COMMISSION ON POPULATION AND DEVELOPMENT
FORTY- FOURTH SESSION

FERTILITY, REPRODUCTIVE HEALTH AND DEVELOPMENT
E/CN.9/2011/3

REPORT OF THE SECRETARY-GENERAL

MS. ANN BIDDLECOM
SECTION CHIEF
POPULATION DIVISION/DESA

11 APRIL 2011

Mr. Chairman,
Distinguished delegates,
Ladies and gentleman,

It is my pleasure to introduce the report of the Secretary-General entitled *Fertility, reproductive health and development* (EC/CN.9/2011/3). This report documents trends in fertility and its proximate determinants, the main challenges in ensuring universal access to reproductive health and ways to accelerate the achievement of the relevant goals and objectives of the Programme of Action of the International Conference on Population and Development.

Since 1970, fertility has decreased in virtually all countries but the start and speed of that decline has varied considerably so that, today, there is great diversity of fertility levels. Currently, 42 per cent of the world population lives in countries with low fertility, 41 per cent in countries with intermediate fertility and 17 in countries with high fertility. In addition, among the 196 countries or areas with at least 100,000 inhabitants, 75 have fertility that is below replacement level, 61 have an intermediate level of fertility and 60 have high fertility.

As the map shows, there are high-fertility countries in almost every continent, except Europe. Similarly, there are low-fertility countries in almost every continent and all countries in Europe, except Iceland, have below-replacement fertility.

By focusing on the diverse experiences and characteristics of low-fertility, intermediate-fertility and high-fertility countries, the report shows that high-fertility countries tend to score poorly in most outcomes related to reproductive health and the determinants of fertility. Although all countries face challenges in ensuring access to reproductive health for all, the challenges confronting high-fertility countries are more daunting, partly because of the rapid population growth that they are still experiencing. Furthermore, without speeding up the reduction of fertility, the challenges associated with rapid population growth will multiply.

Currently, high-fertility countries tend to have lower per capita incomes, higher levels of poverty, lower educational attainment and higher mortality than other developing countries with lower fertility levels. In countries where fertility has declined substantially, it has contributed to accelerate economic growth. Thus, fertility reductions in both developed and developing countries are estimated to have accounted for about 20 per cent of per capita output growth between 1960 and 1995.

Declining fertility has also contributed to poverty reduction. During 1960 to 2000, demographic change alone accounted for a 14 per cent drop in poverty levels in developing countries and could produce an additional 14 per cent reduction during 2000 to 2015 if fertility decline had accelerated in high-fertility countries.

Women in high-fertility countries usually marry earlier than their counterparts in other countries and have higher adolescent birth rates (as the graph shows). Because women who bear children at very young ages have a higher risk of complications from pregnancy and childbirth, delaying marriage until age 18 or later would be beneficial. Improving the educational attainment of girls and young women is another important policy to reduce early marriage and adolescent fertility.

The use of contraception, particularly of effective modern methods, is critical to enable couples and individuals to determine the timing and number of the children they have. As fertility declines, contraceptive use tends to increase (as the graph shows). In high-fertility countries, the percentage of women who are married or in a union and who use contraceptives is very low, generally not surpassing 30 per cent.

Not all childbearing is intended, and women and men who would like to delay or stop childbearing but who are not using any method of contraception are considered to have an unmet need for family planning. Unmet need tends to decrease as contraceptive use increases. Unmet need is particularly high in high-fertility countries, often surpassing the level of contraceptive use (as the graph shows). In addition, overall demand for family planning would be higher if women and men who are not married or in a stable union were also included in the data.

The pathways that have contributed to reducing fertility in intermediate-fertility countries vary considerably, but those countries generally have later mean ages at marriage than high-fertility countries, a lower proportion of women aged 25-29 who have ever been married, a later age at the start of childbearing and higher levels of contraceptive use.

In low-fertility countries, long delays in childbearing are common together with a postponement of marriage. In addition, high proportions of women aged 25-29 remain single and contraceptive use among women who are married or have stable partners is high.

In all countries, the evidence indicates that contraceptive use is usually dominated by one or two methods, indicating that there is considerable room for increasing the range of safe

and effective contraceptive methods made available to those wishing to use contraception.

Mr. Chairman,

The great diversity of fertility and reproductive health outcomes that the world faces is linked to issues of equity. People in low-income countries and the low-income groups in many populations have limited access to information, services and the recommended package of maternal and child care. There is an urgent need to increase support for improving the care of women during pregnancy and delivery and to ensure that all men and women have access to sexual and reproductive healthcare. Particular attention has to be given to service provision for rural populations and for low-income groups in all countries, and for the entire population in countries that still have high fertility. This is all the more important because judicious investments in reproductive health produce results.

For instance, the number of maternal deaths is estimated to have declined from 545,000 in 1990 to 358,000 in 2008. Such a decline has been made possible both by the reduction of fertility, which has more than counterbalanced the increase in the number of women of reproductive age, and by improvements in maternal healthcare. Despite those successes, 65 per cent of all maternal deaths still occur in high-fertility countries and most of them are preventable. Whereas the low- and intermediate-fertility countries as a group have achieved a 55 per cent reduction in their overall maternal mortality, the high-fertility countries will likely miss the MDG5 target because their maternal mortality has dropped by just 28 per cent since 1990.

Addressing existing inequities requires both national commitment and commensurate funding for reproductive health from donors and national Governments. Yet funding has not kept pace with demand—demand that is driven by people's changing fertility preferences, their sexual and reproductive behaviours and, in many countries, by the growing number of people of reproductive age.

Ensuring access to modern methods of family planning, in particular, is a cost-effective means of improving the health of mothers and infants and key to ensuring that people have the means to exercise their reproductive rights. It is estimated that satisfying the unmet need for modern contraception would result in savings of $US 1.5 billion from the reduction of births. Therefore, simultaneous investment in family planning and maternal and newborn health care is cost effective.

Mr. Chairman,

As the report highlights, investing to ensure the attainment of universal reproductive health is not only beneficial in terms of cost effectiveness, it is also essential to ensure that people the world over can exercise fully their reproductive rights. For that reason, achieving that goal deserves higher priority than it has been accorded so far at both the national and international levels.

Thank you, Mr. Chairman.