A REPRODUCTIVE HEALTH INDEX

RIGHTS AND RESULTS
ACKNOWLEDGEMENTS

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INTRODUCTION
The human right to sexual and reproductive health was enshrined at the 1994 International Conference on Population and Development more than 20 years ago. Evidence continues to demonstrate the benefits of investing in reproductive health. Yet, universal access to sexual and reproductive health information, services and supplies is still not a reality. Around the world, we still hear stories like these:

- A young girl in Ghana who cannot even visit a health center unaccompanied by a family member.
- An older woman in Cameroon with 12 children, who wants to end her childbearing in the hopes of making some of her children’s dreams come true.
- A mother of two in Honduras who risks her life as the result of an unsafe abortion.
- A boy in Malawi who searches for information to avoid a sexually transmitted infection because his school does not offer comprehensive sexuality education.

The Reproductive Health Index seeks to quantify the realization of sexual and reproductive health and rights (SRHR). More than any other health area, SRHR faces persistent barriers—lack of high-level leadership and political will, insufficient financial investment, weak health systems, gender inequity and harmful social norms. This Index enables us to understand the concrete steps that countries around the world are (or are not) taking to fulfill citizens’ reproductive rights.

Providing comprehensive, high-quality sexual and reproductive health information and services is neither a simple nor easy undertaking—but the benefits are well worth the effort. Enabling couples to space their children leads to better health outcomes for women and children. Girls with access to contraception can avoid unintended pregnancies, remain in school and take advantage of a variety of opportunities. And healthier families who are able to invest in their children contribute to household, community and state-level development. Overall, contraception continues to be one of the most cost-effective development interventions. Beyond all of these benefits to individuals, families and communities lies the fundamental rationale for investing in SRHR: people have a right to decide if and when to have children.

There are 1.79 billion women of reproductive age around the world, and by 2050 this number is expected to grow to 2.15 billion women. Every one of them deserves to realize this right. Self-determination is an integral part of the human condition. Individuals thrive when they are able to exercise control over their lives, livelihoods and their health. Reproductive self-determination is no different.

The world already knows how to ensure that every individual can make his or her own reproductive decisions. Now is the time to elevate SRHR as a top development priority at the global level and a key national investment at the country level. SRHR must have real commitment, meaningful implementation and wide-reaching accessibility if we ever hope to realize a world in which every girl and boy enjoys a safe, healthy, prosperous life shaped by her and his own choices.
EXECUTIVE SUMMARY
PURPOSE:

Continuing a PAI effort begun in 1995, the Reproductive Health Index is the fifth in a series of reports assessing the status of nations’ sexual and reproductive health and rights (SRHR). While our previous indices frame the issues in terms of sexual and reproductive risk, this iteration deliberately shifts its focus to how to achieve healthy sexual and reproductive health and realize rights.

The aim is to provide an assessment that incorporates a multi-dimensional approach to reproductive health and adds a new perspective to how comprehensive SRHR is defined and measured. The Index and its accompanying report provide a measure of where women in 62 low- and lower-middle-income countries stand in attaining sexual and reproductive health and rights.

A country’s Index score aggregates key dimensions of SRHR into a summary measure of achievement. This summary measure offers a simple and direct way to: understand a larger and more complex set of issues, guide investments, measure progress and spur appropriate action. Accordingly, the Index serves as a catalyst for dialogue and action among policymakers, program designers, program implementers, advocates and donors alike.

The Index provides a snapshot of the status of women’s SRHR in each country and allows stakeholders to see how countries compare to one another. The Index also provides insight on where gaps exist and, consequently, where there are opportunities for targeted attention and investment. Strengths and weaknesses among regions and countries can serve as driving forces of change. A country’s Index score can also serve as a reference point to assess how well government investments, policies and programs are respecting the rights and meeting the needs of women.

It is important to note that while indicators and indices are valuable tools for broad analysis, they cannot measure the full scope of any one issue. A fuller picture of women’s SRHR status requires additional analysis. Accordingly, the chapters of our report provide a more in-depth look at the dimensions of SRHR and provide analysis of information beyond the indicators used to construct the Index.
**METHODOLOGY:**

Based on the 1994 Programme of Action of the International Conference on Population and Development, we define SRHR according to the following four dimensions:

1. Preventing unintended pregnancy;
2. Increasing access to safe abortion and post-abortion care;
3. Helping women safely through pregnancy, childbirth and the postpartum period; and
4. Preventing and treating sexually transmitted infections, including HIV/AIDS.

A fifth dimension, termed the “enabling environment,” captures factors beyond the health system that support sexual and reproductive health and rights.

Rather than measuring the health outcomes corresponding to the dimensions noted above, this Index captures the factors driving the attainment of SRHR. Determinants include access to high-quality, voluntary and affordable health services and supplies; high-quality information; and non-restrictive and non-coercive laws and policies.

To calculate an Index score for each country, 11 indicators representing the dimensions of SRHR were combined into a single measure—the Reproductive Health Index. To view the list of indicators and a full description of how the Index was constructed, please see the report Methodology on page 67.

The Index is scored on a 0 to 100 scale. Therefore, the strongest possible state of SRHR in a country according to the Index would be a score of 100.

**FINDINGS:**

Index scores for the 62 countries included in our study range from 25.5 to 86.5. Though scores vary greatly within that range, the fact that no country received a score of 100 means that there are opportunities to advance the sexual and reproductive health and rights of women in all 62 countries.

- Ninety-three percent of women in Ukraine have their demand for contraception satisfied and 82 percent of women were able to make an informed choice about their contraceptive method as a result of the information they received from their health care providers.
- Ukraine does not place policy restrictions on abortions. This means under Ukraine’s legal framework, women can choose to have an abortion without restriction as to reason.
- A high percentage of women in Ukraine are reported to receive at least four antenatal visits during their pregnancies and almost 99 percent of births are attended by skilled health personnel.
- More than 90 percent of women demonstrate comprehensive knowledge of HIV prevention methods. However, less than half of the women eligible for antiretroviral therapy are receiving treatment.
- Indicators representing an enabling environment were high for women in Ukraine. Most women (more than 90 percent) were not married as children or adolescents and almost 88 percent of married women participate in all household decisions either alone or jointly with their husbands.

**HIGHEST CATEGORY (INDEX SCORES 80 TO 100)**

1 COUNTRY

Ukraine, a lower-middle-income country, is the only nation with an Index score higher than 80. According to World Bank estimates, this Eastern European country’s gross national income (GNI) per capita has risen by $460 from $3,500 in 2012 to $3,960 in 2013. This puts Ukraine’s GNI per capita $165 away from being an upper-middle-income country. Indicators for Ukraine demonstrate that:
Countries in this category are regionally diverse, with Asia, Europe, Latin America and the Caribbean, and Africa all represented. The majority of countries in this category are lower-middle-income countries.

- Data show that an average of 71 percent of women in these countries have their demand for contraception satisfied. However, Ghana and Liberia are outliers, as less than 40 percent of women had their demand satisfied in these countries. An average of nearly 58 percent of women in this category were able to make an informed choice about their contraceptive method as a result of the information they received from their health care providers. However, the ability of women to make an informed choice in Cabo Verde and Mongolia is below 35 percent.
- Abortion is legal under some circumstances in all but one country in this category; in Honduras, abortion is prohibited. In eight of the 16 countries, abortion is permitted without restriction as to reason. Additionally, 11 out of the 16 countries have misoprostol (a drug that can be used to effectively treat certain complications from unsafe abortion) listed on their Essential Medicine Lists.
- The majority of women in these countries report receiving at least four antenatal visits during their pregnancies, except in Rwanda and Kenya, where antenatal coverage is below 50 percent. The majority of births (close to 80 percent) are attended by skilled health personnel, with the exceptions of Kenya and Zambia, where skilled birth attendance is less than 47 percent.
- The percentage of women with an STI or potential STI symptoms who sought advice or treatment from a health professional is less than 64 percent on average. Generally, women in these countries demonstrate a high level of knowledge of HIV prevention, and an average of 71 percent of women eligible for antiretroviral therapy are receiving treatment. However, antiretroviral coverage is notably low in Moldova, Mongolia and Liberia.
- Enabling environment indicators reveal an average of 80 percent of women were not married as children or adolescents and 64 percent of married women participate in all household decisions either alone or jointly with their husbands. Household decision-making is particularly low in the sub-Saharan African nations of Swaziland, Cabo Verde, Ghana and Zambia.

Twenty of the 36 countries in this category are from sub-Saharan Africa. There is a near equal split of low- and lower-middle-income countries in this group.

- An average of 57 percent of women in these countries have their demand for contraception satisfied and an average of 57 percent of women in this category were able to make an informed choice about their contraceptive method as a result of information they received from their health care providers.
- Abortion is legal under some circumstances in 26 countries in this category, two of which allow abortion without restriction as to reason. Abortion is prohibited altogether in ten of the countries in this category. Just over half of the 27 countries in this group have
misoprostol (a drug that can be used to effectively treat certain complications from unsafe abortion) listed on their Essential Medicine Lists.

- Approximately 59 percent of women in these countries report receiving at least four antenatal visits during their pregnancies, and 63 percent of births are attended by skilled health personnel.

- The percentage of women with an STI or potential STI symptoms who sought advice or treatment from a health professional is 54 percent on average. Fifty-seven percent of women in these countries demonstrate a high level of knowledge of HIV prevention, and less than half of women eligible for antiretroviral therapy are receiving treatment. Antiretroviral coverage is as low as one percent in Madagascar.

- Enabling environment indicators reveal that 70 percent of women were not married as children or adolescents, and only 46 percent of married women participate in all household decisions either alone or jointly with their husbands. Household decision-making is particularly low in the sub-Saharan African nations of Malawi, Cameroon, Burkina Faso and Senegal.

### LOW CATEGORY
**(INDEX SCORES 20 TO 39)**
**9 COUNTRIES**

The majority of countries in this category are low-income countries in sub-Saharan Africa. With the exception of a few outliers, indicators for these countries are low on both health and the overall enabling environment.

- An average of only 41 percent of women in these countries have their demand for contraception satisfied, and an average of less than 37 percent of women in this category were able to make an informed choice about their contraceptive method as a result of information they received from their health care providers.

- Abortion is legal under some circumstances in eight countries, but none allow abortion without restriction as to reason. Abortion is prohibited altogether in one country—Mauritania. Only three countries in this group have misoprostol listed on their Essential Medicine Lists.

- Just over a third of women in these countries report receiving at least four antenatal visits during their pregnancies, and less than half of births (41 percent) are attended by skilled health personnel.

- The percentage of women with an STI or potential STI symptoms who sought advice or treatment from a health professional is less than 39 percent on average. Close to 41 percent of women in these countries demonstrate a high level of knowledge of HIV prevention, and less than half of women eligible for antiretroviral therapy are receiving treatment.

- Enabling environment indicators reveal less than half of women were not married as children or adolescents, and only 29 percent of married women participate in all household decisions either alone or jointly with their husbands. Household decision-making is particularly low in the sub-Saharan African nations of Mali and Niger.

### LOWEST CATEGORY
**(INDEX SCORES 0 TO 19)**
**0 COUNTRIES**

Thankfully, no countries had Index scores that fell within the lowest possible range.
RECOMMENDATIONS:

The Index findings demonstrate the need for greater investment in, and targeted attention to, fulfilling the SRHR of women in all countries included in the Index. Accordingly, there is a need to go beyond rhetorical commitment to real action for SRHR. SRHR must be considered an integral component of any health systems strengthening approaches. Women and men, boys and girls face a variety of SRHR needs over the course of their lifetimes. Reproductive health should no longer be a siloed health consideration but rather should be addressed as a foundational aspect of overall health and well-being.

Though gaps in meeting the needs and fulfilling the rights of women may be larger in some countries than others, even those countries with higher scores have room to grow. Our analysis indicates that improving the SRHR of women in these countries depends on three overarching actions:

- **Strengthen political will and financial commitments:** At the national level, family planning and reproductive health programs with high-level political support and sustainable financial resources are more successful. This type of leadership and commitment are critical to ensuring that policies promote meaningful access to contraceptives, resources are made available and reproductive health programs are prioritized.

- **Craft and implement positive policies:** There remains a need to go beyond eliminating policy barriers related to sexual and reproductive health information, services and supplies. Policies need to champion individual reproductive rights, including among historically disadvantaged and marginalized populations. For example, women’s reproductive autonomy should be ensured beyond simply eliminating spousal and parental consent regulations. The reproductive health needs of youth must be openly acknowledged in policies and youth-friendly services need to be prioritized and integrated within existing programs.

- **Provide quality information and services:** Attention is often centered on attracting new contraceptive users to increase contraceptive prevalence rates. However, investing in high-quality information, services and supplies is critical for meeting the needs of current users. Preventing unintended pregnancies depends upon sustaining satisfied contraceptive users, not simply acceptors. This requires greater emphasis on quality information, counseling and overall service delivery that meets the needs of women throughout their reproductive lives.
### Specific Recommendations That Fall Within the Three Categories of Action:

1. **Provide** youth with age-appropriate comprehensive sexuality education in a safe environment.

2. **Provide** access to quality reproductive health information, services and supplies.

3. **Make** childbirth safer by providing adequate antenatal coverage, training and deploying skilled birth attendants to perform deliveries, ensuring facilities can effectively manage complications and provide emergency care, and ensuring women can access quality, life-saving drugs.

4. **Implement** safe and legal abortion services.

5. **Scale-up** antiretroviral therapy and integrate STI and HIV/AIDS programs with other health and development initiatives.

6. **Design** policies and programs that reach all women, including historically disadvantaged and marginalized populations.

7. **Invest** in building the capacity of health systems within countries to ensure effective service delivery.

8. **Strengthen** political will and financial commitments.

9. **Eliminate** child, early and forced marriage.

10. **Bolster** a women’s decision-making power by increasing access to formal education, providing women with opportunities to earn their own income through the formal labor sector and engaging communities to transform harmful social norms.

*For more information about these recommendations, please see our report chapters.*
PREVENTING UNINTENDED PREGNANCY
One of the cornerstones of healthy sexual and reproductive health is the ability to decide if and when to have a child. Despite international affirmations of an individual’s right to determine the number, timing and spacing of their children, millions of people around the world are still not able to realize this right.

Of the 119 million estimated pregnancies in the developing world in 2008, 86 million of these pregnancies were unintended. These unintended pregnancies resulted in 33 million unplanned births and 41 million abortions. These millions of unintended pregnancies also represent a failure to realize the reproductive rights of millions of women around the world.

As a result, more than 200,000 maternal deaths and more than one million newborn deaths are averted. But not all women’s reproductive health needs are being met. Globally, 225 million women have an unmet need for family planning. These are women who want to delay or limit childbearing but are not currently using contraception.

Within all these statistics rests the potential for poor health outcomes, pregnancy complications, maternal morbidity and mortality and newborn mortality. Recent estimates show that satisfying unmet need for contraception could reduce maternal mortality by 29 percent. Healthily spaced pregnancies lead to better health outcomes for mothers, their new babies and their other children. Planned pregnancies also have been associated with healthier behaviors, including seeking antenatal care, breastfeeding and vaccination. Planned and well-spaced pregnancies can only be achieved through access to high-quality contraceptive information, services and supplies. Access to contraception also enables girls to prevent unplanned pregnancies—improving their ability to stay in school. Better-educated girls grow into women poised to pursue economic and employment opportunities.
On the other hand, lack of access to contraceptive information, services and supplies puts lives at risk. Adolescents are particularly vulnerable to obstetric complications and, therefore, face greater health risks from early, unintended pregnancies. Girls aged 15 to 19 are twice as likely to die from obstetric causes as older women. Older women also face risks from unintended pregnancies, particularly when they are not healthily spaced. Women with short intervals between births (less than five months between birth and their next pregnancy) face a risk of maternal death 2.5 times greater than women with longer birth intervals (18–23 months between birth and their next pregnancy).

A CLOSER LOOK

INDICATORS FROM THE INDEX

Though there are a variety of complex and connected elements that contribute to preventing unintended pregnancies, for our Index we selected two indicators to measure this dimension of sexual and reproductive health and rights (SRHR):

- the percent demand satisfied for contraception among currently married women; and
- a composite measure of informed choice.

The first indicator—percent demand satisfied for contraception among currently married women—represents an important indicator around access. While this indicator does not measure the quality of family planning information, services or supplies, it does provide a picture of women’s ability to access contraceptive methods.

The second indicator—informed choice—is a composite of three measures: percent of modern users informed of side effects, percent who were informed about what to do if side effects occur, and percent who were informed of other methods available. This second indicator captures provision of information as an important quality component of reproductive health service delivery.

The two indicators were selected to complement each other by pairing an access measure with a quality-based indicator. In selecting these indicators, we also considered the availability of comparable, high-quality national data. For more information on the selection of all the Index indicators, refer to the Methodology on page 67.

TRENDS AND HIGHLIGHTS

More than 200 million women worldwide continue to have an unmet need for family planning.12

The lack of contraceptive use captured by unmet need may result from a range of factors, including: an inability to access contraceptive services, financial barriers, concerns over side effects, lack of knowledge and cultural or religious objections.13 Among the countries falling in the lowest category on our Index (Guinea, Côte D'Ivoire, Ethiopia, Mali, Pakistan, Mauritania, Niger and Chad), the percentage of married women aged 15–49 with an unmet need for family

*Excludes Bangladesh
Planning ranges from 16 to 31.1 percent. Comparatively, in Swaziland (Index Score: 75.0/100), a top-ranking country, 13 percent of women have an unmet need for family planning. Almost 90 percent of the top-ranking countries on our Index have a demand satisfied of 60 percent of women or higher. Satisfying demand for contraceptive information, services and supplies is tied to a strong, often mature family planning program. Countries seeing relatively rapid gains in contraceptive use—like Malawi, Rwanda and Senegal—can point to high-level political and financial commitments as critical to programmatic strides. (for more on Rwanda, see Rising Star box on page 18).

Countries ranking in the middle and low categories of the Index have more mixed results on the demand satisfied indicator. For example, Bangladesh ranks almost at the bottom of the overall Index, but its percentage demand satisfied for married women is 81.6 percent. Most West African countries fall in the middle or low categories of the Index, and none of these countries, except Guinea-Bissau, break 50 percent of contraceptive demand satisfied. Prior to the Ouagadougou Declaration of 2011, many West African countries lacked political commitment to family planning, which kept it a low priority. Mobilizing government support, including financial resources, will be essential to further progress in the West African region.

*Sierra Leone, Benin, Togo, Nigeria, Burkina Faso, Senegal, Guinea-Bissau, Guinea, Côte d’Ivoire, Mali, Mauritania and Niger.
Trends analysis around quality and choice is limited because of availability of data in these areas. Even our selected informed choice indicator fails to answer several important questions: Are women receiving their method of choice? Is full method mix available? The informed choice indicator only captures the provision of information as a quality consideration around family planning service delivery.

The informed choice indicator has a significant diversity of results that are not tied to a country’s overall performance on the Index. For example, Cabo Verde (Index Score: 73.0/100) and Honduras (Index Score: 68.0/100) score relatively highly on the overall Index but have low scores on the informed choice indicator (Cabo Verde: 31.1; Honduras: 47.5). Such results draw an important distinction: Access does not equal quality. While a substantial portion of women in countries may have their demand for contraception satisfied, this does not necessarily mean accurate and comprehensible contraceptive information is provided at service delivery points. Evidence has shown that many contraceptive users discontinue due to side effects. For example, one study in Nepal (Index Score: 55.6/100) showed that side effects were the most frequently cited reason for discontinuing oral contraceptive pills, IUCDs, injectables and implants. Providing understandable, evidence-based information in conjunction with repeated counseling encounters with well-trained providers can decrease discontinuation.

Attention cannot solely be centered on attracting new contraceptive users to increase contraceptive prevalence rates. Investing in high-quality information, services and supplies is critical for meeting the needs of current users and reducing discontinuation.

Other quality considerations that are essential to respecting and protecting reproductive rights include: ensuring women have a choice among a range of contraceptive methods; providers are well-trained, equipped and supported to provide high-quality services; and policies and guidelines support equitable and non-discriminatory provision of contraceptive information, services and supplies. For example, countries are increasingly embracing task shifting—distribution
of contraceptives by lower-level health workers—as a mechanism for increasing access to a range of contraceptive methods. This approach further promotes contraceptive choice.

The Health Extension Worker program in Ethiopia (Index Score: 39.1/100) has contributed to a doubling of contraceptive use from 13.9 percent of currently married women aged 15–49 in 2005 to 27.3 percent in 2011.17

Despite being a relatively low-ranking country, improving access to contraceptives is an area where Ethiopia has made strides.

Despite the risks of unintended pregnancies, access to affordable, quality contraception remains uneven. Adolescents are particularly vulnerable to obstetric complications and, therefore, face greater health risks from early unintended pregnancies. Even with these dangers, adolescents must often overcome financial, cultural and access barriers to obtain safe, high-quality contraceptive services. For example, in Timor-Leste (Index Score: 46.7/100), less than one percent of married women aged 15-19 were using a modern method of contraception, compared to seven percent and 23.8 percent among women aged 20–24 and 30–34, respectively.18

For more information on youth, see the Youth section on page 55.

**ACTIONS FOR PREVENTING UNINTENDED PREGNANCY**

- **Strengthen political will and financial commitments:** At the national level, family planning programs with high-level political support and sustainable financial resources are more successful. This type of leadership and commitment are critical to ensuring that policies promote meaningful access to contraceptives, resources are made available and reproductive health programs are prioritized.

- **Craft positive policies:** There remains a need to go beyond eliminating policy barriers related to contraceptive information, services and supplies. Policies need to champion individual reproductive rights, including among historically disadvantaged and marginalized populations. For example, women’s reproductive autonomy should be ensured beyond simply eliminating spousal and parental consent regulations. The reproductive
health needs of youth must be openly acknowledged in policies, and youth-friendly services need to be prioritized and integrated within existing programs.

- **Provide quality information and services**: Attention is often centered on attracting new contraceptive users to increase contraceptive prevalence rates. Preventing unintended pregnancies depends upon sustaining satisfied contraceptive users, not simply acceptors. This requires greater emphasis on quality information, counseling and overall service delivery that meets the needs of women throughout their reproductive lives.

- **Expand method mix**: Ensuring the availability of a range of contraceptive methods represents a critical part of offering high-quality contraceptive services. Individuals must be able to access the contraceptive method of their choice. Many countries have been embracing task-shifting, an approach that expands access to contraceptives at the community level, particularly for pills and injectables. In addition to the availability of skilled providers, effective supply chains are critical to ensuring that a range of methods are available at points of service.

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**RISING STAR—RWANDA**

In 2005, the president and prime minister of Rwanda agreed that family planning was an issue that could no longer be ignored. Between 2005 and 2010, Rwanda’s unmet need for family planning declined from 39 percent to 24 percent among married women of reproductive age. During the same time period, the met need for family planning dramatically increased from only 17 percent to 52 percent.

High-level political support for the family planning program included the president, parliamentarians and the National Assembly, as well as local government officials at the district and community levels. Family planning services and commodities are free of charge in Rwanda. In addition to effective leadership and commitment, Rwanda embraced task-shifting and made significant improvements to its supply chain and logistics management systems for contraceptives. The government and its development partners also committed to the need for skilled providers at health facilities to expand method mix. These strategies, along with other interventions, have enabled Rwanda to make tremendous strides in meeting the contraceptive needs of its citizens. As a result, contraceptive prevalence increased four-fold, and the country also experienced impressive declines in infant and maternal mortality.
Endnotes
2 Ibid.
4 Ibid.
5 Ibid.
11 Ibid.
15 Ibid.
20 Ibid.
21 Ibid.
22 Ibid.
INCREASING ACCESS TO SAFE ABORTION AND POST-ABORTION CARE
When women are faced with an unintended or unsafe pregnancy, they should be able to access comprehensive, safe abortion services. Women and couples around the world should have the information and means to decide freely and for themselves whether, when and how many children to have. Every pregnancy should be planned and desired. Unfortunately, not every woman is able to access contraceptive information, services and supplies and many experience contraceptive failures or sexual violence—all of which can lead to unintended pregnancies. Of the estimated 80 million unintended pregnancies each year, over 50 percent of them result in an induced abortion.1 For millions of women in the developing world, there is no access to safe abortion services. Restrictive laws and policies force women around the world to resort to unsafe abortions—decisions that can result in a host of serious complications and even death.

The World Health Organization defines an unsafe abortion as “a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.”2 Unsafe abortions are entirely preventable when women can use contraception to plan pregnancies, have access to safe abortion services and also have the autonomy to make decisions about their reproductive lives.

The vast majority of unintended pregnancies occur because women cannot access quality contraceptive information, services and supplies. Accessibility and availability of contraceptive services reduces reliance on abortion. From 1990 to 2011, increased investment and support for family planning programs contributed to decreased abortion rates across Eastern Europe.3 However, lack of accurate information represents a major barrier to accessing contraception. Lack of information or no access to comprehensive sexuality education puts women and girls at greater risk of unintended pregnancies and unsafe abortion (for more information on adolescents, see the Youth section on page 55).

More than half of the estimated 80 million unintended pregnancies each year result in abortion.4 More than 21 million women worldwide had unsafe abortions in 2008, but women in the developing countries are disproportionately forced to resort to unsafe abortion compared to women in the developed world.5 Almost all unsafe abortions—approximately 98 percent—occur in the developing world.6 Women in the developing world continue to risk death and life-threatening complications in obtaining an abortion. Estimates from 2008 show that abortion-related deaths accounted for 13 percent of all maternal deaths worldwide.7
In addition to the tens of thousands of women who die from unsafe abortion, an estimated five million more women will endure other post-abortion complications.\textsuperscript{8} Between 20–50 percent of women who undergo unsafe abortions end up in a health facility for complications.\textsuperscript{9} These complications include anemia, prolonged weakness, reproductive tract inflammation and secondary infertility.\textsuperscript{10} Comprehensive post-abortion care programs represent a critical piece of the health systems in contexts where abortion continues to be legally restricted and unsafe abortions are the only recourse for women. Post-abortion care refers to a package of services that include: treating complications from unsafe abortions, providing family planning counseling and service delivery to prevent future abortions and provision or referral for any other necessary health service. For post-abortion care programs to effectively prevent, manage and treat potential complications, trained staff must have the necessary supplies and be working under the most recent service delivery guidelines.

Ensuring healthy sexual and reproductive health means enabling individuals to realize their reproductive rights, including access to safe abortion and post-abortion services.

**TRENDS AND HIGHLIGHTS**

Globally, approximately one in ten pregnancies ends in an unsafe abortion.\textsuperscript{11} Since 2003, the global rate of unsafe abortion—14 per 1,000 women aged 15–44—has remained unchanged.\textsuperscript{12}

Rates of unsafe abortion are highest in Africa and Latin America.\textsuperscript{13} However, there are significant regional differences across Africa. Eastern and Middle Africa’s unsafe abortion rate is 36 per 1,000 women aged 15–44, the highest rate for any sub-region in the world.\textsuperscript{14} In Tanzania (Index Score: 50.6/100) for instance, one study showed that among women presenting with abortion complications at a hospital, 46 percent and 60 percent of the procedures were performed by an unskilled provider in rural and urban areas, respectively.\textsuperscript{15}
In settings where access to safe abortion is legally restricted, the percentage of unsafe procedures increases. Eight of the top nine countries in our Index—Ukraine, Vietnam, Armenia, Moldova, Cabo Verde, Kyrgyzstan, Cambodia, Guyana—all allow abortion without restriction as to reason. Among countries ranked in the high category on the Index, 75 percent of countries allow abortion without restriction as to reason, for socioeconomic reasons or to preserve the woman’s mental health. Comparatively, only two countries ranked in the middle of the Index allow abortion without restriction and 10 countries prohibit abortion altogether. Looking at policy restrictions alone, however, does not provide the full picture, particularly with regard to implementation. For example, in Cambodia (Index Score: 69.5/100), a 2005 survey of health facilities found that 40 percent of health staff in hospitals still believed that abortion was illegal; these misconceptions persisted despite the fact the law was changed in 1997.16

The nine countries that fall at the bottom of the Index rankings have much stricter policies that limit the circumstances under which abortion can be performed. Ethiopia, Guinea, Pakistan, Niger and Chad allow abortion to preserve a woman’s physical health; Mali only allows abortion to save a woman’s life or in the case of rape or incest; and Côte D’Ivoire and Bangladesh* allow abortion to save a woman’s life. Mauritania entirely prohibits abortion. Even when countries’ formal legal policies allow abortion procedures under certain circumstances, there are frequently difficult documentation requirements that effectively prohibit women’s ability to obtain a safe and legal abortion.

Not surprisingly, unsafe abortions often result in serious and potentially life-threatening complications. For example, in Burkina Faso (Index Score: 45.6/100) there were an estimated 105,000 abortions in 2012, the majority of which were unsafe.17

Estimates show that approximately 43 percent of women in Burkina Faso undergoing an unsafe abortion had serious complications requiring treatment.18

Quality post-abortion care programs can mitigate the likelihood that women will die or have lifelong disabilities resulting from an unsafe abortion. Misoprostol has become an increasingly integral part of maternal health and post-abortion care in recent years. While more than 64 percent of countries on the
Index have misoprostol on their EMLs, only seven countries have actually included post-abortion care indications for misoprostol: Eritrea, Ghana, Honduras, Kenya, Liberia, Nigeria and Zimbabwe. While this does not mean that the use of misoprostol is necessarily prohibited, including a post-abortion care indication on the EML makes it more likely that misoprostol for treating incomplete abortion is included in other important guidelines, like service delivery guidelines.

**Actions for increasing access to safe abortion and post-abortion care**

Access to safe abortion and post-abortion care can be ensured through several key approaches:

**Ensure access to contraceptive information, services and supplies:** Contraceptive accessibility and availability decreases the reliance on unsafe abortion and should be a standard part of any post-abortion care package. Three out of four unsafe abortions could be eliminated if women's needs for family planning were satisfied.

**Remove legal restrictions on abortion:** Women are likely to have an induced abortion when faced with an unintended pregnancy, regardless of the legal status of abortion. Legal restrictions on abortion must be eliminated because they do not prevent abortions; rather, these restriction force women to resort to unsafe abortions. Restrictive laws affect not only access to safe services but also access to accurate and adequate information. Women in these settings are often not provided with complete, accurate and understandable information about their pregnancies and safe abortion services (if allowed under certain circumstances).

**Implement safe and legal abortion services:** Relaxed or eliminating legal restrictions on abortion is only an effective strategy if policy changes are effectively implemented. Liberalizing laws is a first step, but implementation must be supported to ensure improved access to safe abortion services. The implementation of less-restrictive laws needs to be communicated through clear, accessible guidelines to facilities, service providers and beneficiaries. Once abortion laws become less restrictive, there are a range of actions that must be taken to ensure they are implemented and lead to improved access to services. Providers must be properly trained, equipment and medicines.

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**RISING STAR—NEPAL**

In 2002, the Nepali Parliament legalized abortion to allow: abortion for any reason up to 12 weeks of gestation; in the case of rape or incest up to 18 weeks of gestation; up to any stage of gestation if the woman’s life is at risk. Since 2004, safe abortion services have been made available, including medical abortion in limited settings. Between 2005 and 2013, the maternal mortality ratio in Nepal declined from 310 to 190 maternal deaths per 100,000 live births—one of the lowest maternal mortality ratios among developing countries in Asia.

Nepal did not simply legalize abortion but took the necessary steps to ensure that women had meaningful access to safe abortion services. In coordination with partners, the government implemented a program to train providers, including staff nurses and auxiliary nurse midwives, to perform abortions. The program also improved knowledge about legal abortion and its availability in Nepal. One study showed a decline in the severity of abortion-related complications following the legalization of abortion. The steepest decline in abortion complications occurred during the period 2007–2010, during which time the abortion program expanded. Legalizing abortion services remains a first step toward ensuring that women have access to safe reproductive health information and services. Nepal is a clear example of a country that effectively translated a significant abortion policy change into available services.
must be integrated into the health system and efforts must be undertaken to address the stigma surrounding abortion.

**Expand post-abortion care services:** Quality post-abortion care is critical for preventing devastating, often life-long disabilities and deaths due to unsafe abortions. Post-abortion care services require the availability of quality supplies, both misoprostol and manual vacuum aspiration kits, and trained staff to employ these supplies. In order to effectively integrate misoprostol into post-abortion care programs, it needs to be included on national EMLs and to be actually procured and make it to facilities where services are delivered.

Endnotes
2. Ibid.
5. Ibid.
6. Ibid.
13. Ibid.
14. Ibid.
18. Ibid.
30. Ibid.
The ability to have a healthy pregnancy and safe delivery is another essential component of realizing overall sexual and reproductive health and rights (SRHR). Throughout pregnancy, childbirth and the postpartum period, quality reproductive and maternal health care can effectively ensure positive health outcomes for women and their children.

Maternal mortality has fallen significantly over the past two decades. The global maternal mortality ratio (MMR) has dropped from 380 to 210 maternal deaths per 100,000 live births from 1990 to 2013. As of 2013, 19 countries had achieved Millennium Development Goals target 5.A (reduce by three-quarters the maternal mortality ratio): Belarus, Bhutan, Bulgaria, Cabo Verde, Cambodia, Equatorial Guinea, Eritrea, Estonia, Iran, Israel, Lao People’s Democratic Republic, Latvia, Lebanon, Lithuania, Maldives, Nepal, Oman, Poland, Romania, Rwanda, Timor-Leste and Vietnam. Access to contraception allows individuals to plan pregnancies, which contributes to decreased risk of maternal death (and decreased risk of newborn death, preterm birth and low weight birth). Other positive global trends—including lower fertility rates, higher rates of female education and increased gross domestic product (GDP) per capita—have also contributed to the decline in maternal mortality.

Despite this notable progress, an estimated 289,000 women die annually from pregnancy-related causes—nearly all in the developing world. Preventing maternal deaths and disability relies on the availability and accessibility of quality antenatal care and safe delivery. In low-income countries, preventable causes such as hypertension and hemorrhage are still the driving force behind maternal deaths. The risk of dying from preeclampsia and eclampsia is approximately 300 times higher for a woman in a developing country than for a woman in a higher income country.

For every woman who dies of pregnancy-related causes, an estimated 20–30 women experience severe or lifelong morbidity. 
From obstructed fistula to severe anemia, sustained injuries related to pregnancy and childbirth affect more than 20 million women annually. These injuries can have life-long effects on women’s physical, mental and sexual health and impact their social and economic status.

Delays in recognizing complications and seeking care, reaching the appropriate facility and receiving care once at a facility are significant challenges to providing adequate and timely care in the event of an obstetric emergency. Maternal deaths disproportionately affect those with the poorest access to health services. High maternal mortality and morbidity most often result from inadequate care through the preconception, antenatal, delivery and postpartum stages. As such, they often reflect a weak overall health system. Many of the challenges experienced within the broader health system—including staffing, supplies, inadequate financing and poor infrastructure—directly impact the quality of care necessary for women to safely navigate through pregnancy, childbirth and the postpartum period.

Quality maternal health care includes respect for patients. Emerging evidence has shown that abusive treatment of women during childbirth is a pervasive trend experienced at different levels in many countries. Ranging from verbal abuse to physical punishment and coercion, disrespectful and abusive care deters utilization of health services and compromises the rights of women and girls seeking care.

Interventions exist to end preventable maternal deaths, but helping women safely through pregnancy, childbirth and the postpartum period requires sustained investment and commitment. Governments

**A CLOSER LOOK**

**INDICATORS FROM THE INDEX**

Helping women safely through pregnancy, childbirth and the postpartum period requires a series of health approaches and interventions. For our Index, we selected two indicators to measure this dimension of SRHR:

- the percentage of women receiving at least four antenatal care visits; and
- the percentage of births attended by skilled health personnel.

While there are a variety of indicators available that relate to the state of maternal health, these two indicators represent cornerstones of quality maternal health care. Comprehensive antenatal care is critical to identifying potential complications early so that a woman’s pregnancy can be monitored, treatable conditions can be addressed and families can plan to have a skilled attendant for complicated births. In addition, women can also receive micronutrient supplementation, tetanus immunizations, HIV testing and treatment, malaria medication and insecticide-treated bed nets through antenatal care services.

Safe delivery requires well-trained and supported health personnel, including midwives; facilities equipped with supplies and medicines to respond to obstetric complications; and functioning referral systems for complex cases. Ensuring that women can deliver with a skilled attendant contributes to overall decreases in maternal mortality by supporting women through pregnancy, delivery and the postpartum period. It also fills shortages in the health workforce.

In selecting these two indicators, we also considered the availability of comparable, high-quality national data. For more information on the selection of all the Index indicators, refer to the Methodology on page 67.
must support women in being able to access contraceptive services to space births, receive quality antenatal care, deliver in a respectful environment with skilled personnel, access life-saving medicines in case of complications and receive proper postpartum counseling and care. Sustained, long-term improvements in maternal health rely on explicit commitments to women’s health, which are then supported with financial and human resource investments in the health system.

TRENDS AND HIGHLIGHTS
Available and accessible contraceptive options enable women to time and space their pregnancies, which has a significant impact on reducing risk of maternal death. Vietnam (Index Score: 77.2/100) reached the Millennium Development target of a 75 percent reduction in maternal deaths; such tremendous gains in maternal health are associated with the country’s modern contraceptive prevalence rate of 68.5 percent.\textsuperscript{14,15}

Despite the critical nature of antenatal care, globally only 51 percent of women receive at least four antenatal visits during their pregnancies.\textsuperscript{16} In comparison, in the majority of countries (76 percent) scoring in the high or mid-high category on the Index, 60 percent or more of women received at least four antenatal visits. Countries scoring in the low category on the Index, with the exception of Guinea, were all below the global average of 51 percent of women receiving four antenatal visits.

Women who give birth without a skilled attendant equipped to recognize and respond to complications face a greater risk of not receiving life-saving drugs. For example, Chad (Index Score: 25.5/100), the lowest ranked country on the Index, had a MMR of 980 maternal deaths per 100,000 live births in 2013 (a MMR greater than 300 maternal deaths per 100,000 live births is considered high).\textsuperscript{17} Only 16.6 percent of births in Chad are attended by skilled health personnel. Although Chad ranks lowest overall on the Index, it is not the lowest ranking country in terms of this indicator—percentage of births attended by skilled health personnel. In Ethiopia, only 10 percent of births are attended by a skilled birth attendant.
Unlike several other indicators that appear in the Index, percentage of births attended by skilled health personnel does not show a direct association with a high overall Index score. Countries continue to struggle with ensuring that facilities—designated as Basic Emergency Obstetric Care facilities and Comprehensive Emergency Obstetric Care facilities—are actually able to provide the full suite of required services or signal functions. However, in Malawi (Index Score: 50.9/100) one study found 100 percent of its Comprehensive Emergency Obstetric Care facilities were considered fully functional. Availability of functional emergency obstetric care undoubtedly contributed to Malawi’s declines in maternal mortality from 1990 to 2013.

Within well-equipped enabling environments, trained midwives—who are regulated to international standards—can provide 87 percent of essential maternal and newborn health services. Investment in midwives has reaped significant benefits. For example, Indonesia (Index Score: 49.8/100) developed a village midwife program that included pre-service training and deployment of midwives to health facilities and independently at the village level. The greater deployment of midwives in Indonesia, particularly at the facility level, has been associated with increases in facility births and deliveries with a skilled attendant. Similarly Cambodia (Index Score: 69.5/100) has seen tremendous declines in maternal mortality. Increasing training and utilization of midwives has contributed to Cambodia’s success. For more information on Cambodia’s maternal health transformation, see the Rising Star box on page 32.

**ACTIONS FOR HELPING WOMEN SAFELY THROUGH PREGNANCY, CHILDBIRTH AND THE POSTPARTUM PERIOD**

**Provide universal access to contraceptive information, services and supplies:** Women and couples need access to contraceptive information and methods to realize their right to decide if and when to have children. In addition, pregnancies that are healthily spaced (at least two years between last birth and next pregnancy) result in healthier outcomes for women and their children.
Enable access to adequate antenatal coverage: Increased antenatal coverage helps women prevent and manage pregnancy complications. In addition to screening for maternal complications, antenatal visits are an important opportunity to provide integrated services. Lowering service costs to decrease financial limitations and using community-based mobilization efforts to reach women in rural and remote communities have been effective in expanding the reach of maternal health coverage.

Train and deploy skilled birth attendants to perform deliveries: Skilled birth attendants may include nurses, midwives and doctors. When skilled birth attendants receive effective training in skills needed to manage uncomplicated pregnancies and refer complicated deliveries to high levels of care, they save women’s lives. Skilled birth attendants are most effective when supported with proper education, regulation and referral systems.

Ensure facilities can effectively manage complications and provide emergency care: Skilled birth attendants alone reduce neonatal deaths by 20 percent; the addition of basic emergency obstetric care could double that impact.22 Having an effective referral system to a facility that is equipped and able to provide emergency obstetric care is critical to saving women’s lives and preventing maternal morbidity due to delivery-related emergencies.

Invest in the availability and accessibility of quality, life-saving drugs: Use of three inexpensive drugs—oxytocin, misoprostol and magnesium sulfate—can help prevent and treat post-partum hemorrhage and hypertension, two of the leading causes of maternal deaths. Increasing the availability of these essential medicines by: 1) ensuring their inclusion in clinical guidelines and national drug lists; 2) ensuring facilities are adequately stocked to meet demand; and 3) ensuring health professionals are trained and able to refer cases to facilities that administer these critical drugs will continue to decrease the number of maternal deaths.23,24 The availability of quality maternal health supplies also requires a well-functioning supply chain that ensures these drugs remain effective from procurement to patient.
As a region, Asia has made significant strides in health outcomes for women and children. However, there are disparities across countries in the region. In the not-so-distant past, Cambodia had health statistics similar to many countries in sub-Saharan Africa. In 1990, Cambodia’s MMR was 1,200 maternal deaths per 100,000 live births—higher than the ratio in Benin, Burkina Faso, Democratic Republic of Congo and Haiti.25

Starting in the mid-1990s, the Cambodian government and donors began increasing investments in health.26 A commitment to maternal health emerged around 2005, as evidenced by increased training of providers, the introduction of active management of the third stage of labor as standard practice, safe abortion services, and the deployment of midwives to health units.27 In 2005, the Minister of Health expressed support specifically for midwife-based maternal health strategies.28 As of 2010, 71 percent of births in Cambodia were attended by skilled health personnel. According to the World Health Organization, Cambodia is on track in terms of progress in improving maternal health relative to MDG 5.A and the government is focused on a recently developed Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality. This initiative focuses on emergency obstetric care, skilled birth attendance, family planning, safe abortion, removal of financial barriers and maternal death surveillance and response to accelerate further progress on maternal health.29

PREVENTING AND TREATING STIs, INCLUDING HIV/AIDS
Fulfilling a woman’s sexual and reproductive health and rights (SRHR) requires that she have access to high-quality reproductive health information, services and supplies in order to prevent sexually transmitted infections (STIs). If diagnosed with an STI, all women must have access to safe and effective options for treatment. Failure to protect women’s SRHR results in increased vulnerability to STIs.

Each day, more than one million people acquire a non-HIV STI. In addition to the immediate consequences of the infection itself, STIs carry a range of potential negative effects, including increased risk of HIV, pelvic inflammatory disease, cervical cancer, unfavorable pregnancy outcomes and infertility. Infected individuals are also frequently stigmatized. Stigma and discrimination can have harmful social and psychological effects on those infected, leading to a poorer quality of life. Similarly, stigma and discrimination can create barriers to the access of prevention, treatment and support services.

Surveillance of non-HIV STIs is weak compared to that of HIV/AIDS and needs to be enhanced in order to effectively assess, monitor and design appropriate programs. However, the current data available show the number of new cases of curable STIs rose from 448 million in 2005 to 499 million in 2008, despite the existence of simple and cost-effective interventions. The change from 2005 to 2008 reflects an increase in the incidence of gonorrhea by 21 percent, trichomoniasis by 11 percent and chlamydia by four percent. The incidence of syphilis showed no change.

In 2013, an estimated 35 million people were living with HIV, and nearly 1.5 million people died of AIDS-related illnesses worldwide. Sub-Saharan Africa is disproportionately affected by the epidemic, accounting for nearly 71 percent of new infections in 2013. HIV can affect anyone, but socially marginalized individuals are at a higher risk of infection and are thereby considered key populations. Prevalence among injecting drug users, sex workers and men who have sex with men is repeatedly reported as higher than among the general population. Women of reproductive age are particularly at risk, with nearly 1,000 young women...
Many factors influence the prevention and treatment of STIs, including HIV/AIDS. For our Index, we selected three indicators focused on prevention and treatment as measures of this dimension of SRHR. They are:

- percentage of women age 15–49 with knowledge of HIV prevention methods (using condoms and limiting sexual intercourse to one uninfected partner);
- percentage of women with an STI or STI symptoms who sought advice or treatment from a clinic, hospital, private doctor or other health professional; and
- percentage of women receiving antiretroviral therapy among women eligible.

The first (percentage of women age 15–49 with knowledge of HIV prevention methods) was chosen because access to high-quality, reproductive health information, services and supplies is a prerequisite for preventing STIs, including HIV.

The other two (percentage of women with an STI or potential STI symptoms who sought advice or treatment from a clinic, hospital, private doctor or other health professional and antiretroviral coverage among women eligible) are indicative of women’s access to safe, effective high-quality treatment upon diagnosis of an STI or HIV/AIDS.

Given that proper education and counseling can enhance a woman’s ability to identify symptoms and subsequently seek treatment, the STI indicator can also represent access to high-quality information. And both the seeking treatment for an STI and antiretroviral therapy coverage indicator contribute to prevention. Successful STI treatment by a health professional may reduce the likelihood of transmission, particularly for curable STIs, and antiretroviral coverage is recognized for its ability to prevent HIV infections, particularly among pregnant women, young children and key high-risk populations.

In selecting these three indicators, we also considered the availability of comparable, high-quality national data. For more information on the selection of all the Index indicators, refer to the Methodology on page 67.
to seek treatment. Capacity constraints further inhibit access to high-quality, effective services as countries face a lack of properly trained personnel, laboratory capacity, screening for asymptomatic infections and appropriate medicine supplies. Furthermore, aside from HIV, STIs are not viewed as a priority for public health, and, consequently, prevention and treatment programs are often underfunded and lack appropriate resources.

Though challenges persist in the fight against HIV/AIDS, progress is being made at a global scale. Antiretroviral therapy—typically comprised of three or more antiretroviral drugs—is being used successfully to suppress HIV and prohibit its progression.

Globally, the number of new HIV infections has decreased from 3.4 million in 2001 to 2.1 million in 2013, a marked 38 percent decrease.

TRENDS AND HIGHLIGHTS

While women account for about half of all adults living with HIV globally, they account for nearly 60 percent in sub-Saharan Africa. In this region, infection rates among young women are twice that of young men. Knowing how to prevent HIV is vital to reducing the number of new infections.

Overall, among the countries scored on the Index, when asked about effective methods of HIV prevention, approximately 60 percent of women can properly identify: a) limiting sex to one uninfected partner; and b) condom use. Among the top 17 countries in the Index (which make up the high and mid-high categories), the proportion of women with comprehensive knowledge is drastically higher. In these countries, an average of 75 percent of women identified both prevention methods. Over 85 percent of women demonstrate comprehensive knowledge of HIV prevention in Ukraine, Swaziland, and Cabo Verde—countries ranked in the top ten on the Index. Conversely, among countries in the low category of the Index, the proportion of women with comprehensive knowledge of HIV prevention averages 40 percent and is as low as 19.5 percent in Pakistan (Index Score: 36.7/100).

Knowledge of HIV prevention can be bolstered through comprehensive sexuality education for youth. Kenya (Index Score: 62.6/100), where close to 71 percent of women demonstrated comprehensive knowledge of prevention, has worked to increase knowledge through programs such as the Nyeri Youth Health Project (for more information, see page 39).

A woman’s ability to seek advice or treatment from a health professional for an STI or STI-related symptoms differs among countries in the Index. Overall, an average of about 54 percent of women reported seeking advice or treatment from a health professional. However, countries ranked in the high and mid-high categories of the Index have a markedly higher average of approximately 64 percent. In fact, in three of the top six countries on the Index (Swaziland, Cabo Verde and Republic of Moldova) more than 74 percent of women with an STI or STI-related symptoms sought advice or treatment from a health professional. The opposite trend is seen among countries at the bottom of the Index. Among the countries in the low category on the Index, an average of about 39 percent of women reported seeking advice or treatment from a health professional.
Many countries have seen HIV incidence drop by more than 50 percent between 2001 and 2013. Increasing antiretroviral coverage for women can contribute to a decrease in HIV incidence by preventing mother-to-child transmission. In Ghana (Index Score: 64.9/100), the number of new HIV infections has decreased by 43 percent since 2010. Ghana’s impressive reduction in new infections is due in large part to their success in preventing mother-to-child-transmission through expanded antiretroviral therapy coverage for pregnant women living with HIV. The risk of mother-to-child-transmission decreased from 31 percent in 2009 to nine percent in 2012, coinciding with an increase in coverage among pregnant women living with HIV from 32 percent in 2009 to over 90 percent in 2012.

Unfortunately, World Health Organization (WHO) estimates for low- and lower-middle-income countries show that on average, just over half of the HIV-positive women eligible received the antiretroviral therapy treatment they needed in 2012. Antiretroviral therapy coverage among women varies greatly by country, with levels below two percent in Madagascar (Index Score: 421/100) compared to above 95 percent in Cabo Verde (Index Score: 73.0/100) and Guyana (68.9/100).

**ACTIONS FOR PREVENTING AND TREATING STIS, INCLUDING HIV**

**Design programs and policies centered on human rights:** Countries must address the SRHR of all people in a way that is sensitive to and inclusive of key at-risk populations. The non-criminalization of HIV is critical to meeting the needs of key populations and ensuring they have access to prevention tools and treatment.

**Eliminate the stigma of STIs, including HIV/AIDS:** Increasing knowledge and awareness within the health system as well as among the general population via training, education and literacy programs can help reduce stigma and discrimination.

**Provide access to high-quality comprehensive sexuality education:** Increasing access to information through mechanisms like comprehensive sexuality education is a vital pathway to prevention. In addition to being a key component of prevention, education and counseling can advance a woman’s capacity to identify symptoms of STIs and, consequently, improve the likelihood she will pursue care from a qualified health professional.

**Make barrier methods available as an option for those who are sexually active:** High-quality and affordable barrier methods must be consistently available when and where they are needed. To facilitate this, condoms should be promoted and distributed in both clinical and nonclinical outlets with supplemental community-based distribution to reach key populations. Distribution in traditional settings must involve providers who have been trained to respect the unique sexual and reproductive health needs of youth and ensure condoms are available to them.
SEXUALITY EDUCATION: NYERI YOUTH HEALTH PROJECT IN KENYA

When young people are provided with accurate and relevant information, they are better prepared to make choices that improve their health and protect them from STIs, including HIV.

The Nyeri Youth Health Project in Kenya is a strong example of a culturally sensitive, community-based sexual health program designed to decrease risky sexual behaviors and delay the initiation of sex. The project employed young, well-respected parents from the community, known as “atiri,” in accordance with local traditions. The atiri were trained to be “friends of youth” (FOYs) who could guide young people on issues related to sexuality. FOYs were trained using a sexual education curriculum called *Life Planning Skills for Young People in Kenya* that covered things like adolescent development, pregnancy, STIs, HIV, detrimental traditional practices and child rights. The FOYs worked with youth individually and in groups and also engaged adults in the community to foster a positive environment in which the sexual health issues of youth could be addressed. In partnership with local schools, the FOYs educated teachers to enhance their communication with students about sexual health. Local health professionals were also trained on how to provide youth-friendly sexual and reproductive health (SRH) services so that FOYs could refer young people to these trained providers.

Project evaluation results showed numerous favorable outcomes, including delayed initiation of sex, increased condom use, reduced number of sexual partners, increased communication with parents and adults about SRH and an increase in abstinence among previously sexually active youth. This project reinforces existing knowledge about the success and importance of comprehensive sexuality education programs. However, like many other promising programs, it was implemented many years ago. The project ended in 2000. This signals a continued need for countries to invest in long-term programs that can sustain successful interventions like those used in the Nyeri Youth Health Project.

**Invest in female-controlled methods:** In concert with strategies to eliminate gender inequality, investments must be made in the research and design of female-controlled methods of protection, such as microbicides. Microbicides are topical compounds or suppositories that can protect against STIs, including HIV, and in some cases also serve as a contraceptive. The development of a dual-use method like microbicides could empower women to protect themselves without negotiation with their partners.

**Invest in building the capacity of health systems within countries to ensure effective service delivery:** Funding from governments and donors is increasingly channeled to the entire health sector as opposed to particular health projects. This sector-wide approach can leave historically neglected issues like STIs with diminished funding. It is, therefore, essential that country governments prioritize the prevention and treatment of STIs within the health sector’s agenda.

**Scale up antiretroviral therapy:** As a treatment mechanism for HIV, antiretroviral therapy has resulted in drastic reductions in death and suffering, particularly when used in the early...
stages of the virus. In addition to success in treating HIV, antiretroviral drugs have been recognized for their efficacy in preventing transmission. Accordingly, in 2013 WHO expanded its recommendation to include the use of antiretrovirals for prevention, especially in pregnant women, young children and key high-risk populations.\(^2^8\)

Integrate STI and HIV/AIDS programs with other health and development initiatives: Visits to health facilities come with costs to both the individual woman and the health system. Maximizing the benefits of these visits through integration can increase uptake of services and improve program efficiency.\(^2^9\)

Malawi experienced a decline in HIV prevalence from 16.5 percent in 2003 to 10.3 percent in 2013, alongside a 69 percent decrease in the number of new HIV infections. The success of Malawi’s HIV response to date stems largely from the scale-up of antiretroviral therapy coverage in conjunction with other resourceful interventions.\(^3^0\)

In 2011, Malawi’s Ministry of Health (MOH) implemented an innovative strategy called “Option B+” that made all HIV-positive pregnant and breastfeeding women eligible for lifelong antiretroviral therapy.\(^3^1\) In order to effectively implement Option B+, the MOH integrated antiretroviral therapy with maternal and child health services in primary care facilities, trained nurses to prescribe the drugs, and used a single antiretroviral treatment regimen for both non-pregnant and pregnant adults. The simplification of the regimen resulted in increased knowledge and familiarity of treatment among health workers, along with a more efficient procurement process.\(^3^2\)

Malawi has also worked to increase HIV testing and counseling using innovative approaches to reduce the fear and stigma that can be associated with testing. Mobile testing and counseling vans, door-to-door testing and an intensive annual week-long campaign have helped Malawi increase access to HIV testing and counseling services.\(^3^3\)

Other innovative interventions have demonstrated promising results in Malawi. A cash transfer program evaluated by the World Bank offered payments to families of young girls if they stayed in school. Results show a 60 percent decrease in HIV incidence and a 75 decrease in the incidence of herpes simplex virus Type 2 among participants.\(^3^4\)

These strategies are just some of the interventions that enabled Malawi to make remarkable progress in the fight against HIV. As a result, antiretroviral therapy coverage among pregnant women rose from 26 percent in 2010 to 79 percent in 2013 and the number of new HIV infections for Malawi overall dropped by more than 40 percent during the same time period.\(^3^5,3^6\)
Endnotes
7 Ibid.
10 Ibid.
11 Ibid.
16 http://genderstats.org/Browse-by-Indicator?ind=40&sr=34
31 UNAIDS. AIDSinfoOnline Database. UNAIDS, 2014.
ENABLING ENVIRONMENT FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS
Fulfilling the sexual and reproductive health and rights (SRHR) of women depends not only a strong health system, but on an enabling environment that empowers women to make informed decisions about their own health. An enabling environment is one that, through connected and mutually reinforcing factors, fosters and protects a woman’s autonomy and concurrently removes threats to her decision-making power.

An enabling environment eliminates the gaps between men and women, ensuring equal access to social, economic, and political opportunities. In an enabling environment, women are free from violence, have control over their sexual and reproductive health, are awarded equal rights in property ownership and inheritance, and have equal opportunity to be among the political actors shaping institutions and policies. Unfortunately, gender inequality and gender biases are often guided by deeply pervasive social norms, the scope and intensity of which vary both among and within countries. These norms can have a tremendous impact on a woman’s mobility, representation in government and power to make decisions for herself. Harmful social norms can also foster unequal power relationships within households and societies, placing decision-making outside of a woman’s control.

Child marriage is one factor that substantially restricts and undermines autonomy and detracts from an enabling environment. The practice both deprives girls of their right to make significant life decisions and limits their opportunities to engage in areas that otherwise positively impact autonomy, like education and income earning. Child marriage denies girls their ability to choose for themselves when and whom they marry along with when and how many children they have. Once married, girls are often expected to become pregnant quickly and are likely to feel unable to refuse sex—another fundamental loss of autonomy. Furthermore, adolescent wives are more vulnerable to violence and are prone to diminished educational opportunities due to early pregnancy. The loss of education is
also a crucial loss for a woman’s autonomy, as educational opportunities provide women and girls with the knowledge and skills they need to make informed decisions and can help transform gender norms that limit women’s opportunities. Even where gender norms are restrictive, better-educated women are more frequently able to exercise decision-making power.5

Women with more education are poised to engage in paid employment, which in addition to increasing family income and overall productivity, enhances their decision-making power.6 A woman’s ability to earn her own income not only improves her bargaining power within her household but also increases her ability to grow her individual assets. The accumulation of independent assets allows women to cope with unexpected situations, to invest in and grow her income and opportunities for employment and to leave a marriage should she choose to.7 Decision-making power within her household can be indicative not only of the level of control a woman has over her environment but also of existing gender norms. Social norms have an enormous impact on people’s values and behavior, influencing power dynamics within households and society at large. Accordingly, gains made via laws, access to services, education and income can be constrained by pervasive social norms.8

TRENDS AND HIGHLIGHTS
More than 700 million women alive today were married before they turned 18, and about 250 million were married before their 15th birthday. The practice of child marriage reflects gender inequalities and the social norms that sustain discrimination against girls.9

Child marriage is most prevalent in South Asia and sub-Saharan Africa but differs among countries in the Index. Overall, among countries in the Index, an average of about 30 percent of women age 20–24 were married or in union before they turned 18.
However, countries ranked in the high and mid-high categories of the Index have a markedly lower average of approximately 19 percent. In fact, in the top four countries on the Index, less than 10 percent were married before 18. However, the opposite trend is seen among countries at the bottom of the Index. In three of the four countries at the bottom of the Index (Bangladesh, Niger and Chad), an average of about 70 percent of women were married before 18. While the prevalence of child marriage varies among countries, analysis of data from Demographic and Health Surveys reveals a common theme—educational opportunities are diminished among child brides compared to girls who delay marriage until after 18.

Gender disparities are pervasive on a global scale where women represent less than 22 percent of parliamentarians worldwide. In 2013, 128 countries treated men and women differently under the law in at least one instance. The differences ranged from obstacles for women obtaining identification cards to constraints on owning property and obtaining employment. Twenty-eight countries had ten or more differences in the way women were treated under the law compared to men. Gender inequalities and power dynamics are evident not only in society at large but within households as well. Overall, among the countries scored on the Index, an average of approximately 49 percent of women participate in all surveyed household decisions, either alone or jointly with their husbands. Among the

**Highest Level of Education Attended by Women Age 20-24: Comparing Those Who Were Married by 18 to Those Who Were Not**

- **Ukraine**: Over 70 percent of non-child brides in Ukraine attended school beyond the secondary level, compared to only 38 percent of child brides.
- **Vietnam**: In Vietnam, over 80 percent of non-child brides attended secondary school or higher, compared to only 46 percent of child brides.
- **Niger**: In Niger, almost 96 percent of child brides had no education or did not attend school beyond the primary level, compared to almost 69 percent of non-child brides.
- **Chad**: In Chad, about 95 percent of child brides had no education or did not attend school beyond the primary level, compared to about 78 percent of non-child brides.

top 17 countries in the Index (which make up the high and mid-high categories), the proportion of women who participate in all decisions is drastically higher, with an average of 65 percent. More than 80 percent of women participate in all household decisions in Ukraine, Armenia, Republic of Moldova, Cambodia and Guyana—countries ranked in the top ten on the Index. Conversely, among countries in the low category of the Index, the proportion of women with household decision-making power averages at approximately 29 percent, and is as low as nine percent in Mali (Index Score: 39.1/100). Analysis of data from Demographic and Health Surveys shows household decision-making power is bolstered among women who earn their own cash income.

**ACTIONS FOR FOSTERING AN ENABLING ENVIRONMENT**

**Eliminate child, early and forced marriage:** Policymakers must, at a minimum, pass and enforce legislation that establishes 18 as the legal minimum age of marriage. However, while policies are an important first step, they alone are not sufficient. Strong policies will only be effective at protecting young girls if they are fully implemented and enforced. In addition to legislation on the minimum age of
marriage, policy and program interventions should be designed to empower girls and confront the drivers of early marriage. Programs in the poverty, education and sexual and reproductive health sectors should be coordinated to maximize their effectiveness.11

**Increase access to formal education:**
Education should be provided free of charge to safeguard against financial barriers to access. Education should also be compulsory to increase the likelihood girls will stay in school. Curricula should be developed that are relevant and inclusive of girls and the safety of schools strengthened so that girls feel protected. It is essential that schools do not exclude girls who are married and/or pregnant. Accordingly, alternative or non-formal education programs should be available to accommodate a girl’s unique circumstance.12

**Provide women with the opportunity to earn their own income through participation in the formal labor sector:**
Policies aimed at job creation must also address barriers that prevent women from accessing paid employment, including lack of training, responsibilities as caretakers for their children, access to credit and gender-biased perceptions about women’s abilities.13

**Engage communities to transform harmful social norms that hinder a woman’s autonomy:** Information sharing that highlights alternatives to current practices can be an effective way of transforming longstanding norms. Initiatives that encourage collective action and coordinated efforts can help maximize impact.14 To that end, it is essential to involve men, boys, elders and community members in order to change social norms that sustain harmful practices. Those with the power and authority to support change can serve as effective champions for women and girls.15
India, one of the world’s most populous countries, has seen drastic reductions in fertility in many of its states. However, an area collectively known as BIMARU, which houses over 40 percent of the country’s population, has not experienced the same change. India’s progress in reproductive health, even in states with lower fertility, is threatened by the unequal utilization of family planning and reproductive health services along with early childbearing linked to child marriage.

To address these challenges, Pathfinder International implemented the PRACHAR program, which in Hindi means “to let people know” or “to disseminate.” Designed to improve the sexual and reproductive health of adolescents and young couples, the project engaged all members of the community to shift norms around early marriage, childbearing and barriers to sexual and reproductive health services for young people. The intervention employed reproductive health trainings for youth, contraceptive counseling home visits for young couples, group meetings with male change agents and home visits with parents and pregnant females.

Pathfinder’s program evaluation found that current use of contraception among young married couples increased from four percent to 21 percent; age at first marriage increased by 2.6 years to age 22; and age at first birth was delayed by 1.5 years to age 23.1.

Building on its success to date, the program is currently in its third implementation phase, where it is being scaled-up to the largest district in the state of Bihar. In this phase, Pathfinder International is working with the Bihar government to incorporate PRACHAR’s successful interventions into the state’s health care system. Through this partnership, government health workers will begin integrating PRACHAR’s approaches into their daily activities. This critical government support is expected to increase the program’s reach and impact.

PRACHAR provides an example of a promising program aimed at targeting some of the key factors that contribute to an enabling environment. The program uses some of the fundamental strategies discussed in this chapter, including information sharing with young women and men, young couples, parents and influential community members to transform social norms and increase the uptake of reproductive health services.

Though this program is a powerful example, it alone cannot guarantee an enabling environment for all women and girls in India. Countries must employ a comprehensive, long-term approach that addresses all the components of an enabling environment, including formal education and economic opportunity.
Endnotes
8 Ibid.
12 Ibid.
IN FOCUS: EQUITY
Despite decades of progress in expanding sexual and reproductive health (SRH) information, services and supplies, certain groups consistently face health inequalities. Poor, less-educated, young, rural and marginalized groups have historically been systematically deprived of SRH services or neglected. In more recent history, these groups are often not prioritized within national-level policies and programs. Governments must be held accountable for allowing health inequalities to persist and their consequences—poorer SRH outcomes for vulnerable, underserved and disadvantaged groups.

This Index provides a snapshot of how countries are doing overall to realize the sexual and reproductive health and rights of their citizens. However, this type of aggregate analysis fails to capture a variety of health inequities that exist within countries. A confluence of socioeconomic, social and geographic factors affects a given individual’s sexual and reproductive health. Data needs to be collected at the national and subnational levels so that it can be disaggregated to understand what is happening among various subgroups: urban and rural, rich and poor, young and old. There must be a commitment to ensuring underserved, disadvantaged and historically neglected groups have access to sexual and reproductive health information, services and supplies.

This insert discusses several key sources of inequity that if addressed could vastly improve SRH: socioeconomic status, geography and marginalization of certain populations. In reality, each type of inequity identified here is represented across our four dimensions of sexual and reproductive health and rights (SRHR). In this section, the inequities discussed are only explored in relation to one dimension of SRHR.

**SOCIOECONOMIC STATUS**

Policies and programs must ensure that SRH information, services and supplies are accessible to and meeting the needs of the most socioeconomically disadvantaged. Evidence consistently shows that poorer, less educated women are less likely to be using contraceptives, even when they want to avoid a pregnancy.

Among women in the poorest wealth quintile within developing country households, approximately one-third have an unmet need for family planning.

For example, Zimbabwe (Index Score: 68.1/100) has a relatively high overall contraceptive prevalence rate but there are disparities across wealth quintiles. Only 52.4 percent of women in the lowest wealth
quintile use a modern contraceptive method compared to 63.6 percent of women in the highest wealth quintile. Women in the lowest wealth quintile also rely more heavily on less effective, traditional methods compared to women in higher wealth quintiles.

A UNFPA report looking at 24 sub-Saharan African countries demonstrated that education is also associated with contraceptive use: 42 percent of women with a secondary school education were using a contraceptive method compared to 24 percent women with a primary school education and 10 percent of women with no education.1

**GEOGRAPHY**

Where you live in the world has a tremendous impact on your education, economic opportunities, individual agency and health. The same is true within countries.

Rural populations have consistently faced obstacles to accessing health services, including reproductive health information, services and supplies.

Additionally, as the developing world becomes increasingly urban, residents of urban slums are facing similar challenges to their rural counterparts. For example, physical barriers limit rural women’s ability to access quality maternal health care; as a result, rural women are less likely to deliver with a skilled birth attendant. In urban settings, slum dwellers face similar challenges as public services, including health facilities, are rarely located close to slums. For example, in Kenya (Index Score: 62.6/100) the maternal mortality rate in urban slums—706 maternal deaths per 100,000 live births—was almost double the national average of 488 maternal deaths per 100,000 live births.2

**MARGINALIZED GROUPS**

Sexual and reproductive health programs must meet the needs of diversifying populations. As a result, policies and programs must prioritize and ensure access to historically underserved and disadvantaged groups, including ethnic minorities, the urban poor and marginalized groups like sex workers. Though Vietnam ranks highly on our Index (Index Score: 77.2/100), the country faces disparities in maternal health care. According to one study, rural women in Vietnam have made gains in skilled attendance at birth and antenatal visits. However, these gains were greatest among wealthier rural women belonging to the primary ethnic group, Kinh/Hoa.3 Poor women belonging to an ethnic minority remained much more likely to deliver at home and did not have significant gains in antenatal visits.4

Our Index is a national summary measure, and as such it inherently fails to capture disparities within any given country. Data needs to be collected at the national and subnational levels so that it can be disaggregated to understand what is happening among various subgroups: urban and rural, rich and poor, young and old. There must be a commitment to ensuring underserved, disadvantaged and historically neglected groups have access to SRH information, services and supplies.
Endnotes
4  Ibid.
IN FOCUS: YOUTH
Currently there are 1.8 billion youth between the ages of 10–24 in the world and 89 percent of them live in developing countries.¹ That’s 1.8 billion people who have their entire lives ahead of them to become doctors, start businesses, run for political office and achieve life goals and aspirations. One of the ways to ensure they can achieve their goals is to guarantee they have control over their sexual and reproductive health.

Unfortunately, stigma continues to impede investments in, provision of, and access to sexual and reproductive health services for young people, even though up to 59 percent of girls are sexually active by the age of 18.² As a result, youth often face greater barriers accessing and utilizing sexual and reproductive health services, which hampers their ability to plan for their futures.³

Adolescents are adversely affected by some of the most pressing issues in global health, including early marriage, unintended pregnancy, unsafe abortion and HIV. However, when girls stay in school they delay sexual initiation, marry later, have greater autonomy and are less likely to become pregnant as an adolescent.⁴ Investment in girls’ education and increasing acceptance of and access to youth sexual and reproductive health services will help decrease negative health outcomes and ensure youth everywhere are able to enjoy healthy sexual and reproductive lives.

UNINTENDED PREGNANCY AND EARLY MARRIAGE

Without access to contraception, youth often suffer from unintended pregnancies, whether in or out of marriage. Sixteen million girls aged 15–19 and two million girls under age 15 give birth each year. These pregnancies are often unintended, unwanted, coerced or mistimed.⁵ More than 14 million girls worldwide are married before their 18th birthday, putting them at additional risk for early pregnancy.⁶

When facing a lack of support or resources for an unintended pregnancy, a young person may either seek out abortion services that are often unsafe or carry the pregnancy to term and face health risks associated with early pregnancy (girls aged 15 to 19 are twice as likely to die from obstetric causes as older women.)⁷ In addition to health risks, early pregnancies and marriages often mean a young girl is no longer enrolled in school or working on her own, limiting her autonomy.

UNSAFE ABORTION AND CHILDBIRTH

Maternal mortality remains the second leading cause of death among women aged 15–19.⁸ One of the leading contributors to high maternal mortality among adolescents
is unsafe abortion. Abortion is not legal in most developing countries, and even when it is available, youth are often prohibited from accessing these services. When girls obtain unsafe abortions, they are at risk for severe health consequences due to inadequate care, dirty instruments and lack of knowledge by those administering the procedure.

Almost 14 percent of all unsafe abortions occur in women under age 20, a number that is most likely underreported due to the stigma attached to abortion. Unsafe abortion complications can not only cause death but may also result in infertility. In cultures where a woman’s worth is dependent on childbearing, an infertile young woman may be shunned or cast out of her house.

Young girls are at increased risk for maternal morbidity when giving birth even with a desired pregnancy, and infants born to mothers under 20 are more susceptible to low birth weight, infant mortality and stunting.

HIV

While new HIV infections have fallen by 38 percent since 2001, 40 percent of new HIV infections are among young people aged 15–24. Young women remain disproportionately affected by HIV and are 50 percent more likely to acquire HIV than young men.

Access to testing and treatment is vital for young women so they can live the healthiest life possible and take steps to prevent mother-to-child transmission in current or future pregnancies.

One of the protective factors against the issues discussed is access to education, especially girl’s education. When girls stay in school, they delay sexual initiation, marry later, have greater autonomy and are less likely to become pregnant as an adolescent. Investment in girls’ education and increasing acceptance of, and access to, youth sexual and reproductive health services will help decrease negative health outcomes and ensure youth everywhere are able to enjoy healthy sexual and reproductive lives.
Endnotes

10 Ibid.
IN FOCUS: HUMANITARIAN SETTINGS
Conflict and other humanitarian crises can devastate basic public services, including the health system. In 2013, 81 million people around the world were in need of humanitarian assistance as a result of natural disasters, conflict or other emergencies; half of these individuals were women and girls.1

Of the 62 countries that appear in our Index, 20 countries are considered fragile situations by the World Bank.2 The vast majority of these countries fall squarely in the middle or lower half of the Index.

Too often, sexual and reproductive health is treated as an afterthought during crisis situations and humanitarian settings. Evidence shows that during emergencies, the need for reproductive health information and services rises, but the ability to access critical reproductive health care services declines.

People in humanitarian settings continue to have sexual and reproductive health needs and face increased threats to their reproductive health.3

Despite the existence of international standards for reproductive health care in emergency settings, such as the Minimum Initial Service Package (MISP) for Reproductive Health, these services are often neglected from the start of emergencies, and funding for these programs is often inadequate. Ensuring urgent and effective responses in humanitarian crises requires recognition and commitment to the life-saving nature of sexual and reproductive health information and services. While each country’s circumstances are unique, it is critical to recognize the life-saving and resilience-building nature of sexual and reproductive health information, services and supplies.

Emergency services, basic medical care, sanitation and safe housing are irrefutably priority concerns that must be addressed. Ensuring individuals’ sexual and reproductive health and rights cannot fall by the wayside, even in a crisis. These services should be prioritized in order to: prevent unintended pregnancies, reduce maternal morbidity and mortality, deliver access to safe abortion where legal, prevent sexual violence and reduce the transmission of HIV.

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UNINTENDED PREGNANCY

In humanitarian settings, women still have a need to decide the timing of their pregnancies—exercising this right will make them more resilient. Despite this clear need for contraceptive services, crises-affected countries have some of the highest rates of unmet need for family planning. For example, the unmet need for family planning has actually increased in Chad over time from 17.4 percent of married women in 1997 to 28.3 percent in 2010.4

MATERNAL HEALTH

In addition to supporting resiliency, contraceptive access can save women and girls’ lives by enabling them to prevent an unintended pregnancy in a high-risk situation. Without access to skilled birth attendants, clean and safe health facilities and necessary supplies, giving birth in a humanitarian setting poses tremendous risks. Not surprisingly, maternal mortality ratios are high, with some countries like Chad still approaching extremely high maternal mortality (≥1,000 maternal deaths per 100,000 live births).

ACCESS TO SAFE ABORTION

Humanitarian settings and related conflicts are often characterized by violence against women. As a result, women’s need for a range of contraceptive methods including emergency contraception and safe abortion services cannot be ignored. Women should be able to access safe abortion under any circumstance. However, many countries continue to place strict limitations on abortion. Of the 138 countries around the world that place restrictions on access to abortion, 41 of these countries allow exceptions in the case of rape, including Mali, Liberia, Togo and Zimbabwe.5 Victims of rape must be able to access safe abortion services; medical abortion presents a safe option even in humanitarian settings.

SEXUALLY TRANSMITTED INFECTIONS, INCLUDING HIV

Disease transmission is a serious concern, but sexual and reproductive health (SRH) interventions in humanitarian settings need to go beyond provision of condoms. Recognizing that conditions are even more difficult and there are competing concerns in a crisis situation, the sexual and reproductive health and rights (SRHR) needs of individuals continue to demand greater attention. Individuals need access to a wide range of SRH information and services, including contraceptive access, safe delivery and safe abortion.

Unlike most development scenarios, humanitarian crises can happen unexpectedly and are continuously changing. Ensuring urgent and effective responses in these scenarios requires recognition and commitment to the life-saving nature of SRH information and services. SRHR needs do not stop in a crisis; rather, the risk of adverse outcomes is actually amplified. Sexual and reproductive health must be considered an integral piece of health care in humanitarian settings and prioritized accordingly.
Endnotes
4. UN Development Programme.
ANNEX 1
COUNTRY INDICATORS AND INDEX SCORES
### Rights and Results

**RHI Score Range:**

- **80-100 = Highest**
- **60 - 80 = Mid-High**
- **40 - 60 = Middle**
- **20 - 40 = Low**
- **0-20 = Lowest**

| Rank | Country                  | % Demand Satisfied for Contraception | % Informed Choice | % Grounds on which Abortion is Permitted | % Status of Misoprostol on Essential Medicine Lists | % of Live Births for Which Woman Have Antenatal Care Coverage at Least Four Visits | % of Births Attended by Skilled Health Personnel | % Women with Knowledge of 2 HIV Prevention Methods - Using Condoms and Limiting Sexual Intercourse to One Uninfected Partner | % Women with an STI or STI Symptoms Who Sought Advice or Treatment from a Health Professional | Status of Misoprostol for Postabortion Care (PAC) | % of Women Age 20-24 Who were NOT Married Before Age 18 | % of Currently Married Women Who Participate in All Surveyed Household Decisions | RHI Score  
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**GROUNDS ON WHICH ABORTION IS PERMITTED**

- **Without restriction as to reason** (IV) 100
- **Socioeconomic grounds (also to save the woman's life and health)** (III) 90
- **To preserve mental health (also to save the woman's life)** (II - MH) 60
- **To preserve physical health (also to save the woman's life)** (II) 30
- **In case of rape or incest (also to save the woman's life)** (I - R/I) 20
- **To save the woman's life** (I - SWL) 10
- **Prohibited** (I) 0

**STATUS OF MISOPROSTOL FOR POSTABORTION CARE (PAC)**

- **Listed on EML with PAC indication specified** 100
- **Listed on EML for non-PAC uses (e.g. postpartum hemorrhage or other uses only) or no indication specified** 40
- **Not listed on EML** 0
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<th>% of women with knowledge of 2 HIV prevention methods - using condoms and limiting sexual intercourse to one uninfected partner</th>
<th>% of women receiving antiretroviral therapy among women eligible</th>
<th>% of women age 20-24 who were NOT married before age 18</th>
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ANNEX 2
REPRODUCTIVE HEALTH INDEX 2015
CONCEPTUAL FRAMEWORK, DATA SOURCES AND METHODOLOGY

GEOGRAPHIC COVERAGE

The study ranks 62 low-income and lower-middle-income countries* from highest to lowest attainment of sexual and reproductive health and rights (SRHR). The Index is comprised of nine indicators capturing the drivers/determinants of women’s reproductive health and rights status, as well as two rights-based indicators indicative of an enabling environment.

Data collected prior to 2004 has been excluded from the Index. Twenty countries with four or more missing data points/indicators were not included in this study.

CONCEPTUAL FRAMEWORK

The study’s conceptual framework is based on the 1994 Programme of Action (POA) of the International Conference on Population and Development (ICPD). The POA provides a comprehensive and internationally recognized conceptualization of reproductive health and rights. Stemming from the POA, this study defines SRHR according to the following four dimensions:

- Preventing unintended pregnancy;
- Increasing access to safe abortion and post-abortion care;
- Helping women safely through pregnancy, childbirth and the postpartum period; and
- Preventing and treating sexually transmitted infections, including HIV/AIDS.

Rather than measuring the health outcomes corresponding to the four dimensions noted above, this Index captures the factors driving the attainment of SRHR. Determinants include access to high-quality, voluntary and affordable health services and supplies; access to high-quality information; and non-restrictive/non-coercive legal and policy frameworks. As a result, this Index encapsulates the key dimensions of reproductive rights—including the right to reproductive self-determination; the right to sexual and reproductive health services, information and education; and the right to equality and non-discrimination. Importantly, this study also considers determinants of SRHR beyond the health system, termed the “enabling environment,” which serves as the fifth dimension of the Index.

CONSTRUCTION OF INDEX

Building on the conceptual framework, indicators were chosen based on: 1) their applicability to the drivers of the four dimensions of SRHR defined above and enabling environment; 2) their representativeness of at least one of three dimensions of reproductive rights; and 3) the availability of comparable and high-quality national data.

“Reproductive health is the 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 health system and to its functions and processes. Reproductive health therefore implies that all people are able to have a satisfying and safe sex life and that they have the capability to reproduce and 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.”


* Country classifications are based on those established by the World Bank.

** These countries are: Afghanistan, Central African Republic, Democratic People’s Republic of Korea, Djibouti, El Salvador, Gambia, Georgia, Guatemala, Micronesia (Federated States of), Myanmar, Nicaragua, Papua New Guinea, Paraguay, Samoa, Somalia, South Sudan, Sudan, Syrian Arab Republic, Uzbekistan and Yemen.
The Index is composed of the following 11 indicators:

<table>
<thead>
<tr>
<th>DIMENSION</th>
<th>INDICATOR</th>
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</table>
| PREVENTING UNINTENDED PREGNANCY                | 1. Percent demand satisfied for contraception among currently married women*  
|                                                | 2. Informed choice†                                                       |
| INCREASING ACCESS TO SAFE ABORTION AND POST-ABORTION CARE | 3. Grounds on which abortion is permitted (legal status)  
|                                                | 4. Status of misoprostol for postabortion care (registered on Essential Medicine Lists) |
| HELPING WOMEN SAFELY THROUGH PREGNANCY, CHILDBIRTH AND POSTPARTUM | 5. The percentage of live births for which woman have antenatal care coverage (at least four visits)  
|                                                | 6. Percentage of births attended by skilled health personnel               |
| PREVENTING AND TREATING STIs, INCLUDING HIV/AIDS | 7. Percentage of women with an STI or STI symptoms who sought advice or treatment from a clinic, hospital, private doctor, or other health professional  
|                                                | 8. Percentage of women age 15–49 with knowledge of HIV prevention methods (using condoms and limiting sexual intercourse to one uninfected partner)  
|                                                | 9. Percentage of women receiving antiretroviral therapy among women eligible |
| ENABLING ENVIRONMENT                           | 10. Percentage of women age 20–24 years old who were not married or in union before they were 18‡  
|                                                | 11. Percentage of currently married women age 15–49 who participate in all surveyed household decisions (either by themselves or jointly with their husband) |

* The indicator **percent demand satisfied among currently married women** was computed as follows: **100*(contraceptive prevalence married women/(contraceptive prevalence married women + unmet need for FP married women)).**

† The indicator **informed choice** was calculated as the average of three measures: percent modern users informed of side effects, percent who were informed about what to do if side effects occur and percent who were informed of other methods available.

‡ Because a higher Index score represents a more positive status for women, this indicator was calculated by subtracting the prevalence of child marriage from 100 to reflect the percentage of women who were **not** married or in union before age 18.
Nine quantitative indicators composing the Index are scored on a 100-point scale of 0 to 100. Of the two ordinal/categorical indicators, scores were assigned as follows:

<table>
<thead>
<tr>
<th>DIMENSION</th>
<th>INDICATOR</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>STATUS OF MISOPROSTOL FOR POST-ABORTION CARE (PAC)</td>
<td>Listed on EML with PAC indication specified</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Listed on EML for non-PAC uses (e.g. postpartum hemorrhage or other uses only) or no indication specified</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Not listed on EML</td>
<td>0</td>
</tr>
<tr>
<td>GROUNDS ON WHICH ABORTION IS PERMITTED</td>
<td>Without restriction as to reason</td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td>Socioeconomic grounds <em>(also to save woman’s life and health)</em></td>
<td>III</td>
</tr>
<tr>
<td></td>
<td>To preserve mental health <em>(also to save the woman’s life)</em></td>
<td>II – MH</td>
</tr>
<tr>
<td></td>
<td>To preserve physical health <em>(also to save the woman’s life)</em></td>
<td>II</td>
</tr>
<tr>
<td></td>
<td>In case of rape or incest <em>(also to save the woman’s life)</em></td>
<td>I – R/I</td>
</tr>
<tr>
<td></td>
<td>To save the woman’s life</td>
<td>I – SWL</td>
</tr>
<tr>
<td></td>
<td>Prohibited</td>
<td>I</td>
</tr>
</tbody>
</table>

For the construction of the Index, equal weight is given to all 11 indicators. The final composite score, which is the overall country score, is derived by dividing the sum of the indicators by 11. For 24 countries with three or less missing data points, the final composite score was generated by adjusting the denominator to reflect the total number of data points available. As modeled by the Index, the strongest possible state of SRHR in a country would be a score of 100.

The results of our study show the calculated composite Index scores for the 62 countries range from 25.5 to 86.5. Based on their Index scores, countries are ranked and classified. For comparison to one another, countries are ranked from highest to lowest sexual and reproductive health and rights. To compare a country’s calculated score to the strongest possible state of SRHR, countries are classified as follows: the possible index range of 0 to 100 is divided into quintiles and countries are then grouped based on which quintile their calculated Index score falls:

<table>
<thead>
<tr>
<th>INDEX RANGE</th>
<th>QUINTILE</th>
<th>NUMBER OF COUNTRIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>80 TO 100</td>
<td>HIGH</td>
<td>1</td>
</tr>
<tr>
<td>60 TO 79</td>
<td>MID-HIGH</td>
<td>16</td>
</tr>
<tr>
<td>40 TO 59</td>
<td>MIDDLE</td>
<td>36</td>
</tr>
<tr>
<td>20 TO 39</td>
<td>LOW</td>
<td>9</td>
</tr>
<tr>
<td>0 TO 19</td>
<td>LOWEST</td>
<td>0</td>
</tr>
</tbody>
</table>
### DATA SOURCES

Data were collected and updated until March 1, 2015.

<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>SOURCE(S):</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Antenatal care coverage (at least four visits)</td>
<td>World Health Organization (WHO) Global Health Observatory Data Repository.</td>
</tr>
<tr>
<td>(using condoms and limiting sexual intercourse to one uninfected partner)</td>
<td></td>
</tr>
<tr>
<td>11. Percent women 20–24 years old who were first married or in union before they were 18</td>
<td>United Nations Children’s Fund (UNICEF). 2014. Global Database. New York: UNICEF.</td>
</tr>
</tbody>
</table>

National surveys were also used to supplement the above sources.
DATA LIMITATIONS AND QUALITY

A number of issues related to data quality and availability surfaced throughout the course of the study. National statistics on women’s health are often of poor quality, lacking or outdated, especially where vital registration systems are not well developed. Definitions vary from one country to another and can often vary within countries.

The national-level statistics used in this analysis, while they elucidate the differentials between poor and rich countries, mask differentials in reproductive health within countries. For example, data are often inadequately differentiated by gender, age group, place of residence or socioeconomic status. Also, statistics on coverage of health services do not reflect the quality of available care.

Much of the data collected are from Demographic and Health Surveys (DHS) or similar sources that are only updated every three to four years or in some cases, longer. Consequently, a country may be making significant improvements in SRHR that won’t be reflected in their Index score for several years.

No matter how an index is constructed and how many indicators it has, it will always entail a large degree of generalization and estimation. This is true firstly because indicator selection is largely restricted by data availability and quality. Furthermore, while indicators are valuable tools for a broad analysis, they cannot measure the full scope of any one issue. For example, misoprostol being listed on a country’s EML can be indicative of the road toward increasing availability of the drug. It does not tell us what is actually being provided on the ground. The same is true around policies regarding abortion—abortion may be legal under certain circumstances but that alone does not tell us whether women know that it’s legal or whether or not doctors are willing to provide the service to women who want it and are entitled to it under the law. Accordingly, a fuller picture of women’s SRHR status requires analysis of additional information, often on smaller scales (e.g., subnational level).
I
A REPRODUCTIVE HEALTH INDEX