes slowly since coordination on new norms needs that many people act similarly, but if everyone would consider change acceptable, it would be acceptable. The altering of social norms can occur in different ways and media and family planning programmes have essential roles to play in this process. Apart from spreading information about the cost, availability and effectiveness of different methods of contraception, they constitute social legitimisation, exemplified by the Matlab project in Bangladesh from 1977. Seventy villages were given a birth control/family-planning program, while seventy-nine control villages were not served. The contraceptive use increased from 7 to 33% in 18 months in the treatment villages and by 1980 the fertility rate had declined to two-thirds that of the control villages. The project concluded that contraception was unknown and that people desired fewer children than they were actually having, but were lacking the means to do so. Ray argues that the program was more likely to have signalled that lower desired fertility is good, tolerated and encouraged by society. The decreased fertility would be a response to these signals and the program thus had two functions. Lower fertility was introduced as something good and access to contraceptives was improved. Family planning programmes thus can compensate for ambivalent reproductive motives and create demand resulting in contraceptive adoption, where it otherwise would not take place. (Ray 1998: 323-325)

4.3.2 Maternal health care

To reduce maternal death and illness is recognized as both a moral imperative as well as a key development priority in reducing poverty. Maternal deaths and disabilities have been recognised as violations of women's human rights, strongly linked to women's status in society and economic independence. Women's right to health care is based on the concept of informed choice, enhancing the probability to survive pregnancy and childbirth. The majority of the deaths are the result of problems that are difficult to detect or screen for, since any woman can experience complications during pregnancy, childbirth and the post-partum period. However, the problems are almost always treatable when quality emergency obstetric care is provided and accessible. The access to skilled maternal health care can in most cases prevent deaths and injuries before, during and after pregnancy and can thus be seen as an essential good. Denial of this access for the poor is unacceptable on equity grounds. (UNFPA 2004a)

As the majority of deliveries in developing countries takes place in the home, the underlying causes of maternal mortality have been classified according to the “three delays” model.

- delay in deciding to seek medical care
- delay in reaching appropriate care
- delay in receiving care at health facilities

The three delays result from the lack of information on both the supply- and demand side. The first delay comes from failure to recognize signs of risk, which usually is a consequence of the absence of skilled birth attendants. It may also stem from reluctance within the family or community to send the woman to a care facility due to financial or cultural constraints. The second delay is caused by lacking access to a health facility, available transport or awareness of existing services. The third delay is linked to problems in the health facility including inadequate resources such as lack of skilled personnel and medicines or blood. (UNFPA 2004b) In many locations the supply of safe motherhood services does not exist or is insufficient to meet the demand. Pregnancy care may also not be a priority in the household given its costs in time and money. Many women are still not considered to be worth the investment with harsh consequences for them, their children - who are less likely to survive or grow up with a mother - and ultimately their communities and countries. (UNFPA 2004a)

The result of good RH care combined with the implementation of reproductive rights of women is thus central. The externalities of women’s RH status are obvious through the effects on the children, who constitute countries’ future human capital, implying socio-economic consequences both in the short and long run. (UNFPA 2005b: 12)

Policies

Interventions focusing on maternal mortality reduction should, referring to the above mentioned shortages, prioritize the availability, accessibility and quality of obstetric facilities. Policies have since the mid-1990s focused on strategies considered to be the most effective: expanding women’s access to skilled attendance at delivery; improving services to treat pregnancy complications and the access thereof for women; and ensuring and improving transport systems so care can be received quickly. The connection between access to family planning and maternal health care planning is important, since reducing unwanted pregnancies would reduce many unsafe abortions. The overall quality and capacity of countries’ health systems need to be improved and decentralisation is essential to facilitate the poor’s access to services.

Getting women to seek care

One of the most important aspects of getting women to seek care at health facilities is improving the quality thereof. Studies have found that women find respectful treatment essential and that provider attitudes are the greatest restriction to the use of maternal health services. Despite acknowledging the importance of medical needs, both rural and urban women in Yemen preferred delivering at home, because of fearing, or previous bad experiences with institutional deliveries. Thus training providers is an important element in providing improved care and overcoming clients' reservations about seeking available services. One example of how service utilization rates have risen dramatically was when reduced fees and female providers were ensured and this information was spread through a publicity campaign, at a primary health clinic in Peru. The female clients reported high satisfaction with the services and a preference for female providers. The example also shows the importance of not only improving the quality of the health facility, but also raising the awareness about the quality improvement. (UNFPA 2004c)

Although many countries report investment in maternal health care, only some countries, where most are middle income and a few are poor, have been successful in reducing maternal mortality. All countries that have reduced maternal mortality have done it through a dramatic increase in hospital deliveries (UNFPA 2004b). Progress in most countries has been slow and maternal mortality and morbidity remain very high in several regions, including most of SSA and the poorer parts of South Asia. The implication is that current interventions will need to be scaled up and more resources directed towards them if there is to be an improvement in saving women's and their children's lives and health. (UNFPA 2004a)

4.3.3 Prevention of HIV/AIDS

The HIV/AIDS epidemic is connected to market failure and externalities in many ways. By targeting predominantly people who are the mainstay of the economy and the principal support of their families, the pandemic destroys the very fabric of societies. By exacerbating poverty, it leaves people even more vulnerable to the spread of HIV. (UNAIDSa)

The costs of the epidemic stretch from the individual to the community and the nation. Some of the severe effects of the pandemic are decreased life expectancy, weaker labour force, discouragement of foreign investment and burdens on already overstretched health systems, which all limit economic growth. Africa's per capita annual growth was reduced by 0.8 per cent by AIDS in the 1990s and projections for the next twenty years suggest that the economies in the worst affected countries will be about 20 – 40 per cent smaller than they would have been without HIV/AIDS. At the micro level the households are affected by for

instance the lost incomes, cost of treatment and funerals. Studies of mostly poor households in two Sub-Saharan countries, found that monthly incomes decreased by as much as 66 – 80 per cent because of dealing with AIDS-related sickness. (UNFPA 2005a: 10-11)

Prevention of HIV/AIDS has great potential for positive externalities since not only the individual can protect oneself, but eliminate the risk of spreading the disease to others. Knowledge of how HIV/AIDS spreads and how it can be prevented can be passed on to others at no costs for society. Because of severe stigmatisation surrounding the disease, many infected hide their health status in fear of losing for example jobs and friends. Many people do not even want to get tested fearing a positive result and instead prefer living in uncertainty. This behaviour gives rise to information asymmetries in societies since people do not know or hide their true health status, impeding the true level of HIV/AIDS prevention needed. The lack of information puts other people at risk as well. Hence, the prevention of HIV/AIDS is characterised by the many problems of market inefficiency, arguing for intervention.

Prevention of HIV/AIDS and its related disabilities can translate into a healthier, more productive labour force able to contribute to the household, community and ultimately the country's economy. Though both prevention and treatment are needed, interventions aiming at HIV prevention in Sub-Saharan Africa are at least 28 times more cost-effective than antiretroviral therapy. (Singh et al. 2004: 10) Since more than 75 per cent of HIV cases are transmitted sexually, investment in reproductive health is strategic to prevent the spread of the infection. (UNFPA 2005b: 13)

Policies

Information and communication are among the most important elements of the response to HIV/AIDS. Only with awareness and of HIV is it possible to take effective action. Effective communication is only possible where the silence surrounding the pandemic has been broken, which still has to be done among leaders in government and society in many countries. However, it is essential to bear in mind that knowledge on its own is not sufficient to change a negative behaviour. (UNAIDSb) Examples of preventive strategies that have managed to reverse the spread of HIV follow.

Communication

Two examples of where dark predictions regarding the disease have been proved wrong through effective prevention strategies are Brazil and Uganda. The countries' open communication and far-reaching dialogue about the nature of the disease, modes of transmission and ways of prevention is and has been central. The Brazilian government took the AIDS threat

during the 1990s very seriously and acted immediately through a combination of widespread education campaigns in the newspapers, on billboards and even airwaves, and free condom distribution. In both countries the discussion about the pandemic was started from the top, but it can also be initiated from the grassroots. In countries where the government is not as open about the disease, this perspective may be the even more important. Since the dialogue must involve sexuality and not just public health, open discussions tend to be more prohibited. (Hope 2003: 11)

The decline in prevalence rates in Uganda is not only due to a few specific interventions introduced by the government. There are many NGOs, religious groups and community activists also working to prevent the spread of HIV/AIDS. However, a key factor in the decline is the government's strategic approach to enable non-state actors in their individually targeted messages about prevention. (Parkhurst 2002)

Behaviour change

The ABC model – abstinence for younger adolescents, being faithful within marriage and condom promotion – has been emphasized as key in prevention of HIV/AIDS by behaviour change in Uganda. All three aspects have contributed to decline, but there is disagreement about which has been the most efficient. By investigating Demographic and Health surveys in Uganda from 1988 – 2000, the Alan Guttmacher institute found a steep increase in condom use among unmarried sexually active men and women. Married men reported a small increase in the use of condoms, while there was little change among the married women. The level of monogamy among married people had not changed much, and a significant share of married men is not monogamous and most do not use condoms. (Singh et al. 2003: 130)

The ABC model has been criticised for being too narrow and undermining prevention of the pandemic. Abstinence or faithfulness as the only ways to prevent HIV transmission leave millions of people without the ability to protect themselves. In SSA, risk factors are found within marriage and the illusion of fidelity among supposedly HIV-negative couples. Married, monogamous women are high risk of infection due to their lack of rights within marriage and difficulties to negotiate safe sex. Correct and consistent condom use means real behaviour change and simple provision is not enough. (Sinding 2005)

The male latex condom is the single most efficient available technology to reduce the sexual transmission of HIV... Condoms will remain the key preventive tool for many, many years to come...(WHO - UNAIDS - UNFPA 2004)

Campaigns of behaviour change communication focused on knowledge and use of condoms in Uganda, indicated strong association with higher condom knowledge. Women and men who reported exposure to messages in the mass media were at least twice as likely as those with no exposure to know of condoms as a mean to avoid HIV/AIDS. (Bessingera et al. 2004)

4.4 Coordination of RH –HIV/AIDS policies is efficient

Because of the strong linkages between programmes and services targeting HIV/AIDS and RH, special efforts reaching those excluded from access to services, will lead to more cost-effective programmes with better impact. (UNAIDS 2005c: 9) The spread of HIV and reproductive ill-health have many driving common causes, exemplified by social marginalization of the most vulnerable individuals and groups. Cross-sectoral links and spill-over effects of RH services suggest that some services can be provided most effectively as an integrated package. Condoms provided as part of STI prevention also prevent unintended pregnancies, which may not be attributed to the STI services. Likewise, the condom as contraceptive method protects people against STIs, including HIV/AIDS. Women regularly visiting a clinic for contraceptives can be better informed and connected into existing systems of health care, which makes them more likely to seek prenatal care. (Singh et al. 2004: 7-8, 21) These simultaneous gains emphasize the role of the “C” in the ABC model. Even if a woman abstains until marriage, she is likely to still want and need C, be it condoms or other contraception, to be able to plan childbearing (Cohen 2003: 135).

Men have not until recently been considered in RH interventions, although there is potential involved in doing this. Therefore the next section will highlight the men and the male role specifically.

5 Male involvement

The previous chapter examined how investments in RH can reduce poverty. In this section Male involvement in RH will be explored to investigate why men should be involved and whether it can improve the quality of strategies by making them more efficient. RH investments traditionally have only focused on women, completely neglecting men. Viewing the field of RH only as a woman's issue is a severe mistake, leading to the risk of missing out on the potential of also including men in combined strategies. Many health promoting agencies recognized men's role experiencing that without working with men, change would be very complicated or even impossible. At the ICPD conference men's significance was acknowledged as follows:

Male responsibilities and participation: Basis for action -

men play a key role in bringing about gender equality since, in most societies, men exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and programme decisions taken at all levels of Government. It is essential to improve communication between men and women on issues of sexuality and reproductive health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private life. (ICPD paragraph 4.24) (UNFPA 1995: 27)

Considering that female sexuality often is under male decision and that men are the primary transmitter of HIV/AIDS, understanding of the unequal power-relation between women and men obviously is important. (SIDA) Male-dominated gender-relations influence men in the many roles they play in society - as husbands, fathers, religious leaders, media owners, policy makers, health service providers, and local and national leaders. The role of men have both instrumental and intrinsic values within RH. The instrumental values correspond to how men influence women and the intrinsic values are men's own needs. The health status and behaviour of men affect women's health and reproductive health because men often act as "gatekeepers", supporting or restricting the access to health services of women and children both directly and indirectly. This implicates that men are central in top-down strategies as well as bottom-up strategies, because they control key decisions and access to reproductive health information and services, finances and other resources. Involving men increases their awareness, acceptance and support to their partners' needs, choices and rights. Men's active participation is essential to the success of programs and empowerment of women. (Sternberg - Hubley 2004: 389, UNFPA 1998: 13)

Meeting men's needs results in a win-win situation

Both women and men are more likely to respond to RH information if they see that their own best interests are reflected. The probability of men being good partners and parents is larger if they feel that their involvement matters, and that their participation is respected. Men's greatest need is to become better informed about the risks associated with certain sexual and reproductive behaviours and how to avoid such risks. Meeting men's needs should not absorb much available health care resources.

Some men in leadership positions may be reluctant to promote policies that will improve the status of women because of perceived threat against the status of men. However, experience indicates that male leaders who are provided with relevant data and alternative models of behaviour, can become allies in promoting investments in RH and male involvement in gender equality particularly (UNFPA 2003: 13).

The more informed and effective men become in living safer sexual and reproductive lives, the better the situation will be for themselves, their partners and children. The mutual gains thereby reflect a win-win-situation. (Nadeau - Bankole 2004)

The reality is that although perhaps no longer regarded as part of the problem, men have yet to be seen as part of the solution. (Sternberg - Hubley 2004: 1)

Few would today disagree that involving men in RH promotion is important, but the impact male involvement may have on women and children pose serious questions. Does male involvement contribute to women's empowerment or will it increase men's power over their female partners? (ibid.) It is problematic that few interventions have targeted heterosexual men including detailed evaluation. More interventions and better evaluations of Male involvement are needed, examining the impact on the lives of the men themselves and their families. Although the necessity of involving both women and men in RH strategies was emphasised at the ICPD, there is still a lot to be done to really involve men and thereby improve the strategies.

Male involvement in the key interventions

The studies I refer to have used different methods focusing on different goals, but have had the common aim of involving men in RH policies. The interventions are presented in the following order: family planning, maternal health care and finally prevention of HIV/AIDS.

Family planning

Mere provision of family planning services for men in itself does not seem sufficient to attract them into programs. One reason may be that most services remain designed to meet the needs of women. Critics of male involvement argue that persuading men about the importance of RH will be difficult, fearing that resources aimed for projects targetting women will be reallocated into projects targetting men. These fears seem unsupported since interventions have shown that many men are interested in the wellbeing of their families and support FP. Men often want to be involved and many strategies are successful in involving men when viewed as allies rather than irresponsible partners (Baylies - Bujra 2000).

Fertility preference

The fact that the preferences of fertility differ between men and women, point out the relevance of targeting men if the population growth is to be reduced. Men who often have a central position in reproductive decision making, in general prefer more children than women. Although many women prefer fewer children, many cannot control their own fertility. Lack of access to family planning services and communication on reproductive health issues are obstacles, reflecting the underlying unequal bargaining power in the household. When reports of current contraceptive use were examined closer, among women's reasons for not using contraception, husband's disapproval was frequently brought up. (Sen ed. 2002: 92, 104)

FP strategies targeting men at the community level have been successful, indicating the importance of social norms and signalling acceptance of changed behaviour as seen in section 4.3.1. In Pakistan six case studies evaluated projects aimed at increasing men's involvement in family planning through for example meetings with the press, religious and political leaders. The study found the projects successful in promoting changes in the status of women and reducing family size. (AVSC International 1997) Another successful study concentrated on increasing men's knowledge of contraceptives involving Muslim religious leaders in Bangladesh connecting Islam and FP (Neaz 1996).

Spousal communication affecting contraception use

Spousal communication is often emphasized in FP, sometimes viewed as the first step in a rational fertility decision-making process. Yet this communication remains rare in developing countries particularly. Numerous studies point out that the amount of communication between partners is positively linked with contraceptive use. The effect of spousal communication upon family planning use is influenced by the relative bargaining power of each spouse in the decision-making process. The husband's resistance to contraception may often be sufficient to

hinder use, which will occur less often if the wife opposes contraception. When spouses disagree, the asymmetry will thus more likely hinder family planning aspirations of women.

A project in Ethiopia was designed to test if male involvement in family planning discussions with their wives made a difference to the use and uptake of modern contraceptive methods. An experimental group including 266 couples was compared with a control group of 261 women, and after twelve months modern contraceptive methods were used by nearly half of the experimental couples. The participation of men seemed to make a vital difference to contraceptive use by their partners. (Terefe - Larson 1993)

Spousal communication was also emphasized in a study investigating the connection between spousal communication and family planning use, within the context of exposure to a media campaign promoting family planning in Nepal. The impact of a radio serial was evaluated among couples of reproductive age from 1994 to 1999. Spousal communication at baseline was associated with consequent use of FP, independent of campaign exposure. Among couples who had not been discussing FP previously, exposure led to communication, which in turn resulted in use. The men's dominance in FP decisions over time gave way to joint decision-making, implying an increase in women's decision-making power. In 1994 use was highest among couples in which the husband made family planning decisions (55%). Joint decisions responded to 47% and woman's decisions to 45%. In 1999 those who reported joint decision-making had the highest level of use (66%), followed by couples in which the wife made FP decisions (60%) and those in which the husband made decisions (58%). The radio program, was more effective in changing the attitudes of the younger age group, whose reproductive decisions contribute most to future fertility growth. The study concluded that couples' joint decision-making should be promoted as a strategy for increasing FP use. (Sharan et al. 2002)

Interventions have shown that male involvement can lead to increased use of contraception, but that does not always translate into empowering women. Evidence from family planning programs in the Middle East showed that male involvement had increased men's power over the fertility of women, rather than the desired result in women having more choice. (Cornwall 1998)

Maternal health care

Although men do not bear the physical burden of pregnancy, they can make a great difference by being active partners. Involving male partners, extended families and community members in order to prioritize women's health care during pregnancy, delivery and the post-partum period, has been a successful approach resulting in positive maternal health outcomes of many

programmes. (UNFPA 2004d, UNFPA 2000a: 33) As mentioned in section 4.3.2, the lack of men's support, due to financial and cultural constraints, leads to women's unlikeliness to receive care, with tragic consequences for women and children. The lack of information and knowledge of maternal health care among men has been recognised to hinder the access to service for women. Men are often the ones who decide when a woman's condition is serious enough to seek care. However, another problem is that many men who want to be involved in the health of the women in their lives, are impeded by hospital regulations or poor communication with their partners.

There are many examples of opportunities for men to support maternal health care. To promote safe motherhood, men can plan their families by limiting and spacing births. Every pregnancy is associated with potential health risks even for women who seem healthy and at low risk. Especially unintended pregnancies are likely to be risky, since they may lead to abortion, which in turn can cause complications. Men's participation is crucial in enabling millions of women to avoid unintended pregnancies. If men support contraceptive use they can accompany their partners to FP counselling. Thereby they can get informed and together choose method of contraception corresponding to their needs. Being informed, men can encourage their partners to seek help if side effects occur. During pregnancy, men can assure that their partners gets proper antenatal care, providing transportation or funds to pay for health care. By accompanying antenatal visits, men can become aware of symptoms of pregnancy complications. Men play key roles in avoiding delays in seeking care, which often contributes to maternal deaths when complications of pregnancy occur. Good nutrition is also important during pregnancy and if prioritised, maternal deaths can be reduced to a large extent. Men can also prepare the actual delivery by arranging skilled care and organise transportation ahead of time. After delivery men can help with the heavy housework exemplified by gathering water and taking care of other children. (Population reports 1998)

Informing husbands about the role of health care

The Pati Sampark - "meeting husbands" - program in India is one example of efforts to involve men. The targeted population is characterized by conservative and restricted roles for women and the program was initiated in response to low attendance by high-risk women at antenatal clinics. Eventually all pregnant women regardless of risk status were included in the project. By incorporating husbands into an existing service delivery program, the aim was to improve wives' attendance at the clinics and reduce the rate of low birth weight babies. Skilled male and female staff informed husbands about pregnancy and birth, and emphasised specific roles that they could fill. Husbands of pregnant women who were not attending

monthly antenatal clinics were visited and informed about the value of antenatal care at the start of the program. Men with wives having high-risk pregnancies were informed about symptoms and appropriate treatment. Information about family planning methods and the benefits of spacing children at least three years apart, was given to all men.

The program succeeded in raising men's understanding of antenatal services including vaccinations and routine tests. Greater awareness of contraceptive methods and benefits of child spacing, was also reported among the men who participated. Women whose husbands had participated in the program were more likely to visit the clinics on a repeated basis (6 to 7 times) in comparison to women whose husbands did not take part (2 to 3 times). (RHO)

Prevention of HIV/AIDS

The HIV/AIDS pandemic has put men's sexual behaviour in focus, since many men engage in risky practices, exemplified by having multiple sex partners and not using condoms consistently. This behaviour puts both themselves and their partners at risk for HIV/AIDS.

The spread of HIV is influenced by both social and biological factors. Male to female transmission of the virus is biologically easier since transmission of infection through sexual intercourse is more efficient from male to female than vice versa. The increasing rate of female infection is clearly associated with gender relations contributing to risk as well. Men's perception of risk and their own contribution of transmitting HIV/AIDS is seriously lacking. (Sen ed. 2002: 14, 98)

Norms of female sexual passivity and the social value of virginity complicate information seeking about protection, and raising the question of protection in a sexual relationship for young and unmarried women particularly. When opportunities of independently earning an income are low and thus reducing women's socioeconomic status and bargaining power, risk is likely to prevail. If women's social and economic position is threatened by breakdown in a stable relationship, their ability to refuse sex or demand protection is limited. The role of children for women's social and economic security also influences condom use due to their contraceptive "side effect".

Men on the other hand are expected to have many partners and discourage use of protection such as condoms. Male promiscuity and infidelity are often implicitly accepted, but men may not want to admit this to their long-term partner, fearing weakened power in the relation. Thus the long-term partner is exposed to risk of infection.

Premarital and extramarital sexual behaviour needs special attention, considering that women tend to be infected by HIV at a younger age than men, which comes from girls becoming sexually active earlier than boys. In several Asian and African countries, older men

also seek out virgin girls, considered uninfected, to cleanse themselves from infection. Older men, infected with HIV, persuade girls into sex or buy favours with “sugar-daddy” gifts. (ibid.: 99, 103, Population reports 1998)

Behaviour change - Condom use

As have been mentioned in section 4.3.3 behaviour change is considered fundamental to prevent HIV infection. All contraceptive methods, except for the female condom, are male controlled, whereby male involvement is the key (UNFPA 1998: 13). Some examples of successful policies targeting men, focused on premarital and extramarital sexual behaviour, are the following: An education program targeting Tanzanian truck drivers showed increased condom use from 56 to 74% amongst men. The program consisted of an 18-month intensive phase of education about condom use followed by an 24-month maintenance phase. (Laukamm-Josten et al. 2000) A study of trucking company workers in Kenya saw changed behaviour after cognitive-behavioural intervention. The results showed that condom use increased and that the share of men who had extramarital sex or sex with sex-workers declined. (Jackson et al. 1997) The ‘Male Motivation Project’ by the Zimbabwean Family Planning Council used a wide variety of media and men who had been exposed to the campaign, were significantly more likely to use condoms in relation to men not exposed. (Kim - Marangwanda 1997)

Most HIV prevention efforts focus on premarital and extramarital sexual behaviour, but needs of married and cohabiting couples are just as essential. Condom use by these couples is generally low, due to barriers such as men’s resistance and cultural norms, but resistance to condoms within marriage can be altered. A study in KwaZulu-Natal in South Africa showed that behaviour change is possible through education leading to awareness. The behaviour differed between urban and rural couples and across educational levels, where rural couples lacking education reported lower use of condoms. Although couples’ knowledge of condoms and where to get them was high, use was inconsistent. The level of use among rural and less educated couples was 8% (men) and 11% (women), while it was 29% (men) and 34% (women) among urban and more educated couples. (Maharaj et al. 2005)

6 Summary and conclusions

Because of the many linkages between poverty and RH, investments must be made in RH in order to improve the capabilities of all women and men. It has been widely recognized that although not explicitly included in the MDGs, improving RH underpins all of them. If the goals of sustainable and equitable development are to be achieved, individuals must be able to exercise control over their sexual and reproductive lives. Hence reproductive health and rights must be seen as instrumental means to development as well as ends in themselves, since reproductive rights constitute human rights. The male-dominated gender relationship is essential to address when dealing with the field, since the current structural discrimination of women and their rights at all levels of society is unacceptable. Reaching gender equality should hence be seen as a tool towards development and poverty reduction - offering people capabilities and ownership of their lives and not as a goal to strive for when all other problems have been solved.

Due to the extent of market failures such as imperfect information and externalities – both negative and positive – within the field, active intervention is argued for. The costs extending from lack of family planning, maternal health care and HIV/AIDS prevention are too severe, stretching from individuals to communities and future generations. Correspondingly, the benefits of intervention provide positive externalities for individuals, communities and nations as well as future generations. The costs of cure are devastating, while prevention is necessary and possible. The state acting as social guardian is utmost the responsible agent for leading this work.

Interventions focused on prevention have been acknowledged to be highly cost-efficient, which characterise all three key intervention areas emphasized in this essay: family planning, maternal health care and HIV/AIDS. Methods of prevention exist, but information and access is still lacking among the poor. Empirical evidence from policies targeting the poor has showed benefits improving the capabilities of individuals and thus reducing poverty. Among the benefits of the key interventions are:

- Family planning programmes involving contraceptives have contributed to women empowerment exemplified by expanded economic opportunities and community and political participation.
- By improving the quality of health care facilities and spreading the knowledge about this, more women seek and take advantage of maternal health care.

- Policies focusing on communicating information and behaviour change to prevent the spread of HIV/AIDS, by especially promoting condom use, have resulted in improved awareness about and use of condoms.

Although many aspects of RH are strongly connected with cultural values, it is important to remember that change is possible, although it might be slower than desired. Interventions are central to speed up this process of change. To wait for “automatic” changes is not an option even for the poorest nations in the world.

In order to reach gender equality both sexes need to be involved and take their responsibility. This is not only necessary in developing countries, but also in developed ones. It is very clear that gender equality not only considers women but also men, which is especially obvious in the field of RH. To improve the quality of investments in preventive RH strategies, Male involvement is necessary. Bearing in mind the male-dominated gender-relations throughout society, targeting men and the male role is needed if gender equality is to be reached. Men often act as gatekeepers restricting the access to health service for women and children directly and indirectly, and thus policies must focus at this impediment to be efficient. It is crucial to find ways on how to reach men in order to not only get their support, but encouragement of women empowerment. Reaching men is essential because of their instrumental value, while women empowerment has a more intrinsic significance. One must bear in mind that involving men offers great opportunities. Some of the reasons to why policies within the key intervention areas should target men are:

- If population growth is to be reduced, family planning programmes have to reach the men who in general prefer more children than women and most often control fertility decisions.
- When men support maternal health care, maternal mortality and morbidity can be reduced to a large extent by improved services and access to them.
- Breaking behaviour implying risks not only for themselves, but also for their partners, is crucial if the spread of HIV/AIDS is to be hindered. Involving men is essential since all contraceptives preventing the disease, except for the female condom, are male controlled.

Policymakers must set the goal of gender equality on the agenda and prioritize investment in RH, recognizing RH and gender equality as economic issues both in the public and the private sphere. Fathers and husbands must take their responsibility within households, but also influence policymakers from the bottom-up.

Future research

In order to find better strategies for RH and gender, a lot more research is needed to collect gender-disaggregated data allowing policymakers more informed choices based on analysis of social benefits and costs. That way they would be able to choose the most effective policies in specific contexts. Men as part of the gender concept must also be investigated more profoundly. It is desirable to develop approaches and methodologies to quantify more of the benefits of sexual and reproductive health care, so that studies and interventions can be compared. Until now a lot research has concentrated on how policies can involve men, but research is needed to further evaluate the effectiveness of men's involvement, in order to find out how Male involvement is best designed. Efficiency should be interpreted as positive outcomes in the quality of RH strategies. How men's needs are to be best supported without taking attention and resources away from the focus on women is also important. Research must look not only at the process and immediate outcomes of involving men, but the long-term impacts on men's and women's lives.

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Appendix I

Reproductive health strengthens all the Millennium Development Goals

Goal 1: *eradicate extreme poverty and hunger*

Smaller families and wider birth intervals as the result of contraceptive use allows families to invest more in each child's nutrition and health, and can reduce poverty and hunger for all members of a household. At the national level, fertility reduction may enable accelerated social and economic development.

Goal 2: *achieve universal primary education*

Families with fewer children, and children spaced further apart, can afford to invest more in each child's education. This has a special benefit for girls, whose education may have lower priority than that of boys in the family.

Goal 3: *promote gender equality and empower women*

Being able to decide freely whether and when to have children is a critical aspect of women's empowerment. Women who plan the timing and number of their births also have greater opportunities for work, education, and social participation outside the home.

Goal 4: *reduce child mortality*

Prenatal care and the ability to avoid high-risk births help prevent infant and child deaths. Children in large families are likely to have reduced health care, and unwanted children are more likely to die than wanted ones.

Goal 5: *improve maternal health*

Preventing unplanned and high-risk pregnancies and providing care in pregnancy, childbirth, and the postpartum period saves women's lives. This guarantees well-being through the woman's life cycle and the quality of her life and that of her family.

Goal 6: *combat hiv/aids, malaria, and other diseases*

Sexual and reproductive health care includes preventing and treating sexually transmitted infections, including HIV/AIDS. In addition, reproductive health care can bring patients into the health care system, encouraging diagnosis and treatment of other diseases and conditions.

Goal 7: *ensure environmental sustainability*

Providing sexual and reproductive health services, and avoiding unwanted births, can help stabilize rural areas, slow urban migration and balance natural resource use with the needs of the population.

Goal 8: *develop a global partnership for development*

Affordable prices for drugs to treat HIV/AIDS and a secure supply of commodities would greatly advance reproductive health programmes, and are especially needed in developing countries.

(Singh et al. 2004: 6)

Appendix II

Maternal mortality estimates by region (2000)

Region	Maternal Mortality Ratio (Maternal Deaths per 100,000 Live Births)	Number of Maternal Deaths	Lifetime Risk of Maternal Death, 1 in:
WORLD TOTAL	400	529,000	74
DEVELOPED REGIONS	20	2,500	2,800
Europe	24	1,700	2,400
DEVELOPING REGIONS	440	527,000	61
Africa	830	251,000	20
Northern Africa	130	4,600	210
Sub-Saharan Africa	920	247,000	16
Asia	330	253,000	94
Eastern Asia	55	11,000	840
South-central Asia	520	207,000	46
South-eastern Asia	210	25,000	140
Western Asia	190	9,800	120
Latin America & the Caribbean	190	22,000	160
Oceania	240	530	83

Estimates developed by WHO, UNICEF, and UNFPA.

(UNFPA 2004a)