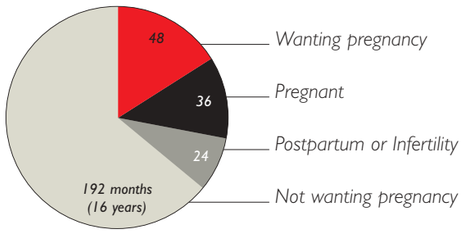
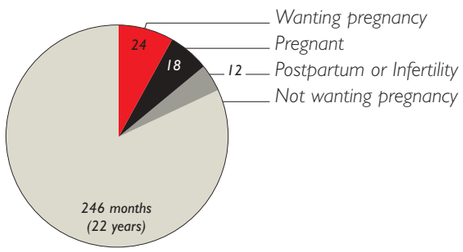
To avoid unintended pregnancies women must use birth control effectively for most of their childbearing years[13]

Women who want 4 children

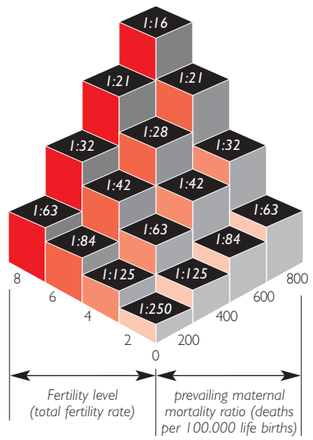


Women who want 2 children



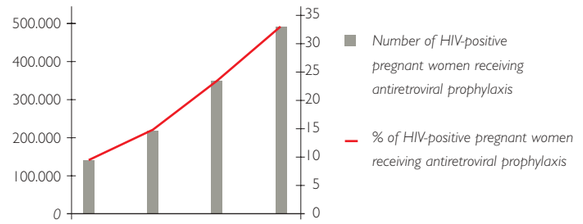
Lifetime risk of dying from pregnancy-related causes

(according to fertility and prevailing maternal mortality ratio)[16]

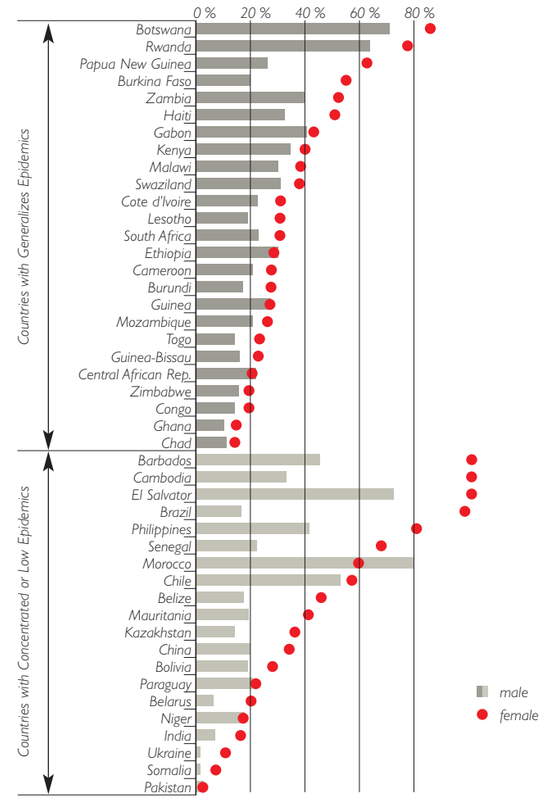


When the risk of dying in pregnancy or childbirth is 800 per 100.000 births, and the fertility level is 8 births per women, the lifetime risk of maternal death is 1:16. A fall in fertility level from 8 to two births, in absence of any change in the risk per pregnancy, improves the lifetime risk from 1:16 to 1:63. The same improvement is achieved by a reduction in the risk of death per pregnancy from 800 to 200 per 100.000, without any change in fertility. Clearly, when both factors operate together, more striking gains in lifetime risk are made.

Number and percentage of HIV-positive pregnant women receiving antiretroviral prophylaxis *(2004 – 2007)*[4]



Comparison of antiretroviral therapy coverage between males and females *(in 2007)*[4]



reproductive health and commodities

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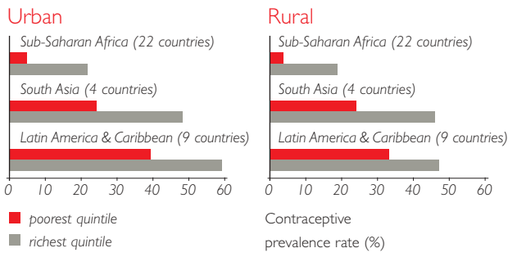
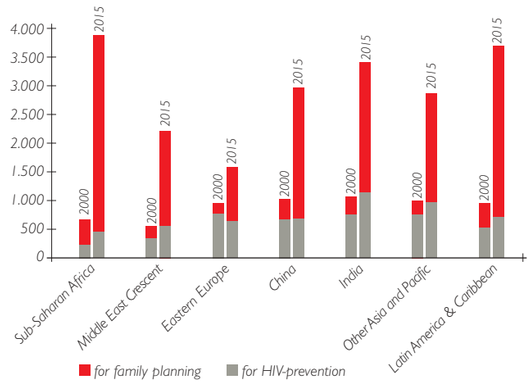
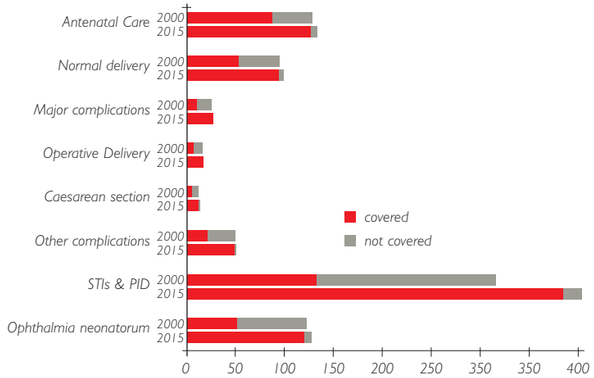
Contraceptives continue to be less accessible to the poor and those living in rural areas[14]



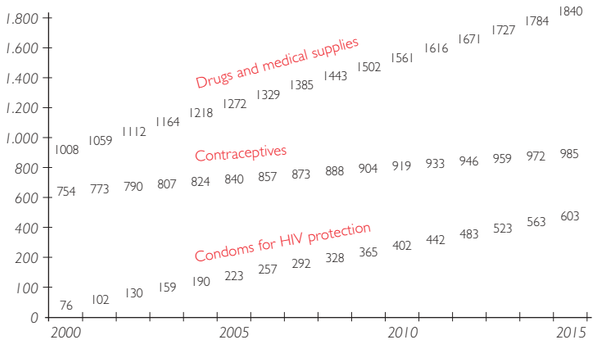
Condoms needed for family planning and for rising protection against HIV *(by region, 2000 and 2015, in millions)*[15]



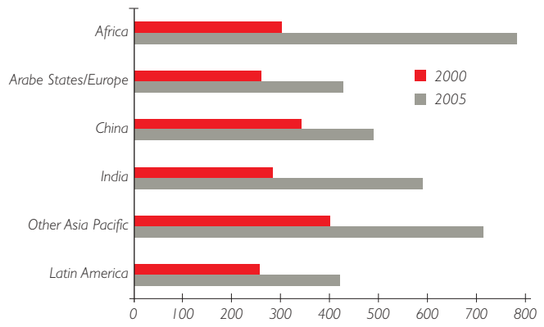
Cases of selected reproductive health conditions *(divided into those covered by services and not covered, 2000 and 2015, millions)*[15]



Annual cost of commodities for reproductive health in developing regions *(2000 – 2015, million U.S. dollar)*[15]



Cost of all reproductive health commodities *(by UNFPA regions, China and India distinguished, 2000 and 2015, million U.S. dollars)*[15]



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1) Alan Guttmacher Institute (AGI): Women with an Unmet Need for Contraception in Developing Countries and Their Reasons for Not Using a Method, 2007
2) WHO, UNICEF, UNFPA, World Bank: Maternal Mortality in 2005
3) UN Department of Public Information: Endpoverty 2015, Fact sheet
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15) UNFPA: Achieving the ICPD Goals: Reproductive Health Commodity Requirements 2000 – 2015
16) WHO: The Effects on Contraception on Obstetric Outcomes, 2004

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reproductive health and commodities

22% of women in developing countries without access to contraception[1]

1.3 billion young people between 15 and 24 years – up to now the biggest young generation – are sexually active or will become sexually active in the next years and will need RH* services. As the acceptance of contraception has increased, a wider range of available contraceptives is necessary.

At present, the supply with contraceptives is more than inadequate – especially underprivileged women and girls do not have access to contraceptives. They often trust in unsafe methods, know too little about their bodies and practice a risky sexual behaviour. Apart from a wide range of affordable or free contraceptives, women and girls also need comprehensive counselling to be able to take informed decisions. In many southern countries, the continuous use of and the knowledge about modern contraceptive methods is still a privilege of the wealthier classes of population. Apart from contraceptives such as (female and male) condoms, (hormone and copper) contraceptive coils, diaphragms, methods of hormonal contraception (birth control pill, implant, vaginal ring, patch, 3 month-injection), emergency contraception and spermicides, other RH commodities are needed to prevent unwanted pregnancies.

For the examination of clients and the conduct of invasive surgical procedures (implanting and removing contraceptive coils and implants, sterilisation/vasectomy and laparoscopy), instruments (speculum, scissors, scalpel, forceps, wound clamps, suture utensils, etc.) are needed. To be able to provide high-quality medical services, the respective health facilities should be equipped with ultrasound, sterilisators, gynaecological chairs, and microscopes, but also with medical supplies such as gloves, syringes, cotton wool wads, microscopy slides, disinfectants, etc.

ICPD, MDGs and SRHC**

According to the UN Population Division's latest prognoses, the reproductive population in the LDCs* will increase by 13% and the additional demand for contraceptives by 28% by 2015.[6] More than 67 million women rely on ineffective birth control methods (periodical abstinence, coitus interruptus), and 137 million women do not use any contraceptives at all although they do not want to have children.

According to the Pearl Index, 85% of these women become pregnant within one year.[7] Minimal progress has been made in southern Africa, where the conception prevalence rate lies under 15% and where the maternal mortality rate decreased by only 3% between 1990 and 2005. This region is far from achieving the MDGs and the goals of the ICPD by 2015. Therefore, the following measures are necessary:

- additional, highquality and affordable services,
- improved planning, implementation and evaluation capacities,
- more financial and technical resources,
- enhanced coordination of donor communities, and
- lobbying for the reproductive rights of women and girls

ICPD/ICPD+5 (1994/1995) and the World Summit (2005) have recognised that the comprehensive supply with SRHC is a prerequisite for the universal access to RH by 2015. SHRC include medication[8] which is – according to the WHO* – "safe, effective and of a highquality, prescribed and used deliberately, and available to and affordable for all people." [9]

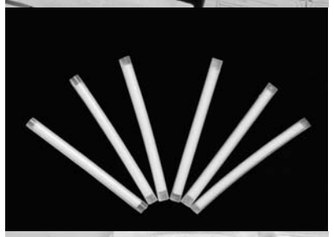
Unfortunately, these requirements are not always fulfilled, and the insufficient, but expensive supply with SHRC without new medication contributes to the poor state of health of many people in developing countries.

Photos

Title) A woman and her infant attend a one-day event promoting family planning and reproductive health among youth in Port Said, Egypt; © 2001 William Mackie/ CCP, Courtesy of Photoshare
1) A health worker in the Fes Province of Morocco demonstrates the use of various contraceptive methods with the IEC family planning demo kit; © 1996 Lauren Goodsmith, Courtesy of Photoshare
2) Norplant ® levonorgestrel contraceptive implants; © 2002 David Alexander/ CCP, Courtesy of Photoshare
3) An adolescent (with back to camera) receives counselling prior to HIV testing at Gulu Youth Center in northern Uganda; © 2007 Gilbert Awekofua, Courtesy of Photoshare
4) The contraceptive supply cabinet at a family planning clinic in Addis Ababa, Ethiopia; © 2006 Sabrina Karklins, Courtesy of Photoshare
5) Close-up of a female condom; © 1999 The Female Health Company, Courtesy of Photoshare
6) Plan B ® (levonorgestrel) emergency contraception; © 2006 David Alexander/CCP, Courtesy of Photoshare
7) A pharmacy in Nepal sells contraceptives; © CCP, Courtesy of Photoshare
8) This community health centre (Puskesmas), providing family planning services in Aceh, Indonesia, was affected by the Tsunami; © 2005 Russ Vogel, Courtesy of Photoshare

Terminology/Abbreviations

ABC *Abstinence – Be Faithful – Condom Use*
HIV *Human Immunodeficiency Virus*
HPV *Human Papilloma Virus*
GFATM *Global Fund for AIDS, TB and Malaria*
ICPD *International Conference on Population and Development*
LDC *Least Developed Country*
MDG *Millennium Development Goal*
PID *Pelvic Inflammatory Disease*
RH *Reproductive Health*
SRHC *Sexual and Reproductive Health Commodities*
STI *Sexual Transmitted Infection*
WHO *World Health Organization*





536,000 deaths of women during pregnancy and childbirth[2]

Over the last 20 years, only little progress has been made in the field of improving maternal health.

In developing countries, women still die during pregnancy, childbirth and soon after childbirth because of insufficient, inadequate or delayed medical treatment.

With the MDG* of "Reducing Maternal Mortality" by 75% by 2015, the world has declared war on maternal mortality. To achieve this goal, the present expenses have to be increased tenfold – if not, 70,000 young women (between 14 and 19 years) will still die every year giving birth to their children[3].

Giving traditional midwives who usually assist women during childbirth further training, informing communities on appropriate behaviour in risk situations, and training medical personnel for emergency childbirths are important measures for the improvement of maternal health.

The respective facilities have also to be equipped with diverse medical supplies. Adequate tests (pregnancy, HIV*, urine, blood), instruments (delivery forceps, stethoscopes, haemodynamometers, etc.), devices (for resuscitation, transfusions, mechanical aspiration, etc.), medication (antibiotics, vaccines, vitamins, anaesthetics, analgesics, antiseptics, parturifacients, infant food, stored blood) and other supplies (bedclothes, plastic sheets, gloves, syringes, etc.) are essential for increasing the chances of a woman to endure pregnancy and childbirth without permanent damage. Minimal requirements for a halfway safe birth are *a razor blade, a bar of soap, a plastic sheet (1 sqm), a piece of string for cutting the cord, and instructions presented in a panel of pictures.* Giving birth with only these few means are common not only in refugee camps and after environmental catastrophies.

Financing SHRC

10% of the worldwide per capita health expenses are needed for RH. In the year 2015, the costs for RH will amount to 36 billion US dollars.[10] Costs for contraceptives, medication and other medical supplies will increase to 3.43 billion; 1/3 of the expenses will be allotted to contraceptives, 1/8 to condoms, and more than half to remaining medication and medical supplies.

Programmes for maternal health are underfunded at the moment, the financial support of contraception is decreasing; only the funding of HIV prevention (condoms in particular) is continuously on the increase.

The reasons for this phenomenon are to find in the obvious cost efficacy of prevention. Additional investments of 4.2 billion US dollars in HIV prevention prevent further 29 million people from getting infected and save costs for later treatments. A lack of funding is one of the reasons why it comes to shortages in the supply with SHRC again and again. A comprehensive approach that involves a variety of sectors can contribute to the solution of the problem, and the involvement of a variety of actors such as the commercial sector, social marketing, NGOs, communities, etc. can contribute to the efficient supply with SHRC.

Many national governments increasingly recognise their obligation in this field and create national budget lines. They are supported by their international partners and strategic partnerships such as the Global Reproductive Supplies Coalition and the GFATM*. In the case of insufficient national budgets, the donor countries will still offer their support, but they will refrain from giving long-term commitments which complicates future planning.

International donors provide for only 233 million US dollars for contraception (condoms for HIV prevention included), although 1.3 billion dollars would be needed to meet the needs of 655 million couples.

15.5 million women live with HIV/AIDS[4]

In southern Africa, HIV is the killer number one. In 70% of the cases, the HI virus is transmitted heterosexually. The risk of young women and girls to be infected is twice as high as it is for young men. The ABC* concept tries to reach particularly all these people who are illinformed, who are forced into unwanted and unsafe sexual intercourse, and whose seeking advice at explicit HIV information centres would be considered a disgrace.

By integrating HIV prevention in the range of services provided for at family planning facilities, a comprehensive package can be offered at one institution. Additionally imparted knowledge on infection paths and methods of protection against STIs* as well as voluntary testing and treatment possibilities are 28 times more costefficient than later necessary treatments of HIV. Only consequent condom use guarantees protection against HIV and other STIs. Per annum, more than 330 million people are infected with syphilis, gonorrhea, chlamydia, trichomonads or HPV*. Suffering from these illnesses increases the risk of HIV infection by the ninefold.

In addition to STIs, women also suffer from other diseases of the reproductive organs. If these diseases remain untreated, they can lead to infertility – a catastrophy for women in the Third World where children strongly contribute to a woman's social status.

Apart from human resources, programmes have to provide sufficient supplies of male and female condoms, various tests, gynaecological instruments for examinations and medical supplies such as needles, syringes, gloves, etc. Medication for the treatment of STIs, of diseases of the reproductive tract and of newborns are also urgently necessary.

Other reasons for Supply deficiency[11]

In addition to financial gaps that have to be closed by the international donor community, the insufficient supply with SHRC is also caused by

- political barriers such as tariffs, taxes, and internatio nal registration mechanisms
- external restraints as regards the purchase of cost intensive medication through pharmaceutical com panies and exporting countries, and other trade restrictions
- international laws such as patent rights
- insufficient, ineffective or inadequate logistic systems
- inefficient supply channels and supply chain manage ment
- lacking technical and human resources
- inefficient coordination of the stakeholders
- lacking quality control of the counselling offered

Sufficient supply with SHRC is given[12, 13] if the client

- can make a choice: s/he can make a choice between a vast range of methods based on correct information and without being influenced by the counsellor
- can receive the chosen product: the product is available in time, at a low cost, at the preferred place, in the requested extent and in the desired form
- can use the chosen product: s/he can use the chosen product correctly and to her/his advantage