



Partners in Population and Development (PPD)

**5th Asia Pacific Conference on Reproductive and Sexual Health and Right,
Beijing, China, 18-20 October 2009**

Plenary Session 3

on

**Promoting and Enhancing Partnership in Sexual and Reproductive Health
and Right: Aid for Family Planning and Reproductive Health
in Financial Crisis, South-North-South Cooperation,
Roles and Involvement of Donors**

Keynote Presentation

by

**Mr. Harry S. Jooseery, Executive Director
Partners in Population and Development (PPD)**

INTRODUCTION

I would like in the first instance to briefly speak on the salient features that are impacting on Sexual and Reproductive Health and Rights in general before addressing the issue of partnership and networking especially in the context of financial crisis.

The ICPD was indeed a landmark that redefined Family Planning, Reproductive Health and Population policies all around the world. 15 years after ICPD there is much to celebrate. The conceptual framework of reproductive health, including family planning has been universally accepted and this has indeed refocused family planning and reproductive health policy in many countries around the world. The new dynamism and synergy created by the paradigm shift from family planning to sexual and reproductive health ushered a revolution in the ways social welfare was looked up. The spirit generated at ICPD was echoed at the Beijing Conference in 1995 and subsequently at UNGASS, Millennium Development Goals, Beijing +5, Maputo Plan of Action, the Glion Call to Action, New York Call to Commitment and the Beijing +10 to mention just a few.

Impressive gains have been achieved since ICPD:

- Over 50% of the couples worldwide are now using family planning
- Annual world population growth is now 73 million compared to 93 million in 1994
- Life Expectancy has increased from 61 to 63 years
- Childhood death has decreased by 10%

- More girls are in school and status of women has improved

On the other hand we need to note the sad reality that maternal mortality has shown no decline in absolute numbers and we are still talking of 500,000 women that die yearly due to avoidable complications related to pregnancy and childbirth, most particularly in the less developed countries. The scourge of HIV/AIDS has devoured millions of lives, seriously affecting the prospects of the economic and social development in the many countries in Asia and Africa. New challenges and crises related to food security, environmental degradation, violence against women, migration, refugees and aging require new thinking and determined action. Let us see briefly some of the major issues of concern:

1. The Population Growth

There is a resurgence of the population growth factor. You would realize that population has quadrupled in 100 years and the slowing of the general world population growth rate masks the rapid increase in population growth rate of the developing world making the poor more destitute than ever. Two sharply different patterns of population growth are evident. Little growth or even decline in most wealthy countries and continued rapid population growth in the world's poorest countries.

The population growth rate of the world is 1.17 while that of developing countries is 2.2 and industrial country is 0.7. Complacency over the past years on the issue of population especially in developing countries has created a wide section of poorest of the poor, the "bottom billion" population as they are called, with less than US\$1 per day. This is threatening health, stability and security. The upsurge of domestic violence, sexual abuse, violence on girls and women are indicative of social disruption that may lead to severe consequences.

Worldwide, women now average 2.6 children during their lifetimes, 3.2 in developing countries excluding China, and 4.7 in the least developed countries. Lifetime fertility is highest in sub-Saharan Africa at 5.4 children per woman. In the developed countries, women average 1.6 children. Some countries are undergoing explosive and possibly unsustainable population growth. For example, Pakistan was among the vanguard countries in Asia in strengthening Family Planning program more than 5 decades ago. Despite this history, fertility has declined more slowly in Pakistan than in most Asian countries. In 1950, Pakistan had a population of 37 million people and has now reached 164 million. In 1970, there were 5 million more people in Bangladesh than in Pakistan and by 2050 it will have 62 million more people than in Bangladesh. This shows the success of Bangladesh Family Planning program. 70% of married women in Pakistan do not use any FP method and this has remained so since the past 10 years. Family Planning for the past decade lost its centrality in the development

agenda as a result of shifts in international health and development priorities. This has created an estimated 13 million women in the developing world who want to avoid a pregnancy but do not have access to any Family Planning Method.

2. The Scourge of Maternal Mortality

The second factor, which is also related to the population pressure is the scourge of maternal mortality. Despite some improvement, maternal mortality continues to be very high in developing countries. Of the many health indicators that demonstrate comparison between developed and developing countries, maternal mortality shows the greatest disparity. Maternal mortality represents one of the widest health gaps between developed and developing nations, with 99 percent of all maternal deaths occurring in developing countries. Every year, eight million women suffer severe complications as a consequence of pregnancy, childbirth and unsafe abortion. Every minute, at least one woman dies from complications of pregnancy and childbirth. In developed countries, there are approximately 27 maternal deaths per 100,000 live births each year. In developing countries, the average is 18 times higher, at 480 deaths per 100,000. About half of the maternal deaths occur in Sub-Saharan Africa alone and one third takes place in South Asia. Country-level differences in maternal mortality are even more dramatic.

Globally, 40-60 million women seek termination of an unwanted pregnancy under unsafe conditions in a year. Worldwide, almost 20 million unsafe abortions occur each year, of which 95% take place in the developing world. One in eight pregnancy-related deaths, an estimated 13% are due to unsafe abortions in the world. Poor maternal health also affects the chances of survival of the newborn. Although progress in infant and child survival has been made, an estimated 9.4 million babies still die shortly before or after their birth.

Poverty is the root cause of the double tragedy of high maternal mortality rates and excessive fertility in developing countries. It exerts its influence through illiteracy, malnutrition and a low status of women. Maternal deaths could be avoided if the proper health resources and services were available to women in developing nations.

3. The Reproductive Health Factor

The number of women in Reproductive age was 2.1 billion in 2008 and almost half of them live in low income counties where average yearly GNI per capita income is less than \$ 975. Worldwide, an estimated 250 million years of productive life are lost every year as a result of reproductive health problems. Reproductive health conditions including HIV/AIDS - are the leading cause of death and illness in women worldwide (15-44 years of age), and the second

leading cause of death and illness when both men and women of reproductive age are taken into account.

It is encouraging that fertility rate in the world has fallen from 2.9 in 1994 to 2.58 in 2008. But Sub-Saharan Africa still has the highest fertility rates of any world region – 5.4 births per woman on average – double that of Asia (excluding China) and more than three times that of Europe. That is how the poor disproportionately bear the consequences of poor reproductive health, especially impoverished women and young people.

One of the factors underlying high maternal mortality rates is the low use of modern contraception. Only 18 percent of married women in sub-Saharan Africa use modern methods of family planning. An estimated 35 million women in sub-Saharan Africa have an unmet need for family planning. They want to delay or stop childbearing but are not using any contraceptive method.

These are in fact glaring disparities in access to reproductive health care between rich and poor, within and among countries. Women with unintended and unwanted pregnancies are more than twice as likely to be victims of involuntary sexual intercourse and physical abuse from a partner. Many batterers are also rapists who forbid the use of birth control, refuse to wear condoms and physically prevent their victims from seeing a doctor. Poor reproductive health reduces productivity and earnings, constrains investments in children and leads to untold private suffering. Poverty also aggravates poor reproductive health, contributing to risky behaviors, such as unsafe sex fueling the spread of HIV infection and other sexually transmitted infections. This situation can no longer persist. The most affected bottom billion population continues to face food, shelter and sanitation crises which constantly loom upon them. We cannot inadvertently jeopardize the future generation and allow 30 women to die every hour from preventable pregnancy related causes.

4. The Economic Factor

Economic progress has been achieved easier and faster in countries that have provided reproductive health services, including family planning. An analysis of 53 countries by UNFPA between 1953 and 1990 showed that 8% of the total economic growth can be attributed to higher adult survival rates. In general, poor people become ill more often and have less access to health services than more affluent people.

When a country invests in reproductive health programs, including family planning, it saves money and improves the general health of its people and productivity. For example, for every peso spent on family planning, the Mexican Social Security Administration saved 9 pesos on maternal-infant health care expenses. A study undertaken recently in Bangladesh reveals that the total loss caused to sufferers due to a shortage of oral pills, injections and condoms during

the one year study period is equivalent to 4,306 million hours in terms of time and USD 876 million in terms of monetary value. I would like here to congratulate Bangladesh and the FPAB of Bangladesh for the very good work.

According to the UN report "World Economic and Social Survey 2005," if rich countries keep their promises made during the Millennium Summit, Official Development Assistance (ODA) will increase to \$130 billion by 2010. But, it is unfortunate that for the past 10 years, investment in social welfare in most developing countries has staggered at a low level. Funding for Family Planning as a percentage of all population assistance has fallen from 55% in 1995 to 7% in 2005.

World Bank projects the real GDP growth to be slowed down across all developing countries in 2009. The Bank also estimates that a 1 percent decline in developing-country growth rates traps an additional 20 million people in poverty and that 100 million people have already been driven into poverty by high food and fuel prices. To achieve the needed resources to implement the MDGs fully and on time, serious financial commitments made at the Millennium Summit urgently need to be followed-up and implemented. Of particular importance is the need to make progress towards the ODA 0.7 percent of GNP by the northern countries and 100% debt cancellation. The Millennium Project Report estimates that US\$195 billion are required to be mobilized for development. 0.7% of GNP of donor countries near approximately US\$ 200 billion per year compared to the present ODA of about US\$ 70 billion per year. The UN Millennium Project's findings show that an additional US\$ 130 billion per year would be more than enough to scale up critical interventions to achieve MDGs in developing countries.

The situation has been exacerbated by the present economic downturn for which developing countries cannot bear the brunt of responsibility. The economic crisis in East and South-East Asia has transformed itself into a social crisis, particularly visible in such forms as rapidly rising unemployment, the mounting incidence of poverty and deterioration in health and educational services. There is evidence that many of the impoverished people have been compelled to cut their consumption of health services to dangerously low levels. For many in the impoverished groups, the education of children is no longer affordable, leading to drop-outs at all educational levels. The rising incidence of poverty is likely to compound health and educational problems by causing more widespread malnutrition, especially among children. The crisis has also had a considerable impact on the state of reproductive health in some of the countries, with budget cuts forcing many government hospitals to abandon preventive programs, including contraceptive services.

Parliamentarians need to debate on these issues more and more. Even though poverty and sexual and reproductive health are closely intertwined, many public policies treat them as separate issues. National laws and policies must address not only access to sexual and reproductive health services from a rights

perspective, but also take into consideration people's ability—especially poor women's—to pay for essential reproductive health services, including the prevention of unwanted pregnancies. It is time that Reproductive Health products are distributed free of charge to all and we urge that parliamentarians and policy makers take concrete actions for free RH products in all countries of the world.

5. The Environmental Factor

Global warming increased the average temperature of the Earth's near-surface air and oceans since the mid-20th century. Increasing greenhouse gas concentrations resulting from human activity such as fossil fuel burning and deforestation caused most of the observed temperature increase since the middle of the 20th century. The latest data on climate change indicate that the global surface temperature will probably rise a further 1.1 to 6.4 °C in the twenty-first century.

The growing health impacts of climate change affect different regions in markedly different ways. The places that have contributed the least to warming the Earth are the most vulnerable to the death and disease higher temperatures can bring. The World Bank stated last week that the developing world will suffer about 88% of the damage from climate change accounting for also one third of greenhouse gases in the atmosphere. The World Bank also stated that the costs of mitigating and adapting to climate change would add-up to around 300 billion dollars a year from 2030.

By 2030 climate change may expose 90m more people to malaria in Africa alone. Similarly, meningitis outbreaks in Africa are strongly correlated with drought. Both are likely to increase. Diarrhoea is forecast to rise 5% by 2020 in poor countries because of climate change. Dengue fever has been expanding its range. About 60% of the world's population will be exposed to the disease by 2070.

Poor countries are particularly prone to flooding. Climate change is overwhelming the social and other arrangements that in the past allowed countries and people to cope with floods. National budgets can ill afford the cost of improving defenses.

The biggest vulnerability is that the weather gravely affects developing countries' main economic activities such as farming and tourism. Since two-thirds of Africa is desert or arid, the continent is heavily exposed. By 2080 as much as a fifth of Africa's farmland will be severely stressed.

In India the gains from the Green Revolution are already shrinking because of local pollution, global warming and waning resistance to pests and disease. Yields of the main Indian crops would decline by a further 4.5-9% over the next 30 years because of climate change.

We are deeply aggrieved by the loss of about 4000 lives due to the last month's quake and tsunamis in Jakarta, Indonesia. I take this opportunity to send my sympathy to the Board Member and the people of Indonesia for their loss.

6. Socio-Cultural Factors

It is unfortunate that many developing countries are still patriarchal with strong gender discrimination and other forms of social exclusion adversely effecting Reproductive Health. The rise of religious bias and fundamentalism retards progress and unfortunately contributes enormously in making girls and women easy prey to male dominance. In Africa alone, 100 million women and girls have had genital mutilation. 27 out of the 46 states in Africa still practice Female Genital Cutting. Religious opposition to Modern Contraception, Abortion and Women Empowerment in some parts of the world is very strong. In many counties the right for RH is completely denied to women and girls, and discrimination against them exacerbates their sufferings. Social stigma against the victims of AIDS, people with diverse sexual orientation, divorce women are very strong in developing counties.

PARTNERSHIP BUILDING – THE WAY FORWARD

In light of the prevailing gloomy RH landscape of developing countries, we cannot continue to do business as usual. Globalization has made the world small and imbued with fierce competitions from all sides. The imperative of globalization dictates that if we need to survive, we need to be not only the fittest, but also the smartest. We acknowledge that we need not only to be practical, but pragmatic and proactive. Business with a difference entails that we adapt constantly to address core issues.

The present Sexual and Reproductive Health landscape is so multifarious that it cannot be addressed by any single entity. We need to partner with governments, Intergovernmental Organizations, NGOs, Civil society, private sector, donor organizations and stakeholders to be able to meet ICPD goals and MDGs. Government alone cannot address all the SRH needs of people and there are issues that are so controversial and sensitive in SRH that many governments deliberately shy away, like abortion, RH services to adolescents and the unmarried, sexual education to teenagers, and where NGOs have played vital role and helped to change policy decisions. The 8th MDG emphasizes the need to build partnership and build coalition to reduce poverty and enhance quality of life on planet earth. One of the most effective partnership initiatives is in forging ties among and between developing countries through South-South Cooperation.

SOUTH-SOUTH COOPERATION

We believe that Population and RH are intrinsically linked to health, well-being, and development. It is unfortunate that this linkage has for decades not been fully understood and that Family Planning and population program has lost its centrality in development agenda. Lack of investment in FP/RH has contributed to accentuate poverty and inhibit socio-economic development. While we welcome additional investment in HIV/AIDS which has indeed helped lowering the disease burden and its incidence in developing countries, we deplore that this has been at the expense of investment in FP and RH. We need to adopt an integrated approach that will meet the needs of all for FP, RH, MCH, HIV/AIDS/STDs in a synergistic manner.

As explained earlier, countries where the RH landscape is the worst are in the South. The economic crisis has hammered heavily on these counties, suppressing all gains and efforts made. Time is more than opportune to partner with all stakeholders especially to address the problems of the south by the south. Developing countries possess a wealth of knowledge and expertise that can marvel and sprinkle extraordinary energy that can reshape their destiny. Over the years, the developing world has acquired impressive knowledge, developed immense capacity and expertise, new technologies in Reproductive Health, and if these are effectively shared among each other, many of our population related issues would be solved. South-South Cooperation has been highlighted at ICPD as a mechanism that “promote cost effectiveness and sustainability.”

Bangladesh, Brazil, China, India, Tunisia, Thailand, Indonesia, Uganda, Kenya, Ghana, and South Africa have made impressive achievements in the area of Family Planning, Women Empowerment, Adolescent Sexual Health, Community participation, HIV/AIDS and Capacity Building and this need to be shared with all. The involvement of NGOs in Bangladesh in FP and Women Empowerment through Micro Credit is a reference to the whole world and needs to be replicated by all in the South. Tunisia excels in capacity building and has an impressive pathway in promoting women’s rights. South Africa Adolescent SRH program and training initiative, Thailand and Uganda’s success in addressing HIV/AIDS are a few examples. Despite the economic downturn, the BIC countries (Brazil, India and China) have showed themselves as important shock-absorbers and their economic growth rate has shown positive increase. They have given a signal to the West: the latter can no more rule the world alone. The West should also embrace the Rest, especially the BIC countries which are now emerging as the new economic powerhouses.

TRIANGULAR COOPERATION

However, South-South Cooperation does not imply no cooperation with the North. While we glorify the technical expertise and knowhow in the South, we need also to acknowledge that the North has resources that the South needs, to enable it move forward. The amount of development and resources available in the North is far beyond the reach of present day Southern countries. SSC is an initiative to valorize the potentials of the South without devalorizing the contributions that the North can make in South. South South Cooperation should be perceived as complementary to North South Cooperation and as such it is important that the triangular South-North-South cooperation be promoted. It is true that the North has not provided pledged ODA to the south and as a consequence FP and RH program has tremendously suffered in the South. Jeffery Sachs contends that many countries of the South desperately need assistance from the North essentially because they are so destitute that they immediately eat up all that they get. He said: "The rich countries do not have to invest enough in the poorest countries to make them rich; they need to invest enough so that these countries can get their foot on the ladder of development. After that, the tremendous organization of self-sustaining economic growth can take hold".

We welcome Japan, Spain and UK increased ODA to meet FP and RH needs in developing countries. We do welcome also President Obama's public commitment of \$63 billion for global health, some of which will go to strengthen public health systems, whose inadequacy is the key reason that the MDGs 5 is so far off track. It is also welcoming to witness a new South South ODA emerging with Brazil, India and China investing more in their international Cooperation.

CONCLUSION

Health system development is a recent challenge of healthcare in the region. The poor and other vulnerable groups in the Region continue to have poor access to quality health services. Those who need health services the most—groups with high burdens of morbidity and mortality—tend to use them the least because they face high barriers to access. Many kinds of disparities exist in terms of health risks, health-seeking behavior, access to services, responsiveness of the system and of providers, and health outcomes.

Health systems have become increasingly fragmented, which is generally an obstacle to effective delivery of health services and efficient achievement of health goals. Actions to strengthen health systems need to build system capacity and not just divert capacity from one part of the system to another to meet short-term goals.

As we are now passing very critical time with tough challenges, it seems that a nation alone cannot improve the health of their citizens by taking actions that lead to responsive, well resourced, efficient and well-regulated health systems. A recently disseminated document identified six health system building blocks, while addressing key cross-cutting concerns of equity, quality, gender and human rights. The six building blocks are:

- Health service delivery that promote safe and quality care.
- Health workforce that are qualified and competent.
- Health information systems that provide reliable information for effective follow-up.
- Medical products and technology that offers high quality services.
- Health financing that ensures access to needed services.
- Leadership and governance that provide effective strategic and policy frameworks.

These six building blocks remind us again that we could not succeed unless we act in partnership and in coalition. We need to marshal our respective competences and capacities to meet the global challenge. We believe that Governments from the South have the potentials to raise the standard of living of their citizens, the capacity to enhance social welfare and the capability to promote development in the countries.

I reiterate the hope that RH/FP regains the attention it deserves. Investment in promotion of the health system particularly in RH/FP remains a cornerstone for development, and indeed South-South Cooperation an effective strategy to attain ICPD and MDGs in developing countries, in complement with North South Cooperation. We welcome the Economic recovery at the doorstep. We cannot and should not talk of a health recovery. Health is not to be lost and regained. The right to health is a fundamental human right and is the concern of all from all sectors and quarters. Let us synergize our efforts and build meaningful coalition and partnership to alleviate the sufferings of our brothers and sisters especially those most vulnerable in developing counties.

Thank you.