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I. Introduction

1. In the post-2015 period, the future development agenda will unfold in the midst of dramatic demographic transformations: a global population of 7.3 billion, projected to reach 8.4 billion by 2030; with the largest ever cohort of young people between the ages of 10 to 24 years old, and of persons over the age of 65; increasing internal and transnational mobility; a rising number of small and one-person households; and an unprecedented scale of urbanization. These dynamic changes in the structure and living arrangements of the human population are coinciding with rising aspirations for human development, aspirations that seek not only health, security and justice for all people everywhere, but also for future generations, requiring that development delivers equality and progresses in harmony with nature.

2. In the Programme of Action of the International Conference on Population and Development, Member States recognized the unassailable link between dignity, human rights and health, population dynamics and sustainable development. The findings and conclusions of the 20-year operational review of the Programme of Action beyond 2014, contained in the report of the Secretary-General on the framework of actions for the follow-up to the Programme of Action (A/69/62), affirmed that these elements cannot be detached from one another.

3. The realization of dignity and human rights depends on reducing inequalities that are broadly recognized as undermining durable economic growth and sustainable development. The commitment of the international community at all levels of international cooperation, in various declarations and instruments, to gender equality and sexual and reproductive health and reproductive rights, is not only an aspiration for dignity, but is also pivotal to creating the enabling conditions for women to define the direction of their lives, expand their capabilities and elaborate their chosen contributions to society.

4. Inequality has special relevance for human mobility, because lack of opportunity may force people to seek decent work elsewhere. Because adolescents and young people, including an increasing proportion of young women, have high rates of migration to pursue education, employment and greater life chances, age structures and economic inequality affect the extent to which countries experience high rates of rural to urban migration and whether they are more likely to be sending or receiving new international migrants. In conditions of political conflict or environmental crisis, inequality and poverty are no less critical, for while all are likely to experience instability, those with the fewest resources will suffer the greatest and most enduring disruptions.

5. The present report highlights population themes that are central to realizing the future we want and to defining a post-

II. Mobility and urbanization

6. The human population is increasingly mobile, and it is characterized by major shifts in physical and social space, including rural and urban location, temporary

example internally displaced persons in the Sudan, or Afghan and Palestinian refugees.

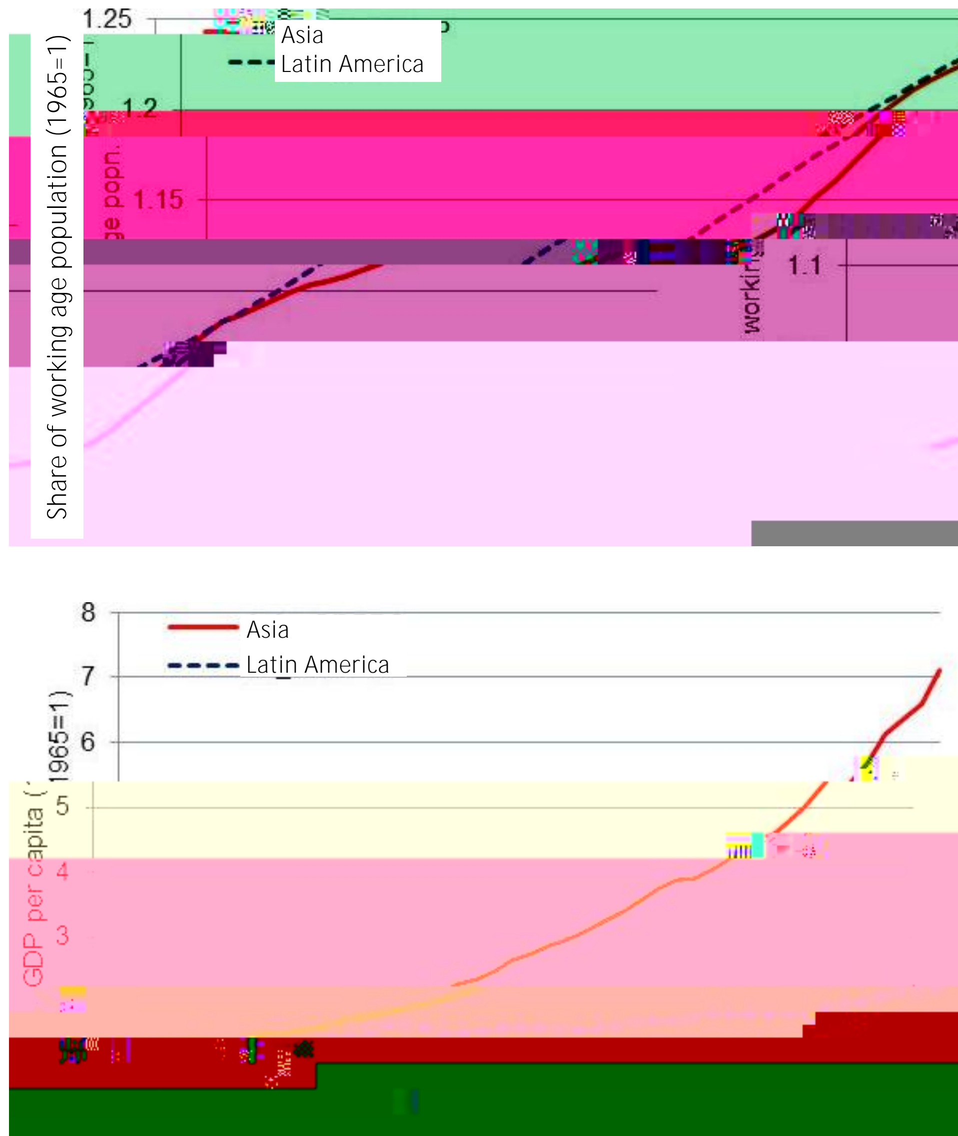
14. Displacement and insecurity sometimes affect a significant proportion of a given country s population. For example, in 2013 more than half of the population of the Central African Republic was in need of urgent humanitarian assistance, yet this situation garnered little global attention compared to other humanitarian emergencies. Such contrasts highlight the need for more equitable systems of response so that such crises do not go unnoticed in the global agenda.

15. In 2013, disasters across the globe, the large majority climate-related, resulted in the displacement of 22.4 million people. With the impacts of climate change

19. Results of the WAVE study (Well-being of Adolescents in Vulnerable

on labour-intensive export-
countries (Brazil, Russian Federation, India and China), shows a higher GDP per capita associated with higher public per capita investments in health, greater literacy and more years of schooling (see table 1).

Figure II



Goals	Targets
16.a	Strengthen relevant national institutions, including through international cooperation, for buil1 0 637(n)-29(t)]TJETQ1f0 1 246.05 659.5 Tm0 g[(b)-41(

of six United Nations agencies to improve the health of women and children, is promoting gender awareness through media that highlights problems of gender and human rights and gender-sensitive reproductive health care. In Burkina Faso and the Niger, schools for husbands (*Ecoles de Maris*) are engaging men to support women s reproductive health and positive change for women and girls. In India, Promundo has tested innovative gender training for schoolchildren, with measurable effects on the respect boys show to girls, including a decrease in support for sexual harassment of girls.[19]

36. The empowerment of women and girls requires ensuring equality of opportunity and outcomes in work, compensation and the right to govern. Women are disproportionately more likely to be illiterate and among those in informal and fragile employment, and they have fewer opportunities for leadership in both the public and private sectors. Women are also disproportionately responsible for the family, including providing care for older persons and those with special needs, creating a double burden of responsibility for many women. Gender parity in the workplace and co-responsibility within the family are both necessary for women s empowerment.

IV. The critical value of sexual and reproductive health and reproductive rights

37. Social and economic discrimination against girls and women has special ramifications within sexual and reproductive relationships, including marriage. Central to fulfilling the human rights of girls and women is the matter of protecting them from unintended pregnancies, maternal morbidities, unsafe abortion, sexually transmitted infections and HIV and the risk of early death, and ensuring that adolescent girls can stay in schools and fulfil their potential. Complications from pregnancy and childbirth together remain a significant cause of death among adolescent girls between 15 and 19 years of age in developing countries. The continuing burden of maternal mortality, affecting an estimated 289,000 women in 2013,[20] reflects the fatal confluence of gender discrimination and persistent gaps, nationally and globally, to ensuring universal sexual and reproductive health and reproductive rights.

38. Currently, an estimated 225 million women in developing countries are not using effective methods of contraception.[21] Access to contraceptive services and information is a human right, central to gender equality and women s empowerment, and a key fac0 0 1 159.9842889( )ET EMC /P ⁄MCID 78/Lang (en-G9p)-41(t)-22(i)-34(v)-26538 239.21 Tm TJET EM

autonomously. The principle of autonomy, expressed through free, prior, full and informed decision-making, is central to medical ethics, and is embodied in human rights law. People should be able to choose from a range of safe and reliable contraceptive methods and to refuse any options. Informed decisions should be based on comprehensive information, counselling and support that are accessible to all people, without discrimination.

39. Investments over the past 15 to 20 years have yielded measurable progress in sexual and reproductive health and reproductive rights, but aggregate gains mask stark disparities in access to sexual and reproductive health services across and within countries, particularly among those in the lowest wealth quintiles.[9] Further investments in sexual and reproductive health and reproductive rights are cost-effective, since for every dollar spent on contraception the cost of pregnancy related care is reduced by $1.47. Of much greater consequence is the potential to save lives. By reaching 100 per cent coverage for maternal care and contraception, annual maternal deaths would be reduced from 290,000 women annually to 96,000.[21] The life-saving benefits of these investments extend far beyond the women and girls to their families, societies and the economy.

40. UNFPA through its global programme to enhance reproductive health commodity security supports the efforts of 46 countries to build stronger health systems and ensure access to a reliable supply of contraceptives and condoms for family planning, the prevention of HIV and sexually transmitted infections, and life-saving medicines for maternal health. As a result, the use of modern methods of contraception has increased over the last three years by 17.7 per cent in Rwanda, 14.5 per cent in Ethiopia and, over the last five years, by 8.9 per cent, 8.8 per cent and 8.1 per cent in Sierra Leone, Liberia and Uganda, respectively. There are notable gains in method mix, with three methods of contraception available at more than 70 per cent of rural service delivery points in Burkina Faso, Côte d Ivoire, Ethiopia, Gambia, the Lao People s Democratic Republic, Nepal, the Niger, Nigeria and Sierra Leone, and at least five modern methods at 100 per cent of tertiary level service delivery points in most of those countries.

41. The programme also supports countries by training service providers, including in long-acting reversible contraceptive methods, and in implementing action plans for demand generation, with a focus on young people. Further life-saving medicines, misoprostol, magnesium sulfate and oxytocin, among others, are now increasingly available in programme countries, including Burkina Faso, Ethiopia, Haiti, Nigeria, the Niger and Sierra Leone.[23]

A. A needed revolution in health-system strengthening

42. Inadequate investments in long-term health-system strengthening has left the world vulnerable to unnecessary suffering and death. The health systems of countries in sub-Saharan Africa and South Asia cannot provide quality care for large numbers of their people due to inadequate numbers of health workers, a lack of requisite commodities, or both. Even within middle- and high-income countries,

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health-system coverage or quality is often inadequate for the poor, the uninsured and undocumented and those facing social discrimination.

43. Human resources are the cornerstone of health systems, yet the global health worker shortfall is over 7 million, exacerbated by the uneven distribution of health-care workers across and within countries. A major expansion of health-worker training is sorely needed, including sound career structures, fair remuneration and recognition to ensure retention and rational distribution.

44. The above-mentioned UNFPA H4+ programme is organizing national appraisals to identify and provide the most cost-effective interventions to increase coverage of quality sexual, reproductive, maternity, newborn and child health in high-burden countries. A key feature of H4+ support has been addressing the widespread need for skilled health workers. The H4+ report, *State of the World s Midwifery 2014*, provides a rich analysis and argument for the potential of midwifery to meet many of these needs, and the H4+ programme has spearheaded the standardized training of midwives worldwide. The number of health workers receiving direct specialized training for reproductive, maternal and newborn care through H4+ initiatives is growing, including an estimated 6,500 health-care providers in five African programmes in 2013 alone.

45. Innovative financing of health systems is also needed, as reflected in the recent establishment of the Global Financing Facility.[24]

plan, as well as to revise the national population policy and national health policy in 2011 and 2012.

55. In Indonesia, UNFPA helped link the National Statistical Office and the National Board for Disaster Management to integrate census and village-level infrastructure data into the Indonesian disaster data and information database. The resulting database provides a comprehensive baseline of population and infrastructure at risk when disasters strike, allowing for a more accurate assessment of potential impacts, and responses which are better targeted to vulnerable populations.

56. Data can also support advocacy for social change, and the growing availability of national-level data on the prevalence of female genital mutilation since 1989 has been instrumental in garnering political support to outlaw and eliminate it. In partnership with national statistical offices, the Demographic and Health Surveys first gathered data on the prevalence of female genital mutilation in the Sudan in 1989, extending that to a total of 16 countries by 2002, and more since; repeat surveys have allowed for the monitoring of changes in the practice of female genital mutilation. The availability of sound data on female genital mutilation contributed to legislative momentum for change, and laws outlawing it passed for the first time, or were amended to strengthen prohibitions, in 14 of these countries following their first national survey on female genital mutilation (see figure III).

57. Likewise, surveys on the prevalence of violence against women have provided growing evidence for policy reform. UNFPA has supported research on violence against women within, among others, eight countries of the Pacific, the Cook Islands, the Federated States of Micronesia, Kiribati, Nauru, Palau, the Marshall Islands, Samoa and Solomon Islands, and supported an analysis of existing data on such violence in Fiji, Papua New Guinea, Tonga and Vanuatu. These findings inform the universal periodic review and reporting to the Committee on the Eo omunive(a)-37( )-8653fp

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complications, with a risk of severe morbidity and potential mortality, if life-saving emergency obstetric care is not provided. In addition, more than one million women who were using modern contraception may no longer receive services because of the disruption to the health system.

65. UNFPA has worked closely with Governments and other partners to provide personal protection equipment, disinfectant materials and reproductive health supplies and equipment, helping health workers provide safe, compassionate care to pregnant women. To help ensure demand for sexual and reproductive health services is being met, UNFPA is also supporting mobile clinics and tent-based outreach to pregnant women, recruiting hundreds of midwives to provide maternal health and contraception and scaling up support for commodities and community-based distribution of contraception.

VII. Conclusion

66. The transformational post-2015 development agenda envisaged by Member States requires a comprehensive approach to issues such as peace and security, poverty and weak health and other public systems, together with increasing population mobility and unplanned, under-serviced urbanization.

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