Thanks very much for sending the draft strategy paper. I read it with interest and congratulate you on the content. I think it's a very strong statement and very reassuring to all of us in the SRHR community. We especially appreciate the mention of IPPF and our inclusion in the Danish Government's strategic plan. I attach a copy with some editorial suggestions - mostly in the first part of the paper. In addition, I did want to say that we hope you might include a few more references to IPPF in your discussion of the Thematic Actions, particularly the sections on young people and on linking SRHR and HIV/AIDS activities. Considering that these subjects, along with access (including RH commodity security), lie at the heart of the "5 A's" and that IPPF has been playing a leading advocacy and services role, I thought a mention of how well IPPF's priorities and strategies line up with Denmark's might be possible. Also, you mention in several places Denmark's expectations regarding UNFPA leadership. I believe IPPF plays a comparable role on the NGO side and that we are willing and able to take on hard issues (e.g., youth services and abortion) that UNFPA won't touch. Indeed, the best reason to support us is that we can do what UNFPA, working mostly with and through governments, can not. That creates great synergy between UNFPA and IPPF and makes a strong case for continuing to work closely with us both.

Again, congratulations on a very nice job. I hope the present version survives the review process more or less intact and that it isn't watered down.

Warm regards,
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The Promotion of Sexual and Reproductive Health and Rights

Strategy for Denmark's Support

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Foreword

People's sexual and reproductive health and rights are fundamental for promoting development, fighting poverty and, thus for achieving the Millennium Development Goals (MDGs).

At the September 2005 World Summit, heads of government committed themselves to achieving the goal of universal access to reproductive health by 2015. They committed themselves to integrating this goal into strategies to attain the MDGs, including those aimed at improving maternal health, promoting gender equality, reducing maternal and child mortality, combating HIV/AIDS and eradicating poverty.

This commitment is not new. In 1994, 179 governments agreed to achieve the goal of universal access to reproductive health by 2015 at the International Conference on Population and Development (ICPD) in Cairo. But ~~it~~ the reaffirmation at the World Summit was~~is~~ crucial. It has rightly mainstreamed~~s~~ the ICPD-goal into the global consensus on how to reach the MDGs – a linkage widely neglected when the MDGs were introduced in 2000.

The commitment also paves the way for including the key ICPD goal of universal access to reproductive health information and services (contraception) in the MDG targets and indicators, and emphasizes the need to further strengthen implementation efforts if the goal of sexual and reproductive health and rights for all is to be reached by 2015.

Population issues and sexual and reproductive health and rights will remain high on Denmark's Development agenda. We will draw on the 2005 World Summit momentum to advance the implementation of the ICPD Programme of Action and the principles and the rights it stands for. Only by empowering people to claim these rights will they emerge out of poverty.

1. Summary

Denmark is firmly committed to promoting sexual and reproductive health and rights for all.

Sexual and reproductive health is a human right, which is essential to good health and human development. For Denmark, the rights issue is key. People should be able to take their own decisions about their sexual and reproductive lives and have the means to do so. This includes access to reproductive health services and information and to safe and to legal abortion. Enabling people to have fewer children, if they want to, helps to stimulate development and reduce poverty, both at the individual and the macro-economic level.

Danish policy, support and cooperation within the field of population is based on the twenty-year Programme of Action (PoA) adopted by the International Conference on Population and Development (ICPD) in Cairo, 1994 and the additional goals and indicators adopted at the Special Session of the United Nations General Assembly in 1999 (ICPD+5).

The full implementation of the ICPD PoA and ICPD+5 is central to the achievement of the Millennium Development Goals (MDGs), and thus to poverty reduction, which is the overall objective of Danish development assistance.

Box 1: The Eight Millennium Development Goals

Goal 1: Eradicate extreme poverty and hunger
Goal 2: Achieve universal primary education
Goal 3: Promote gender equality and empower women
Goal 4: Reduce child mortality
Goal 5: Improve maternal health
Goal 6: Combat HIV/AIDS, malaria and other diseases
Goal 7: Ensure environmental sustainability
Goal 8: Develop a global partnership for development
The MDGs have a total of 18 targets and 48 indicators.

The overall goal of this strategy is to contribute to the ICPD goal of universal access to sexual and reproductive health and rights, including for youth. With the MDGs as the common framework for poverty reduction and the driving force for international development cooperation, the focus will be on contributing directly towards achieving MDG3, MDG5 and MDG6, as well as contributing indirectly to the achievement of MDGs 1, 2, 4 and 7.

Denmark will continue to cooperate with and support international organisations, governments and partners to promote and defend everyone's right to sexual and reproductive health and to ensure that all governments and other partners remain committed to realizing the internationally agreed goals and targets on sexual and reproductive health and rights.

This strategy recommends actions for Danish support and cooperation at the International level and at country level, as well as strategic actions for Danish efforts within the following four thematic areas: Promoting gender equality and empowering women; Improving sexual and

reproductive health; Young peoples' access to information and services; and Linking the response to HIV/AIDS and SRHR.

2. The ICPD Programme of Action

The 1994 International Conference on Population and Development in Cairo moved population policies and programmes away from a focus on human numbers to a focus on human lives. It placed emphasis on improving the lives of individuals and increasing respect for their human rights. The twenty-year Programme of Action underlined the integral and mutually reinforcing linkages between population and development.

ICPD established a new agenda with three main themes: human rights, women's empowerment and sexual and reproductive health and rights. The strength of the new agenda was in its emphasis on the empowerment of women and the improvement of their political, social, economic, and health status as a highly important end in itself as well as essential for the achievement of sustainable development. It established that women's rights are human rights.

The ICPD objectives and goals are sustained economic growth in the context of sustainable development; education, especially for girls; gender equity and equality; the reduction of infant, child and maternal mortality; and the provision of universal access to reproductive health services, including family planning and sexual health.

Box 2: Reproductive Health

Reproductive health is 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. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. *(ICPD Programme of Action Para. 7.2)*

A special session of the United Nations General Assembly (ICPD+5) was held in June 1999 to discuss progress and challenges in the first five years of implementing the Cairo Agreement. The ICPD+5 document gave high priority to reproductive and sexual health in the broader context of health sector reform. It stressed the need for involving men, making sexually transmitted diseases, including HIV/AIDS, an integral component of SRH programmes at the primary health care level, and addressing the needs and rights of adolescents. New benchmark indicators were introduced for education and literacy, reproductive health care and unmet need for contraception, maternal mortality reduction and HIV/AIDS.

In 2004, halfway through the ICPD Programme of Action, several international meetings were held ~~on~~ to review progress and challenges. Progress in meeting the ICPD goals had been considerable in some countries while there had been little or no change in others, especially in Africa. There were improvements in areas such as child mortality and girls' access to education, but other areas such as maternal mortality and adolescents' sexuality had not received the attention they deserved other than on paper. However, the general picture masked huge intra-

country differences between regions, districts and population groups, with the poor and vulnerable being most disadvantaged with respect to their health status and rights.

Abortion was one of the most controversial issues at Cairo and threatened to block the consensus, but a compromise was reached by making it a matter for national decision-making. Unmarried young couples or individuals' access to reproductive health services including contraception and sexuality education and information were also controversial issues together with acceptance of modern family patterns and the resistance to public interference (vs. parental rights) in SRH matters and practice.

Growing international pressure has weakened political and financial support for sexual and reproductive health and rights. Some countries are reluctant to reconfirm the commitments they made in Cairo in 1994. This has made it difficult to move the political agenda on sexual and reproductive health and rights forward and to accelerate progress towards the full implementation of the ICPD PoA. Especially within the field of HIV/AIDS prevention, where condom use is a key issue, the focus on abstinence and the opposition to young unmarried peoples' access to condoms has lead to a backlash which threatens some of the hard-won gains of the ICPD and the Beijing Platform of Action.

3. Promoting Social Development

A Rights-Based Approach

Danish efforts within the field of sexual and reproductive health is based on a rights-based approach, which views citizens not as passive receivers of services or beneficiaries of programmes but as active rights-holders. States have obligations to respect these rights and protect their citizens against violations. Fulfilling the right to sexual and reproductive health will require the building of responsive, equitable health education and legal systems, as well as addressing underlying determinants of SRH. It implies that states, policymakers and others are accountable to their people. It is recognised that fulfilling these rights will require time, money, commitment and action.[1]

Box 3: Sexual and Reproductive Rights

Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other relevant United Nations documents. These rights rest on 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 Programme of Action. Para. 7.3)*

The Rights-based approach was reaffirmed and extended by the Fourth Conference on Women in Beijing in 1995: "human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality …". This paragraph is regarded as setting forth a definition of sexual rights.
(Beijing Declaration and Platform for Action. Para 96)

International Legal Framework:

1. Universal Declaration of Human Rights 1948
2. The International Covenant on Economic, Social and Cultural Rights 1976
3. The Convention on the Elimination of all Forms of Discrimination Against Women 1979
4. The Convention of the Rights of the Child 1989
5. UN Commission on Human Rights 2004

Sexual and Reproductive Health and Rights

Promoting sexual and reproductive health and rights has high priority in Danish development assistance. It is an integral part of Danish multilateral and bilateral policy dialogue and support. Denmark considers it an important – and necessary - task to actively promote, defend and protect these rights.

It is crucial for Denmark that the international commitments made and goals and targets set in the twenty-year Programme of Action (PoA) and at the Special Session of the United Nations General Assembly in 1999 (ICPD+5) as well as in the Beijing Platform for Action (1995) are under no circumstances evaded, renounced or in any other way weakened. Danish policy, support and cooperation within the field of population are based on these documents. There has been many attempts to undermine international commitments since 1994, and it is foreseen, that also in coming years, there will be a continuous need to ensure that the Cairo-agenda, and the principles and rights it stand for, is actively confirmed and promoted as central and necessary element in fighting poverty and achieving the MDGs.

Denmark deliberately uses the term "sexual" together with reproductive to underline that sexuality and the purpose of sexual activity/relations is not limited to reproduction. This approach is rooted in the belief that sexual health care and human sexuality are also contributing to the quality of life and well-being – both mentally and physically and are enhancing personal relations.

Denmark is convinced that women should have access to safe and legal abortion and post abortion care. Without access to safe and legal abortions, women are not fully able to decide freely on matters related to their sexual and reproductive health and, thus, not able to fully enjoy their human rights. Abortion should not be promoted as a method of family planning. Denmark believes that the best way to avoid abortions is through improved access to reproductive health services and information and the empowerment of women.

In accordance with the ICPD-agenda, sexual and reproductive health and rights are promoted through an integrated approach. Sexual and reproductive health is affected by the socio-economic, cultural and political environment, and related to individual and collective rights and responsibilities. Sexual and reproductive health and rights are closely interlinked with promoting gender equality and fighting HIV/AIDS. Increased understanding and acceptance of this will serve to improve synergies and impact both in international development cooperation and at country level.

Danish efforts will involve broader development interventions through a number of sectors that impact women and adolescent girls' health – not least education of girls.[2] The health sector, however, is the prime provider of the essential sexual and reproductive health services. It is essential that the sector has the capacity to meet the peoples' needs qualitatively and quantitatively, especially with respect to gender and protection against coercion and discrimination. Health staff has a proactive role in informing users about their rights and options in relation to reproductive health, fertility regulation, sexual abuse and violence, all of which are human rights issues.

HIV/AIDS [3]

Combating HIV/AIDS is a strategic priority for Danish development assistance, with special focus on Sub-Saharan Africa. The HIV/AIDS strategy of April 2005 aims to strengthen and focus Denmark's contribution towards reaching the internationally agreed HIV and AIDS targets through its multilateral and bilateral development cooperation. Denmark supports the development of comprehensive global and national strategies that address HIV/AIDS in a balanced way, inte-grating prevention, care and treatment interventions. Priority areas of intervention include addressing the specific needs of women and girls, adolescents and young people, children and orphans and people in conflict situations. Integrating sexual and reproductive health and HIV/AIDS efforts, and fighting stigma and discrimination are other priorities.

Gender Equality [4]

Gender equality is a key crosscutting issue in Danish development assistance. The strategy on gender equality in Danish development assistance (2004) highlights three overall entry points to working with gender equality: promotion of equal rights, women's access to resources and

equal influence. Empowerment is a key condition for enabling women to demand and make use of equal rights, resources and influence and thus for gender equality.

Box 4: Women's Empowerment

Empowerment is a key condition for enabling women to demand and make use of equal rights, resources and influence and thus for gender equality. The concept implies that each individual acquires the ability to think and to act freely, to take decisions and to fulfil his or her own potential as a full and equal member of society.

International efforts in the field of gender equality focus in particular on violence against women during peacetime and situations of armed conflicts, sexual and reproductive rights in relation to health, HIV and AIDS, and access to resources. The strategy emphasises mainstreaming of gender equality in sector support and in national Poverty Reduction Strategies, and in the support for human rights, democratisation and good governance.

Promoting gender equality demands changes to existing power structures, the status and role of women and men. Men's responsibility for supporting women's SRHR is vast – as a decision maker, father, husband, lover, brother and son. Men's participation in changing women's SRHR is far more important than previous policies have reflected. Violence against women, family planning, prevention of STI and respecting women's rights are all related to how men and women interact. Women's SRHR is highly related to the prevailing perceptions of women's roles and rights in society and in the family, the more gender inequalities the poorer the SRHR of women.

Education [5]

It is well documented that girls' education is a key instrument for empowering girls and women and for improving their SRHR, including the prevention of HIV/AIDS. Being in schools, even in schools of poor quality, is protective from a reproductive health standpoint – delaying sexual initiation, increasing chances of condom use, and decreasing forced sex.

At the same time, education is an opportunity to teach adolescents girls and boys life skills including population, reproductive psychology and physiology issues. Denmark promotes life skills education as part of the standard national teaching curricula for pupils and teachers. Danish efforts to promote girls education are based on Education for All - The Dakar Framework for Action and the United Nations Girls Initiative.

Children and Young People [6]

To further develop its assistance to children and young people, Danida has developed guidelines to secure inclusion of children and young people the various sector programmes when appropriate. They list the main priorities, structured according to the Millennium Development Goals - six of the MDGs refer specifically to children, as they point to safeguarding the rights of children to health, education, protection and equality - and provide a course of action for follow-up and review. The guidelines also include a chapter about Children and young people in crisis, conflict and injustice. These situations make children and young people more vulnerable towards sexual violations and unsafe sex. UNICEF, UNFPA and Danish NGO's are central partners for Denmark.

In accordance with the guidelines, the terms youth and young people will be used for persons aged 10-24.

4. Strategic actions at International and National Level

Danish International Cooperation – strategic actions

SRHR and the full implementation of the ICPD PoA will be promoted in international fora, agreements and resolutions. Denmark will seek to influence international organisations at all levels and will fund work carried out by international organisations.

The UN Economic and Social Council, the Commission on Human Rights, the UN Commission on Population and Development, and the Commission on the Status of Women set political norms with respect to human rights and gender equality. WHO and UNESCO are standard setting organisations for health and education respectively, with a specific mandate to promote and monitor global norms and standards, and they also provide technical assistance to support this normative function. Influencing these political and technical norm-setting organisations and fora to further promote SRHR and the implementation of the ICPD PoA is central to this strategy.

The EU plays a vital role in promoting SRHR at the political level. Since Cairo, the EU has demonstrated strong political commitment to realising people's SRHR. This commitment has been supported by substantial financial contributions. The EU has been influencing the population agenda internationally and plays an important role in stemming ICPD-opposition. Not least at the 2005 UN World Summit, the EU played an active role in ensuring that the ICPD-goal of sexual and reproductive health and rights was integrated into the global consensus on how to reach the MDGs. The Joint Statement on the European Consensus on Development, adopted in November 2005, fully reflects EU's strong commitment to SRHR and the Cairo-Agenda, both as part of the common EU vision of Development and as part of the EC Development policy. EU's political leadership will continue to be crucial for the promotion of SRHR.

The major international organisations whose work contribute to promoting the Cairo Agenda and the implementation of the ICPD PoA are UNFPA, WHO, UNICEF, UNAIDS, UNIFEM, UNESCO, EU and WB. Important international non-governmental organisations include International Planned Parenthood Federation, Family Care International, Population Council, HIV/AIDS Alliance, Ipas and International Women's Health Coalition. Also a number of Danish non-governmental organisations are active partners. Annex 3 lists central partners for Danish support and cooperation within the field of SRHR.

Being responsible for monitoring the implementation of the ICPD PoA and being the world's largest international source of funding for population and reproductive health programmes, UNFPA is a strategic partner for Denmark in the implementation of this strategy – at international and country level. UNFPA is an influential advocate for gender equality, women's empowerment and reproductive rights together with prevention of HIV/AIDS among girls and women and prevention of the mother to child HIV-transmission. In addition, an important area is UNFPA's continued efforts to build national capacity to manage reproductive health commodity security, with a long-term focus on building national capacity to take over this task.

Denmark will continue to support and further strengthen UNPFA in carrying out its global leadership role in promoting and defending everyone's right to sexual and reproductive health and assisting governments and other partners in realizing the international agreed goals and targets on sexual and reproductive health and rights - as an end in it self and as precondition for promoting development and fighting poverty, and thus for achieving the MDGs.

To this end, it is important that UNFPA strengthens national ~~authorities~~authorities' capacity to incorporate reproductive health and gender issues in the development of national PRS, health and education sector programmes, as well as contributes to UN harmonization with government SRHR strategies and work programmes.

To carry~~ing~~ out its global leadership role and to further advance implementation of the ICPD goal, it is essential that UNFPA cooperates closely with and is supported by all relevant partners. Denmark will support national leadership and ownership and promote cooperation among all partners and initiatives by being an active partner in coordination fora and sharing all relevant information with national and external partners. Furthermore, Denmark will encourage ~~to~~ the efficient and effective participation of multilateral donors in SWAps, harmonisation and in simplifying of rules, regulations and procedures of multilateral organisations as well as optimising the effect of donor assistance in accordance with the donor harmonisation recommendations agreed upon in Paris in 2005.

Denmark will work with its development partners (national governments, multilateral and bilateral organisations, NGOs and other civil society organisations) to

1. Promote Sexual and reproductive health and rights and the full implementation of the ICPD PoA in international fora, agreements and resolutions;
2. Continue to work strategically to draw more donors and partners into development coalitions around SRHR, in order to ensure greater political and financial commitment and reduce opposition;
3. Continue to support the EU's leadership role in promoting SRHR issues;
4. Continue to influence political and technical norm-setting organisations to further promote gender equality and SRHR;
5. Strengthen dialogue on sexual and reproductive health and rights in the Executive Boards of UN organisations and with and among the organisations;
6. Strengthen UN organisations at country level to further the fulfillment of their mandates vis-a-vis SRHR and the ICPD-agenda;
7. Continue to support international and regional NGOs working with SRHR, HV/AIDS and gender equality.
8. Emphasise the need to include SRHR in humanitarian responses to crisis situations.

Country Level – strategic actions

Ensuring universal access to SRH information and services will require strengthening of health, education and legal systems and the recognition by governments of their duties in this regard, including through increased allocation of funds for these sectors.[7] Donors also have a responsibility for supporting governments to do so. Increasing the power of citizens, especially the poor and marginalised, to make claims for education and health care is essential, as is an open dialogue on controversial issues such as youth sexuality, abortion, and women's empowerment in order to bring about real change.

Health and education systems in the developing world are pluralistic, with a variety of service providers in the government and non-government sectors. In most developing countries the government sector is by and large characterised by insufficient resources - financial, physical and human - and weak planning and management structures both at district and central levels, contributing to poor performance. Inequity and gender inequality are major problems, with limited access to education and health care services in remote areas, and user fees acting as a barrier especially for the poor and for women who do not have access to money. It is government's responsibility to regulate the private sector, but this receives low priority. The quality of services varies greatly both in the private and public sectors.

Changes in staff attitudes can be necessary to ensure that the staff's own moral codes do not result in disrespectful/discriminatory treatment (for example, towards orphans, people living with HIV/ AIDS, street children, marginalised groups), sexual exploitation of young people and especially girls, or denial of information and services (such as sex education in schools, contraceptives to adolescents and unmarried persons, abortion and post-abortion care).

The increasing "brain drain" of qualified health and education personnel to industrialised countries poses a severe threat to developing countries. In Africa, this problem is worsened by the AIDS epidemic as well as the low wage levels, frustrating working conditions and lack of carrier development opportunities in the public sector. The "brain drain" is also related to changes in industrialised countries, where fewer people find it attractive to work in the public sector. Addressing this problem will require actions both in developing as well as industrialised countries.

Denmark recognised early the need to strengthen public systems, including at the district level, and has supported health and education sector reforms and public sector reforms as part of its development assistance. Experience has shown the need for increased emphasis on collaboration with multiple partners within and outside the specific sector. Denmark continues to emphasize the need for equity, not just in terms of access but also in terms of improved health and education status for the poor. In this context, it sees information technology as a powerful and as yet untapped resource for human development.

Denmark will work with its development partners (national governments, multilateral and bilateral organisations, NGOs and other civil society organisations) to:

1. Support actions to ensure that Poverty Reduction Strategies include the MDGs, emphasise SRHR, HIV/AIDS and gender issues, and that national budgets reflect theses priorities;
2. Within the Sector Wide Approaches continue to promote and support the development and implementation of national and local priorities in provision of services (including for SRH and HIV/AIDS);
3. Promote stronger coordination and cooperation between national governments, UN organisations and EU at country level; (UNFPA, WHO, UNICEF, UNAIDS, UNIFEM and UNESCO, World Bank)
4. Support government to plan and secure the availability of family planning commodities and services (UNFPA);
5. Strengthen the capacity and efforts of country statistical agencies to regularly conduct demographic and health surveys, collect and analyse sex-disaggregated data (including data on violence against women, maternal deaths and their underlying factors[8]) (UNFPA, UNDP);
6. Actively support civil society advocacy efforts on all aspects of sexual and reproductive health and rights of women and youth, in order to promote public and political commitment.

5. Thematic actions

Promoting Gender Equality and Empowering Women – MDG 3

MGD3 (gender equality and women's empowerment) focus on equal access to education, the share of women in wage employment outside agriculture, and seats held by women in national parliaments. In addition to these, Danish assistance will also reflect the broader concerns of ICPD with the full involvement of women in policy- and decision-making processes, eliminating all forms of violence against women and ensuring women control over their fertility. It will advocate for the implementation of the Security Council Resolution 1325 on Women, Peace and Security (October 2000), which urges increased participation of women at all decision-making levels in national, regional and international institutions and mechanisms for conflict prevention, reconciliation and reconstruction and the incorporation of a gender perspective into peace-keeping operations.[9]

Discrimination against Women and girls

Women's rights are human rights, yet women often have less access to food, land, education, employment, resources and influence than men. Though 177 states have ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), there continues to be a gap between rights and reality in most countries, reinforced by gaps in laws and/or by cultural traditions and social, economic and political structures.

Box 5: Human Sexuality and Gender Relations

Human sexuality and gender relations are closely interrelated and together affect the ability of men and women to achieve and maintain sexual health and manage their reproductive lives. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the physical integrity of the human body, require mutual respect and willingness to accept responsibility for the consequences of sexual behaviour. Responsible sexual behaviour, sensitivity and equity in gender relations, particularly when instilled during the formative years, enhance and promote respectful and harmonious partnerships between men and women. *(ICPD Programme of Action Para. 7.34)*

Numerous laws, policies and regulations affect sexual and reproductive health, including laws on the minimum legal age of marriage[10], access to contraceptives and abortion, women's consent to marriage and equal rights to divorce. Women in many countries do not have the right to own and inherit land or to take loans and credit. In many countries women cannot seek health care for themselves or their children without the permission of their family (husbands, mothers-in-law, older and senior relatives), either for economic or cultural reasons.

Violence against Women

Violence against women takes many forms and includes physical, sexual and emotional abuse by intimate partners, sexual exploitation or rape by close acquaintances (teachers, relatives and people in authority) or strangers, female genital mutilation/cutting, trafficking of women and children, forced prostitution, and sexual assault and rape in situations of armed conflict, civil unrest and disaster. Studies show that between 4% and 20% of women experience violence during pregnancy, with consequences for themselves and their babies such as miscarriage, premature labour and low birth weight.[11] Such violence is seldom officially reported, although one-third of all women in the world experience violence.[12] Violence is found in all layers of society, though aggravated by poverty. Violence generates fear, causes physical and

psychological damage and its specific consequences for sexual and reproductive health include unwanted pregnancy, unsafe abortion, chronic pain syndromes, sexually transmitted infections including HIV, and gynecological disorders. Gender violence arises from historically unequal gender relations. Changes in women's roles can be threatening to men and it is therefore necessary to involve men in changing social perceptions of men's and women's roles.

Promoting gender equality requires actions in the health as well as in other sectors. The latter are addressed in this section, while actions in the health sector are presented in section 5.2. Similarly, issues related to the health of young people are presented in section 5.3.

Important partners for promoting gender equality and women's empowerment are national governments including ministries of finance, law, education, health and local government, and civil society organisations. International partners are the Commission on Human Rights (CHR), Commission on Population and Development (CPD), Commission on the Status of Women (CSW), ECOSOC, EU, UNESCO, UNFPA, UNIFEM, UNHCR, World Bank, like-minded donors, international and Danish NGOs, and NATO and OSCE for peace-keeping and security operations.

Denmark will work with its partners to:

1. Strengthen women's legal rights to SRH through improved legislation, increased knowledge of legislation both among civil servants and the general public, and improved monitoring of adherence to legislation;
2. Influence international organisations with a mandate for promoting conflict- and crisis management to systematically incorporate the recommendations of Resolution 1325 in civil and military missions, and support the implementation of the action plan (S/2005/636) across the UN system;
3. Strengthen public and political commitment to women's SRHR by advocating for holding decision-makers at all levels accountable for improving women's status
4. Support NGOs in advocating for changed attitudes among people from all parts of society, including the older generation, policy-makers and teachers, with respect to gender roles, SRHR, HIV/AIDS, abortion, early marriage, violence against women, rape and sexual abuse
5. Promote the involvement of organisations working with women's empowerment, gender issues and SRHR in the analysis, development, implementation and monitoring of the national Poverty Reduction Strategy.

Improving Sexual and Reproductive Health – MDG 5

The fifth MDG is to improve maternal health. In 2005 this was the most off track MDG. The target is to reduce the maternal mortality ratio by three-quarters between 1990 and 2015. The indicators focus on maternal mortality rates and the proportion of births attended by skilled birth personnel, Danish assistance will take a more comprehensive approach and will, thus, also address abortion, access to contraception and emergency obstetric care, and young people's rights to information and services, all of which are part of the ICPD PoA.

Maternal Mortality

Pregnancy and childbirth continue to threaten the lives of a majority of the world's women. Of all the human development indicators, those related to maternal health show the greatest discrepancy between developed and developing countries. Approximately 15% of all pregnant

women and girls suffer from a life-threatening complication which cannot be predicted or prevented through ante-natal care. Nationally representative surveys in Malawi and Zimbabwe suggest that the risk of pregnancy related death is eight to nine times higher in HIV-positive women.

To reduce maternal mortality, it is necessary to prevent unwanted pregnancy (through effective family planning services), manage unwanted pregnancy safely (through abortion, where legal, and universal post-abortion services) and prevent deaths from complications of pregnancy or delivery. Improving women's access to health facilities, improving community recognition of obstetric emergencies, and improving the ability of existing medical institutions to deliver quality obstetric care, are all necessary. However, services will continue to be under-utilised if they are perceived negatively by pregnant women and their families, as the poor are often subjected to rude and discourteous behaviour by staff.

Preventing pregnancy-related deaths requires a skilled attendant at delivery backed up by access to 24-hour 7-day-a-week emergency obstetric care services, and a functional referral system with access to transportation. Evidence from the field has shown that the training of traditional birth attendants (TBAs) did not have a significant impact on the maternal mortality rate. It was also found that antenatal care could not predict obstetric complications occurring in women without high-risk characteristics. The concept of a 'skilled attendant'[13] was therefore introduced in 1999 One of the indicators for MDG 5 is the number of births attended by skilled health personnel.

In most countries where maternal mortality is high, there are too staff with midwifery training and only medical doctors are authorised to carry out surgeries. The MDG 5 Task Force recommends changes in "scope of profession" regulations and practice to empower mid-level providers, including skilled birth attendants, to perform life-saving procedures safely and effectively. Poor health of the woman and inadequate care during pregnancy, childbirth and the postpartum period negatively affects the health and survival of her newborn.

Abortion

It is estimated that 15% of all recognised pregnancies end in a spontaneous abortion/miscarriage, often incomplete and requiring post-abortion care. In many developing countries, abortion is a serious and neglected public health problem. About 45 million women seek abortion each year, 19 million of them in unsafe circumstances, and 40% of these unsafe abortions are performed on young women aged 15 –24 years.[14] An average of 13% of maternal deaths are related to unsafe abortions, though for some areas this figure is as high as 25 – 30%. Unsafe abortion is also associated with ill-health, such as infection and infertility.

While the unmet need for effective contraception contributes to this problem, it is important to recognise that unintended pregnancies also occur due to human error or contraceptive failure. Deaths and ill-health due to abortion could be almost totally prevented through the provision of appropriate services. Even in countries where abortion is legal, there is limited awareness of

this, and access to abortion and post-abortion care is limited. In countries where abortion is illegal, well-off women in cities are more likely to be able to access safe abortion, while poor rural women are forced to resort to unsafe procedures. Evidence from many countries shows that legalising abortion does not result in increased abortion rates.

Contraceptives

Contraceptive services are the primary health intervention for preventing unwanted pregnancies and in the last fifty years there has been a steady rise in the demand for contraceptives both for preventing pregnancy and the spread of HIV/AIDS. They have helped reduce the global fertility rate from 5.0 per women in 1960 to 2.7 in 2001. Since then, however, the ICPD-opposition has severely affected the availability of contraceptives in many developing countries. The Danish government is supporting the promotion of female condoms in its programmes in Africa, both for HIV/AIDS and family planning and has also increased its support to UNFPA's global programme to enhance reproductive health commodity security.

Sexual and Reproductive Ill-health

There is need for a life-cycle approach to address women's changing needs at different stages of their lives. Women of all ages suffer from sexual and reproductive ill-health, though the focus of health programmes has mainly been limited to certain aspects of women's reproductive function. When it was demonstrated that HIV spread much faster in countries where STIs are common, syndromic treatment of sexually transmitted infections was introduced to men and women but had limited success especially in managing vaginal discharge syndromes in women. There has been little focus on other reproductive tract infections, though they are also important for HIV prevention.

Box 6: The Size of the Problem

Maternal mortality and morbidity

About 530,000 women die of pregnancy-related causes each year,[15] 99% of them in the developing countries. For every woman who dies, 30 others suffer from acute complications, in total 15 million women per year. The lifetime risk of dying in childbirth is 1 in 20 in Africa, compared to 1 in 2,800 in he developed regions.

Sexual and reproductive ill-health

Sexual and reproductive health problems account for 18% of the total global burden of disease and 32% of the burden among women in the reproductive age-group (15 – 44 years) worldwide, of which sexually transmitted infections including HIV, account for 16%. Pregnancy and childbirth-related morbidity and mortality for 12%.[16] In sub-Saharan Africa, sexual and reproductive ill-health, including HIV/AIDS account for over 60% of the total burden.

Abortion

There are 45 million abortions a year, 19 million of them under unsafe conditions and nearly 70,000 deaths (13% of maternal deaths) are related to abortions. In Africa, 1 in every 150 abortions leads to death, compared to 1 in every 85,000 abortions in the developed world.[17]

HIV/AIDS

HIV/AIDS accounts for 6% of the global burden of disease. There are nearly 40 million people living with HIV/AIDS, of whom 25 million live in sub-Saharan Africa. While worldwide, nearly half of those infected are women, in sub-Saharan Africa 57% are women.[18]
It is estimated that in 2003, only 8% of those in need of ART received it (4% in sub-Saharan Africa) and only 8% of pregnant women were offered treatment for preventing mother-to-child transmission.[19]

Other Sexually Transmitted Infections20

In addition, there are 340 million new cases of curable STIs each year in the reproductive age-group, many of which are not treated. Untreated infection increases the risk of HIV/AIDS by 10.

Unmet need for contraception43:
201 million women have an unmet need for effective contraception, including 64 million women who use traditional methods.

Female Genital Mutilation/Cutting21
World wide 130 million girls and young women have experienced FGM/FGC. An additional 2 million are at risk every year.

Fistula is a devastating problem for over 2 million young women caused by prolonged labour, immature childbearing resulting in incontinence, making them social outcasts. Female genital mutilation (FGM) and poor diet are contributing factors, while violent rape can also result in fistula. FGM is mainly found in Africa, and its long-term complications include infections, chronic pain and excessive growth of scar tissue as well as psychological suffering. Ending this traditional practice will require going beyond the health issues and addressing society's cultural and social values.

The sexual and reproductive health needs of men received little attention in public health services until the HIV/AIDS epidemic brought them into focus. Men need more information on all aspects of sexual and reproductive health.

Strategic Actions for Improving Sexual and Reproductive Health
Important partners for improving sexual and reproductive health are national governments including ministries of finance, education, health and local government, and civil society organisations. International partners are EU, UNESCO, UNFPA, UNAIDS, UNICEF, WHO, World Bank, like-minded donors, international and Danish NGOs.

Denmark will work with its partners to:

1. Ensure greater focus on the achievement of MDG5/Maternal health;
2. Enable women and men to control their own fertility by supporting access to information and services for contraception, abortion (where legal), universal post-abortion care and infertility treatment;
3. Address sexual and reproductive ill-health through a life-cycle approach, with special focus on obstetric fistula, FGM, sexually transmitted infections;
4. Support the development of a well-functioning system, accessible/affordable for all, for safe delivery at community, health centre and district levels, with basic and comprehensive emergency obstetric care services, round-the-clock functional referral systems and skilled attendance at all deliveries;
5. Support the development of midwifery including supporting review and change of regulations and practices to empower mid-level providers to perform life-saving procedures.
6. Support the implementation of evidence-based priority interventions for neonatal survival, including antenatal, natal and postnatal care packages, including PMTCT where relevant22
7. Encourage men to support and engage in the promotion SRHR.

Young people: Access to information and services[23]

There are no specific millennium development goals for youth, but there are indicators for primary education, HIV-prevalence among persons 15-24 years of age and their knowledge on

transmission of HIV/AIDS, proportion of orphans 10-14 years in school, and unemployment rates for male and female youth between 15-24 years.

Box 7: The Situation of Young People[24]

- Nearly half of the world's population of 6.4 billion is under the age of 25.
- Some 1.2 billion people are between the ages of 10 and 19, 87% of them live in developing countries.
- About 57 million young men and 96 million young women aged 15-24 in developing countries cannot read or write.
- Worldwide, an estimated 352 million children between ages 5 and 17 were economically active in 2000, over 246 million of them working illegally and nearly 171 million in hazardous conditions.

HIV/AIDS

- An estimated 6,000 youth each day become infected with HIV — one every 14 seconds. The majority are young women.
- At the end of 2001, an estimated 11.8 million young people aged 15-24 were living with HIV/AIDS, of whom 7.3 million were young women. Only a small percentage of these young people know they are HIV-positive.
- Two-thirds of newly infected youth aged 15-19 in sub-Saharan Africa are female.
- More than 13 million children under age 15 have lost one or both parents to AIDS. The overwhelming majority of these AIDS orphans live in Africa.

Early marriage and childbearing

- 82 million girls in developing countries who are now aged 10 to 17 will be married before their 18th birthday.
- In some countries, the majority of girls still marry before their 18th birthday.
- Worldwide, some 14 million women and girls between ages 15 and 19 — both married and unmarried — give birth each year.
- Pregnancy is a leading cause of death for young women aged 15 to 19 worldwide, with complications of childbirth and unsafe abortion being the major factors.
- For both physiological and social reasons, girls aged 15 to 19 are twice as likely – and girls under age 15 five times as likely to die in childbirth as those in their twenties.

Living on the margins

- The number of youth in the world surviving on less than a dollar a day in 2000 was an estimated 238 million, of whom 60 million were in sub-Saharan Africa.
- Each day, 5,000 children become refugees. (Children of both sexes are especially vulnerable to sexual abuse in conflict and emergency situations.)
- Global estimates of street children vary from 100 million to 250 million, and their numbers are rapidly increasing.

The ICPD PoA was the first international document that recognised adolescents' reproductive health needs. It was also the first time that governments were obliged "to protect and promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies." This was to take place with full participation by adolescents in the "planning, implementation and evaluation" of reproductive and sexual health information and services. To achieve this "countries should, where appropriate, remove legal, regulatory and social barriers to reproductive health information and care for adolescents." *(ICPD PoA, Para. 7.45--7.47)*

Yet young people constitute a group whose sexual and reproductive health needs continue to be largely ignored, which is reflected in the data on HIV/AIDS, teenage pregnancies and deaths. Adults in many countries, including health staff, continue to disapprove of young people's sexuality and wrongly believe that information and education on sex will promote sexual promiscuity. In addition, conservative forces are again promoting abstinence at the cost of access to information and services.
Cross-generational transactional sex (exchange of sex for gain, ranging from consensual to coercive relationships), is a growing problem due to poverty and unequal power relations.

Married and unmarried female adolescents face different problems, with the former being treated more like adults and the latter as children who should not engage in sex. Married adolescents are often isolated, out of school, and away from familiar social networks, with decisions regarding their health care being made by husbands or mothers-in-law. As they are expected to prove their fertility, they are exposed to unprotected sex. Both married and unmarried adolescents lack knowledge and access to health services and contraception.

Box 8: Geracao Biz

In Mozambique only 5% of the 15-19 years females use modern contraception methods. The high rate of AIDS and unwanted pregnancies along with the low rates of literacy threatens Mozambique's productive capacity. About 85% of all girls have their first child before the reach the age of 19 years. This could continue for several decades if the youth is not targeted now to be change agents of the future.

"Geracao Biz" is a programme for adolescents and young peoples' SRHR incl. AIDS prevention in and out of schools as well as a youth friendly health programme. UNFPA is coordinating the programme covering about 40% of Mozambique. A 2004 evaluation was positive and recommended the programme to scale up to cover the whole of Mozambique.

"Geracao Biz" is training the youth to perform dramas and conduct peer education with the aim of promoting SRHR including preventing HIV/AIDS via counselling. It is supporting community youth groups, developing teaching and information materials, training school teachers in facilitating SRHR knowledge to the school kids and training and equipping health staff to meet young peoples needs for SRHR services. The programme is implemented by an international NGO in collaboration with the three ministries Health, Education and Gender/Youth and Sport. The Scandinavian countries and Holland support the programme and plans for going to scale are developed.

The provision of genuinely youth-friendly services through designated clinics has shown impressive results, but the problem lies in establishing sufficient numbers of clinics to meet the needs of such a large population group, given existing financial and human resources. It is therefore necessary to mainstream access for youth by changing attitudes of new and existing health staff and making all existing services youth-friendly. (This applies not just for youth but also for the poor and disadvantaged.)

Young people are not a homogenous group, and programmes will therefore need to be tailored to meet the needs of different groups of youth (15 – 24) and young people (10 – 24). At the same time, it must be recognised that they are both resourceful as well as vulnerable. Their genuine involvement in programming is therefore essential, keeping in mind the successes achieved through peer-led programming.

Important partners for improving sexual and reproductive health are national governments including ministries of finance, education, health and local government, and civil society organisations, especially youth/young peoples' organisations. Internationally, the Committee on

the Rights of the Child (CRC) is an important forum, while central EU, UNESCO, UNFPA, UNAIDS, UNICEF, UNIFEM, WHO, World Bank, like-minded donors, international and Danish NGOs.

Denmark will work with its partners to:

1. Strengthen the legal rights of young people to SRH through improved legislation, increased knowledge of legislation and improved monitoring of adherence.

2. Strengthen public and political commitment to young peoples' SRHR by advocating for positive attitudes among community gatekeepers (parents, teachers, religious leaders, employers, community leaders, and the media) towards adolescent SRHR programmes and for postponement of marriage and first pregnancy.

3. Ensure and mainstream access to youth-friendly services, including by making existing services youth-friendly.

4. Support the education sector in developing and implementing school-based programmes on comprehensive life skills and gender equality, and support NGOS in the provision of the comprehensive life skills package as a co-curricular activity as well as for young people out-of-school.

5. Promote the integration of the rights of children and young people to sexual and reproductive health in education and training programmes for human rights, democratisation and good governance.

6. Support programmes to protect children and young people of both sexes from violation of their sexual and reproductive health and rights (abuse and exploitation), including in situations of armed conflict and disaster.

Linking the Response to HIV/AIDS with SRHR/MDG 6

Goal 6, which is to combat HIV/AIDS, makes no reference to sexual health, despite the fact that 70% of new HIV infections today are sexually transmitted. While the ICPD promoted an integrated approach to HIV/AIDS and SRHR (at the same time not fully recognising the enormity of the threat posed by HIV/AIDS), the increasing de-linking and competition for funds between HIV/AIDS and SRHR over the last decade has been sealed by the MDGs.[25]

There are many reasons for linking responses to HIV and SRHR.[26] The overwhelming majority of HIV transmissions are sexually transmitted or associated with pregnancy, childbirth and breast-feeding. The prevention, diagnosis and treatment of STIs are core reproductive health concerns as well as important HIV prevention interventions, and both HIV-prevention and SRHR efforts must focus on sexuality and reproduction. Both sexual and reproductive ill-health and HIV are rooted in the same social pathologies, including unequal gender relations, sexual violence, discrimination against sexual minorities, conflict and poverty. People with HIV are also people with sexual and reproductive health needs – and sexual and reproductive health rights. For instance, an HIV+ woman might want a child and needs counselling on how to prevent it from being infected, and once pregnant, she will also need antenatal, delivery and postnatal care (including contraception), treatment to prevent transmission of the virus to her child, and perhaps ART for herself.

Effective HIV/AIDS and SRH programmes must address the status of girls and women, gender dynamics, violence and power. They must also address the stigma and discrimination associated with HIV/AIDS. Similarly, efforts to mobilise and empower vulnerable groups

should address human rights, gender equity issues and other factors that spread HIV and contribute to poor SRH.

The inadequacy of health systems in many poor countries has led to the development of separate programmes for the provision of HIV testing and counseling (VCTs), HIV prevention, care and support and now antiretroviral treatment. On the other hand, SRH programmes have considerable knowledge and tools for providing information and influencing sexual behaviour as well as experience in procuring and distributing contraceptives. It is now important that these programmes focus on cooperation rather than on competing for scarce resources. Given the inter-relationship between TB and HIV/AIDS, and their indirect contributions to maternal mortality, and the inter-relationship between HIV/AIDS and STIs, it is important that referral links are established between MCH clinics, VCTs, and TB and STI services.

Important partners for improving sexual and reproductive health are national governments including ministries of finance, education, health and local government, and civil society organisations. International partners are EU, GFATM, UNESCO, UNFPA, UNAIDS, UNICEF, UNIFEM, WHO, like-minded donors, international and Danish NGOs.

The Strategy for Denmark's Support to the International Fight against HIV/AIDS (2005) emphasises the need for linking HIV/AIDS and SRHR and lists the following actions for doing so:

Denmark will work with its partners to:

1. Support national and international partners, such as UNFPA and IPPF, with the aim of strengthening the integration of HIV prevention efforts with reproductive health services and visa versa (including HIV counselling and testing, STI management, family planning and prevention of mother to child transmission programmes) in order to ensure that the services are complementary and not competitive.
2. Actively support the full recognition of the importance of linking HIV/AIDS and sexual and reproductive health and rights at the global level, including at relevant international summits and conferences.
3. Ensure that the linkages between HIV/AIDS and sexual and reproductive health are addressed within national development plans and budgets, including health sector reforms, poverty reduction strategy papers (PRSPs), sector wide approaches, UN instruments, country assessments and the development assistance framework.
4. Promote female condoms and research and development of female controlled prevention such as microbicides.
5. Promote strategies and programmes that ensure that HIV/AIDS and sexual and reproductive health programmes contribute to the overall strengthening and sustainability of health systems.
6. Support commodities programmes that can ensure adequate supply of condoms.

In addition, Denmark will advocate at the international level with the GFATM for a broader perspective on the use of funds (for example, that SRHR aspects are considered).

Through its Private Sector Development Programme, Danida encourages private companies, trade unions and employers' organisations to develop HIV/AIDS information campaigns and

work-based prevention programmes. For such programmes to be effective, it is necessary to broaden their scope to include sexuality and reproductive health and rights.

Box 9: Ways of Linking SRH and HIV/AIDS

Two high-level consultations in Glion, Switzerland (May 2004) and in New York (June 2004) specifically called for:

- Provision of an essential package of sexual and reproductive health information and services to all people reached by AIDS programmes, including voluntary counselling and testing and services to prevent mother-to-child transmission of HIV.
- Provision of an essential package of HIV/AIDS information and services to all people reached by sexual and reproductive health programmes.
- Greater emphasis on HIV prevention among women and prevention of unintended pregnancy among HIV positive women as elements of a strategy for reducing HIV infection among infants.
- Recognition of the links between reproductive health and HIV/AIDS programmes in budgets and poverty reduction strategy papers.

Research for Planning and Action

To effectively promote SRHR, there is need for more knowledge about socio-cultural norms including gender issues, and sexual behaviour especially among young people, in order to improve programme interventions. Not enough is known about the concept of reproductive rights within specific cultures, social milieu and political contexts nor about service providers' versus users' perceptions about what constitutes good services, for instance in relation to deliveries, and programmes for young people.

There is also need for simple and affordable diagnostic tools and treatment methods for STIs and RTIs, other contraceptive methods, new/better vaccines against specific diseases such as HIV and cervical cancer, and effective drugs for use in the third stage of labour (oxytocins) that can be delivered within the communty by relatively unskilled health workers.

Researchers have also pointed out that the current definition of the disease burden of sexual and reproductive ill-health does not deal adequately with co-morbidities such as malaria, anemia and TB, nor does it include FGM, rape, ill-health in relation to use of contraceptives, infertility, and conditions of the male sexual and reproductive organs.[27]

Finally, there is need for information on the coverage and utilisation of services including equity aspects, reasons for non-utilisation of existing services, and ways of linking HIV/AIDS with SRH.

Denmark has supported research in some of these areas for several years and recognises the need for greater focus on, and resources for, these important areas.

6. Achieving Results - from Words to Action

Implementation of this strategy will monitored through:

- UNFPA's The State of the World Population, and annual UNFPA country reports.
- Progress reporting on MDG3, MDG5 and MDG6 done by UNICEF, WHO, UNESCO, UNAIDS and UN Population Department.
- Annual reporting on the action plans related to organisation strategies for the multilateral organisations.
- Regular reviews of programme support, where relevant.
- Annual reports from Danish and international NGOs and ENRECA.
- Position papers and instructions for international meetings and conferences and reports dealing with SRHR.
- Ad hoc evaluations of SRHR support will be carried out as deemed necessary.

UNFPA monitors global and national progress on the ICPD PoA and annually publishes *The State of the World Population,* which, together with the annual UNFPA country reports, will be the key sources for monitoring progress towards the ICPD-goals.

UNICEF, WHO, UNESCO, UNAIDS and UN Population Department are responsible for reporting on the indicators defined to measure progress towards the achievement of MDG 3/Gender Equality and Empowerment of Women, MDG5/Maternal Health and MDG6/HIV/AIDS. UNDP is responsible for the MDG Country progress reports.

To better monitor progress towards MDG5/Maternal Health, Denmark supports the recommendation by the Millennium Project Child Health and Maternal Health Task Force on an additional target and indicators. The target suggested is "Universal access to reproductive health services by 2015 through the primary health care system, ensuring faster progress among the poor and other marginalised groups". New indicators suggested are: "Coverage of emergency obstetric care; Proportion of desire for family planning satisfied; Adolescent fertility rate; Contraceptive prevalence rate and HIV prevalence among 15-24 year-old pregnant women."

As a part of the Ministry of Foreign Affairs' decentralisation process, the Danish representations and embassies have assumed greater responsibility for all development assistance. This implies that they are main responsible for monitoring the performance of bilateral activities at country level and contributes to monitoring of the performance of multilateral organisations, based on strategies for programme countries and organisational strategies for multilateral organisations.

In addition to above mentioned monitoring performed by the multilateral system, reporting on progress in the implementation of the strategy will be included in existing reporting systems such as the regular reviews of programmes for health, education and good governance, where relevant. It will not be possible to measure the extent to which changes in SRH indicators can

be attributed directly to Denmark's assistance or efforts, as several partners and organisations are involved in supporting national government policies, plans and programmes.

Also with regard to Denmark's cooperation and dialogue with international institutions and multilateral organisations, Denmark is one of many partners seeking to influence policies, decisions and activities. Therefore, the performance assessment on Denmark's specific targets, as set out in the organisational strategies and action plans, does not measure the effect of Danish efforts, but rather to which extend the organisation as such is making progress towards the indicators set.

Annex 1: ICPD Goals and Millennium Development Goals[28]

ICPD Goals and Objectives	Millennium Development Goals and Targets
…raise the quality of life through population and development policies and programmes aimed at achieving poverty eradication, sustained economic growth in context of sustainable development (para. 3.16)	**Goal 1: Eradicate extreme poverty and hunger** Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger
….countries should further strive to ensure complete access to primary school or equivalent level of education by girls and boys as quickly as possible and in any case before 2015 (para. 11.6)	**Goal 2: Achieve universal primary education** Target 3: Ensure that, by 2015. children everywhere, boys and girls alike, will be able to complete a full course of primary schooling
Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes (Principle 4)	**Goal 3: Promote gender equality and empower women** Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015
By 2015, countries should aim to achieve an infant mortality rate below 35 per 1000 live births and an under-five mortality rate below 45 per 1,000 (para. 8.16)	**Goal 4: Reduce child mortality** Target 5: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate
Countries should strive to effect significant reductions in maternal mortality by 2015: reductions by one half of 1990 levels by 2000 and further one half by 2015 (para. 8.21)	**Goal 5: Improve maternal health** Target 6: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
….by 2005, ensure at least 90 per cent, and by 2010 at least 95 per cent, of 15-24 age group has access to IEC and services to develop life skills required to reduce their vulnerability to HIV infection; that by 2005 prevalence is reduced globally, and by 25 percent in the most-affected countries (ICPD+5 para. 70)	**Goal 6: Combat HIV/AIDS, malaria and other diseases** Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases
…population issues should be integrated into formulation, implementation, monitoring and evaluation of policies and programmes relating to sustainable development (para.3.5)	**Goal 7: Ensure environmental sustainability** Target 9: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation Target 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum-dwellers
ICPD Goals and Objectives	Millennium Development Goals and Targets
…strengthen the partnership between governments, international organizations and the private sector in identifying new areas of cooperation (para. 15.l5a)	**Goal 8: Develop a global partnership for development** Target 12: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system (Includes a commitment to good governance, development and poverty reduction both nationally

	and internationally) Target 13: Address the special needs of the least-developed countries (Includes: tariff- and quota-free access for least-developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries and cancellation of official bilateral debt; and more generous official development assistance for countries committed to poverty reduction) Target 14: Address the special needs of landlocked countries and small island developing states (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly) Target 15: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term Target 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth Target 17: In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries Target 18: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications

Annex 2: Selected Current and Proposed MDG Indicators

The following Table shows the UN organisations responsible for reporting on the MDGs.

Goal	**Target**	**Indicators**
3: Promote gender equality and empower women	4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	9. Ratio of girls to boys in primary, secondary and tertiary education (UNESCO) 10. Ratio of literate women to men, 15-24 years old (UNESCO) 11. Share of women in wage employment in the non-agricultural sector (ILO) 12. Proportion of seats held by women in national parliament (IPU)
5: Improve maternal health	6: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	16: Maternal mortality ratio (UNICEF-WHO) 17: Proportion of births attended by skilled health personnel (UNICEF-WHO)
6: Combat HIV/-AIDS, malaria and other diseases	7: Have halted by 2015 and begun to reverse the spread of HIV/-AIDS	18. HIV prevalence among pregnant women aged 15-24 years (UNAIDS-WHO-UNICEF) 19. Condom use rate of the contraceptive prevalence rate (UN Population Division) 19a. Condom use at last high-risk sex (UNICEF-WHO) 19b. Percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (UNICEF-WHO) 19c. Contraceptive prevalence rate (UN Population Division) 20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years (UNICEF-UNAIDS-WHO)

Additional Indicators for Maternal Health Proposed by the Millennium Project Task Force on Child Health and Maternal Health

Goal	**Targets**	**Indicators**
Goal 5: Improve maternal health	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio, *ensuring faster progress among the poor and other marginalised groups.* *Universal access to reproductive health services by 2015 through the primary health care system, ensuring faster progress among the poor and other marginalised groups*	Maternal mortality ratio Proportion of births attended by skilled health personnel *Coverage of emergency obstetric care* *Proportion of desire for family planning satisfied* *Adolescent fertility rate* *Contraceptive prevalence rate* *HIV prevalence among 15-24 year-old pregnant women*

Annex 3: International organisations mandated to promote SRHR

United Nations Population Fund (UNFPA)
UNFPA is responsible for monitoring the implementation of the ICPD PoA, and is an influential advocate for gender equality, women's empowerment and reproductive rights together with prevention of HIV/AIDS among girls and women and prevention of the mother to child HIV-infection. UNFPA is also the world's largest international source of funding for population and reproductive health programmes as well as directly managing one-quarter of such assistance to developing countries. UNFPA is at an increasingly rate strengthening national authorities capacity to incorporate reproductive health and gender issues in the development of health and education sector programmes and national PRS, as well as contributing to UN harmonization with government SRHR strategies and work programmes. In addition, an important area is UNFPA's continued implementation of the Global Programme to Enhance Reproductive Health Commodity Security, with a long-term focus on building national capacity to take over this task.

With regard to HIV-prevention UNFPA's strategic focus is on HIV-prevention among young people, comprehensive condom programming, HIV-prevention among women and young girls incl. promoting the linkages between HIV-prevention and SRH. According to the UNAIDS cosponsors' division of labour UNFFPA is the lead organization for the areas: Provision of information and education, condom programming, prevention for young people outside schools, prevention efforts targeting vulnerable groups and prevention among sex-workers.

UNICEF (United Nations Children's Fund)
UNICEF is the lead agency and secretariat for United nation's Girls' Initiative (UNGEI). its efforts in relation to the ICPD PoA are most clearly spelled out under the focus area on HIV/AIDS and children, and in this regard UNICEF focuses on prevention of HIV/AIDS among girls, adolescents and young people and strengthen local capacities in protecting and supporting orphans' physical and sexual abuse and raise awareness of the links between HIV/AIDS and SRHR. Furthermore, UNICEF is challenged to further clarify and strengthen its role in implementing the ICPD PoA in close coordination with relevant partners in its humanitarian as well as in its development work, and in the focus area of child protection from violence, exploitation and abuse, in which regard UNICEF focuses on the rights of children and young people to protection. According to the UNAIDS cosponsors' division of labour, UNICEF – together with WHO – is responsible for prevention of mother to child HIV-infection transmission.

United Nations Development Fund for Women (UNIFEM)
UNIFEM provides financial and technical assistance to innovative programmes and strategies to advance women's empowerment and gender equality. The Fund focuses its activities on four strategic areas: reducing feminised poverty, ending violence against women, reversing the spread of HIV/AIDS among women and girls, and achieving gender equality in democratic governance in times of peace as well as war. UNIFEM plays an important role as a catalyst for incorporating gender equality into the UN development policies and activities.

Joint United Nations Programme on HIV/AIDS (UNAIDS)
UNAIDS is a co-sponsored programme of the UN created in response to concerns that international efforts to combat HIV/AIDS had been too fragmented and health-centred. It is comprised of ten co-sponsoring agencies (UNICEF, UNDP, UNFPA, UNESCO, WHO, World Bank, UNODC, ILO, WFP and UNHCR) and a Secretariat. Its core mandate is to "Be the advocate for global action on the epidemic. It leads, strengthens and supports an expanded response aimed at preventing transmission of HIV, providing care, support and treatment, reducing the vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic." UNAIDS has played a leading role in drawing attention to the feminisation of the HIV/AIDS epidemic, including through the creation of a Global Coalition on Women and AIDS in 2004. Promoting the "Three Ones" principles is a core priority through active follow up on the recent recommendations from the Global Task Team (GTT).[29] With respect to SRHR, a challenges for UNAIDS will be to further strengthen its gender focus as well as to promote integration of SRH into national HIV/AIDS efforts.

World Health Organisation (WHO)
WHO has a global health mandate including normative and technical assistance, focusing on health problems found mainly in low-and middle-income countries. There is increased emphasis on development objectives in WHO's work. At global level, WHO advocates for strengthening the health sector in developing countries, while simultaneously channeling assistance to country level through its global programmes (HIV/AIDS, TB, malaria, essential drugs, child and adolescent health, reproductive health, vaccines). WHO provides technical assistance at regional and country level within the "*Country Focus*" framework based on Country Cooperation Strategies (CCS) in support of developing countries' achievement of the health related MDG targets. WHO in partnership with other organisations also assists in monitoring country results for these targets.

WHO supports SRHR through its normative and technical work, but funding shortages and lack of agreement on the rights-based approach to SRH among the organisation's 192 Member States have impacted on WHO's efforts in this area. There is room for further strengthening of WHO's involvement in PRS, SWAps and other developmental fora, as well as in coordination, harmonisation and alignment mechanisms in order to make SRH an integral part of national planning.

United Nations Educational, Scientific & Cultural Organisation (UNESCO)
In the field of education one of its most important roles is the role as international coordinator on Education for All, the UN Literacy Decade and the UN Decade on Education on Sustainable Development. Of special relevance regarding educational aspects of sexual reproductive health and rights are: UNESCO works with health in schools, including its skills-based approach to health, hygiene and nutrition education. UNESCO also has an educational programme on HIV/AIDS and education called EDUCAIDS, and has initiated a programme for teacher training with special focus on Sub-Saharan Africa. Denmark endorses UNESCO's role a normative and capacity building agency within the field of education.

European Union (EU)
The European Community has supported the ICPD from its beginnings in 1994 and sees the comprehensive Cairo agenda as the overall policy framework for action. The EU formally endorsed the ICPD Programme of Action in 1996 and its population policies and programmes in developing countries are based on these principles. A new Regulation adopted in 2003 specifies that the European Commission and Member States will continue to contribute to the wider effort to support SRHR policies and programmes in developing countries and continue to play a leading role in this area. In November 2005, the EU adopted a Joint Statement on the European Consensus on Development. Both the EU and the EC part underlines the importance of ICPD and SRHR.

The EU is committed to upholding the principles agreed at the ICPD and ICPD+5 and collectively sharing the financial burden defined in the Programme of Action. Currently, the EU provides more than 60% and the European Commission approximately 10% of global financial support to the ICPD goals. The EU has shown substantial political leadership in promoting SRHR issues and worked actively to ensure that the September 2005 UN World Summit integrated the ICPD-goal into the implementation of the MDGs.

Global Fund to Fight AIDS, TB and Malaria (GFATM)
The GFATM was established in January 2002 after the UN Special Session on HIV/AIDS, as a financial mechanism for supporting public and private sector and NGO programmes to fight HIV/AIDS, tuberculosis and malaria in developing countries.

United Nations High Commissioner for Refugees (UNHCR)
UNHCR fills an important function by coordinating reproductive health interventions to conflict-affected people. Until recently, such interventions were mainly aimed at refugees in camps, but increasingly focus is also on internally displaced people, host populations and others who may not be displaced, but are otherwise affected by armed conflict. Areas where efforts need to be made to mitigate the effects of conflict and displacements include: fertility and family planning, sexually transmitted infections – including hiv/aids, sexual and gender-based violence, safe motherhood, and adolescent reproductive health.

United Nations High Commissioner for Human Rights (UNOHCHR)
As part of its mandate UNOHCHR has a special focus on the right of women and children to protection in conflict situations in its efforts at country level.

World Bank
The World Bank's mission is to work for a world free of poverty and the Bank is a central partner in efforts made to meet the Millennium Development Goals. The Bank provides substantial support in the field of reproductive health, through lending, analytical and advisory activities, capacity building and NGO Partnerships. The main challenge for the Bank in the area of reproductive health are to link work in population and reproductive health to poverty reduction strategies and country assistance strategies, building capacity to support services e.g. procurement of drugs and contraceptives under SWAPs and strengthening linkages with HIV/AIDS. Denmark supports the World Bank's strategy in the area of population and reproductive health. It is important that the Bank maintains its focus on reproductive health and applies a more rights based approach to the issue.

Regional Development Banks
Regional development banks, such as the African Development Bank, have a development mandate, which is delivered through commercial and concessional lending to governments. Denmark emphasises the need for much greater coordination between the regional development banks and national governments, as well as for harmonisation of aid management procedures.

International NGOs
Denmark supports several international NGOs, including the International Planned Parenthood Federation (IPPF), the Population Council and Family Care International.

IPPF is a global network of member associations in 148 countries and the world's foremost vol-untary, non-governmental provider and advocate of sexual and reproductive health and rights. Its new Strategic Framework (2005-2015) emphasises five strategic priorities on which it will focus: adolescents/young people, HIV/AIDS, abortion, access and advocacy.

The Population Council is the leading NGO in the area of population-related research, while Family Care International carries out advocacy to strengthen international and national commitment to promoting SRH, provides technical assistance to governments for capacity building and innovative activities, and develops communication materials on SRHR.

[1] The UN Millennium Project Task Force on Child Health and Maternal Health cites the principle of 'progressive realisation' in human rights treaties, which requires states to take all appropriate steps to realise a right 'to the maximum extent of available resources'. Its report highlights three critical issues: action must be concrete, deliberate and targeted; budget allocations are relevant; and some interventions must take priority over others. UN Millennium Project 2005. *Who's Got the Power? Transforming Health Systems for Women and Children.* Task Force on Child Health and Maternal Health

[2] Key issues for promoting the integration of SRHR into the planning, implementation and reviews of Danida's sector programme support, along with checklists for each sector, are contained in *Integrating Sexual and Reproductive Health and Rights into a Sector Wide Approach to Danish International Development Assistance.* Danida. 1999.

[3] Royal Danish Ministry of Foreign Affairs. 2005. *Strategy for Denmark's Support to the International Fight against HIV/ AIDS.*

[4] Royal Danish Ministry of Foreign Affairs. 2004. *Strategy for Gender Equality in Danish Development Cooperation.*

[5] Ministry of Foreign Affairs - Danida. 2001. *Education Sector Policy.*

[6] Ministry of Foreign Affairs. undated. *Guidelines for Children and Young People in Danish Development Cooperation.*

[7] This is closely related to public sector reform.

[8] The MDG Task Force recommends support to the continuation of the Women's Indicators and Statistics Database (WISTAT) series and the publication of *Trends in the World's Women* based on WISTAT. UN Millennium Project 2005. *Taking Action: Achieving Gender Equality and Empowering Women.* Task Force on Gender Equality.

[9] The Resolution also calls on all parties to armed conflict to take special measures to protect women and girls from gender-based violence, particularly rape and other forms of sexual abuse, and all other forms of violence in situations of armed conflict; as well as to take into account the particular needs of women and girls in refugee camps and settlements.

[10] Out of 159 countries for which data are available, the legal minimum age is: 15 years or below in 33 countries, and 38 countries have no legal minimum age

[11] WHO. Reproductive Health. Report by the Secretariat to the 57th World Health Assembly. Document A57/13, 15 April 2004.

[12] Amnesty, nr.3 2004 (Tema: Vold Mod Kvinder).

[13] *"a skilled attendant is an accredited health professional — such as a midwife, doctor or nurse — who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.*"

Source: *Making Pregnancy Safer: The Critical Role of the Skilled Attendant.* A joint statement by WHO, ICM and FIGO, 2004

[14] WHO. *Reproductive Health.* Report by the Secretariat to the 57th World Health Assembly. Document A57/13, 15 April 2004.

[15] WHO, UNICEF and UNFPA, 2004. *Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF and UNFPA,* Geneva.

[16] UN Millennium Project 2005. *Who's Got the Power? Transforming Health Systems for Women and Children.* Task Force on Child Health and Maternal Health.

[17] *ICPD at Ten. A Report Card on Sexual and Reproductive Health and Rights.* 2004. Population Action International, International Planned Parenthood Federation and Family Care International.

[18] UNAIDS/WHO, 2004. *AIDS Epidemic Update,* December 2004.

[19] UN Millennium Project 2005. *Combating AIDS in the Developing World.* Task Force on HIV/AIDS, Malaria, TB, and Access to Essential Medicines, Working Group on HIV/AIDS.

[20] *State of the World Population 2004.* UNFPA.

[21] UNFPA home page

[22] See Table 3.5 in *Who's Got the Power? Transforming Health Systems for Women and Children.* Task Force on Child Health and Maternal Health

[23] Common international definitions: adolescents (10 –19 years old), youth (15—24 years) and young people (10 – 24 years old). In many countries youth can go up to 35 – 40 years, which has consequences for youth policies etc.

[24] www.unfpa.org/adolescents/facts.htm. (accessed September 27, 2005)

[25] The establishment of a Global Fund for HIV/AIDS, TB and Malaria, and WHO's decision to move HIV/AIDS from the sexual and reproductive health section to the infectious and communicable diseases unit contributes to this separation.

[26] Jeffrey O'Malley. *Can This Marriage Work?* in Countdown 2015: ICPD at Ten. Population Action International, International Planned Parenthood Federation and Family Care International.

[27] AbouZahr C and Vaughan J.P. *Assessing the burden of sexual and reproductive ill-health: questions regarding the use of disability-adjusted life years.* Bulletin of the World Health Organization. 2000. 78 (5).

[28] UNFPA 2004. *Investing in People*

[29] The " *Three Ones*" principles are: one agreed HIV/AIDS action framework for overall coordination; one national AIDS coordinating authority with a broad based multi-sector mandate; and one agreed country level monitoring and evaluation system. Building on the "*Three Ones*" a Global Task Team (GTT) was established in March 2005 to improve coordination among bilateral and multilateral donors and to align their support to national AIDS responses. UNAIDS has been assigned a leading role in this process.