



ICPD Beyond 2014 Expert Group Meeting on Women's Health: Rights, Empowerment and Social Determinants



ICPD =

International Conference on
Population and Development
Beyond 2014



Follow-up to the implementation of the Programme of Action of the International Conference on Population and Development beyond 2014

ICPD Beyond 2014 Expert Group Meeting on Women's Health: Rights, Empowerment and Social Determinants

(UNFPA/WP.GTM.2)

Distr.: General 9 December 2013

Original: English

MEETING REPORT

Mexico City, Mexico

29 September – 2 October, 2013



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BACKGROUND OF THE MEETING



The 1994 International Conference on Population and Development (ICPD) and subsequent intergovernmental meetings established global consensus on the importance of universal access to sexual and reproductive health, and protection of reproductive rights (SRHR).¹ Governments have repeatedly recognized that **SRHR are necessary for women's and girls' overall health and empowerment**; for their ability to benefit fully from education, training, and productive work, as well as to participate in social, political and economic life; and for their enjoyment of all human rights. Governments have further recognized that the disempowerment of women and girls, other abuses of their human rights especially violence and sexual coercion, along with, social and economic disadvantages severely inhibit achievement of their SRHR.

The ICPD Beyond 2014 Coordinating Secretariat, as part of the global review of the implementation of the ICPD Programme of Action, and in collaboration with WHO, convened an expert meeting from 29 September to 2 October, 2013 in Mexico City, Mexico. It complements the ICPD Beyond

1 As stated in the ICPD Programme of Action, "Reproductive health...in the context of primary health care should, inter alia, include: family-planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family-planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV/AIDS should always be available, as required. Active discouragement of harmful practices, such as female genital mutilation, should also be an integral component of primary health care, including reproductive health-care programmes." (7.6)

2014 International Conference on Human Rights hosted by the Netherlands in July 2013, and the Global Youth Forum hosted by Indonesia in December 2012, by focusing on the health, empowerment and human rights specifically of women and girls.

The **primary purpose** of the meeting was **to generate recommendations on effective ways to accelerate progress toward universal access to an integrated package of core sexual and reproductive health services, and protection of the sexual and reproductive rights of girls and women for both the ICPD Beyond 2014 Global Report and the post 2015 development agenda.**

Drawing on seven background papers and country examples, as well as their own individual experiences and knowledge, expert participants **produced prioritized recommendations** for accelerated national and international policies and programs for sexual and reproductive health and rights. The meeting focused on the three primary SRHR challenges identified by the ICPD Beyond 2014 Conference on Human Rights in July 2013:

- **Equality** in access,
- **Quality** of services, information and education, and
- **Accountability.**

A second purpose of the meeting was to identify and assess ways in which country-based work to achieve universal access to sexual and reproductive health and rights, as well as related work at the regional and global level, could provide a foundation for prevention of and services for selected non-communicable diseases in girls and women.

Participants in the meeting included experts and officials from 21 countries, 5 UN agencies including WHO, the World Bank, UNDP, UN-Women, and UNFPA, 7 international organizations, 6 youth organizations, a scientific journal, 4 universities in the North, and 2 foundations.

The main recommendations produced by consensus by the meeting participants follow.



THE CHALLENGES TO BE ADDRESSED NOW AND THROUGH THE NEXT DECADE



From 1990 to 2010, global health improved markedly: Life expectancy increased in almost all countries by 11 to 20 years, for many reasons including improvements in sexual and reproductive health and rights (SRHR). Certain SRHR indicators showed remarkable improvement: for example, contraceptive use in developing countries rose from 8% in the 1960s to 62% in 2007 and maternal mortality worldwide declined from 543,000 estimated deaths per year in 1990 to 287,000 in 2010.²

Despite this overall progress, some countries experienced declines in life expectancy, due significantly to AIDS and to increases in non-communicable diseases (NCDs). Even more significant are the stark disparities in progress within and across countries in health status and in access to services by income level, group characteristics, residence and experience of conflict or humanitarian disasters. In addition, significant shifts in population dynamics, particularly age structure, have led to increased complexities in the global burden of disease and ill health, with most countries now having to cope not only with communicable diseases, mental health, and sexual and reproductive health problems, but also with NCDs, traffic injuries, violence or other trauma.

Significant sex and age differentials exist in the relative burdens of these health problems. Most can be prevented by education and outreach to adolescents, and by enhancing the range of health information and services available to both adults and adolescents, especially women and girls.

2. AbouZahr, Carla, "Trends and Projections in Mortality and Morbidity", paper prepared for the ICPD Beyond 2014 Expert Meeting on Women's Health – rights, empowerment and social determinants, Mexico City, 30th September – 2nd October 2013.



THE PERSPECTIVE OF THE MEETING



Following on the ICPD beyond 2014 Bali Global Youth Forum and the International Conference on Human Rights^{3,4}, the Mexico meeting adopted human rights as its foundation. Like the two earlier events and the overall ICPD beyond 2014 review, the meeting discussed gaps in implementation of the Programme of Action of the ICPD and its key actions, challenges to filling them, and issues that have emerged or become more pressing since the ICPD.

While recognizing the commitments in the Programme of Action on multi-sector investments and actions to achieve human rights and the empowerment of women and adolescents, the Mexico meeting focused on closing gaps in sexual and reproductive health and rights. Drawing on seven background papers (see Appendix 1) and their own expertise, participants made recommendations to accelerate progress toward universal SRHR, emphasizing that, regardless of a country's resource levels, human rights and other standards require that every country undertake progressive realization of the right to health, including SRHR, and related human rights. They stressed the human rights requirements of non-retrogression and of allocation of the maximum available resources to this end.

3 *ICPD Beyond 2014 Review: Bali Global Youth Forum Declaration*, Bali, Indonesia (4-6 December 2012).

4 *ICPD Beyond 2014 International Conference on Human Rights Conference Report*, Noordwijk, The Netherlands (7-10 July 2013).

IV

THREE OVERARCHING RECOMMENDATIONS



Participants agreed that the major gaps in implementation of the Programme of Action, its key actions and subsequent agreements are the three identified by the Human Rights Conference: **wide inequalities** in access to information and health services necessary for SRHR; **poor quality** of many SRHR investments, particularly SRH services, to date; and **lack of effective accountability** mechanisms and processes. Each of these is reviewed in the following sections, along with participants' three overarching recommendations that apply also to recommendations 4-11.

Equality

Despite notable progress toward SRHR, people in the two lowest wealth quintiles have been left behind, along with people marginalized for other reasons, such as residence in hard to reach rural and urban areas, and personal characteristics such as age and marital status, sexual orientation and gender identity, ethnicity and race, disability and stigmatized occupations such as sex work, among others. This gap can only be closed if work to complete the MDGs, and the post-2015 agenda, focus specifically on reaching the underserved, in all aspects of policy design, legislative and regulatory reform, service delivery and program implementation, monitoring and accountability.

Current discussions on health in the post-2015 agenda give considerable weight to using “universal health coverage” as a strategy and means to ensure that everyone has access to health care without risk of financial hardship. As this concept is further developed, along with the definition of the post-2015 agenda, meeting participants urged that priority be given to

the **bottom two wealth quintiles**, including in hard-to-reach rural and urban areas, and to others who are commonly excluded from SRHR services by law and in practice, **especially disadvantaged women and girls**, while recognizing the responsibility of men and boys for their own sexual health and for respecting and protecting the SRHR of girls and women.

Recommendation 1: Governments must specifically plan to reduce inequalities in SRHR through the following actions:

- a. **Reorient the primary health care system to provide SRH information and services as one of its key priorities**, with effective referral to higher levels of SRH care such as EmONC (emergency obstetric and newborn care);
- b. **Include essential core SRH services** (contraception, safe abortion, maternity care, STI and HIV prevention and treatment) **in both supply and demand side financing schemes**;
- c. **Remove legal, policy and regulatory barriers** to the availability and accessibility of SRHR services and information, especially those that restrict adolescents' access, and those that restrict specific SRH services, such as emergency contraception and safe abortion.

Quality

Participants underlined the urgent imperative to **reorient the health sector to support each person in a holistic way**, rather than simply delivering inputs and specific ser-

vices based on targets. This requires that SRHR services meet both human rights and public health standards.

Recommendation 2: Governments, other key actors and the international community must take specific and comprehensive actions to improve the quality of SRHR services and information, including as a priority:

- a. **SRH services must be improved to meet human rights, medical ethics and public health standards, meaning that they:**
 - I. **Are available, easily accessible and affordable**, especially to women and adolescents, as indicated above under equality;
 - II. **Maintain privacy and confidentiality** and also maintain accurate health records for each person
 - III. **Treat all persons with respect and support their decision making** through non-directive and nonjudgmental provision of information, and without pressure based on service delivery targets or personal views;
 - IV. **Ensure that all facilities and equipment, logistics and supply systems, and health care providers and supervisors, are adequate to provide good quality services**, including provisions for privacy, toilets and water, seating, accessibility (location, hours of service), etc.

- b. **SRHR information, counseling and education, including comprehensive sexuality education, must support human rights by being:**

- I. **Non-judgmental and non-directive**, recognizing that the purpose is to enable people, especially women and adolescents, to exercise good judgment, make decisions, and seek health services for their SRHR;
- II. **Evidence-based, accurate and complete**; include their health rights not only needs, and where and when to seek services; and facilitate skills building for personal health care and relationships;
- III. **Accessible to all** through a variety of media, available especially to people who are disadvantaged.

Accountability

The accountability of States for their obligations under human rights instruments, including the right-to-health requirements of availability, accessibility and quality, is fundamental for the protection and fulfillment of SRHR. Governments can and should hold themselves accountable for meeting these human rights obligations, as well as respond to external monitoring and evaluation, especially by their own citizens.

States and their external partners, especially donors, have commonly tracked “inputs” (money, human resources, commodities) and macro level “outputs” and “outcomes” (e.g., national changes in school enrollment or literacy; changes in overall patterns of mortality; and the like). Achieving the ICPD SRHR agenda requires indicators that track progress toward human rights and public health standards of availability, accessibility (including affordability) and quality. Such indicators must focus on persons not inputs and outputs, and would monitor, for example, progress toward removing legal and other limitations

on people's ability to remain well and to seek health services, changes in inequalities of access, and improvements in the quality of the information and services provided in both the public and private sectors.

Meeting participants emphasized the central importance of funding and strengthening independent, non-governmental organizations to monitor and hold the State and other key actors accountable, while making the following recommendation to governments.

Recommendation 3: Governments, with the participation of key stakeholders, should greatly enhance and act on their own accountability obligations, as well as respond effectively to external stakeholders, by:

- a. **Clearly defining national and subnational SRHR goals and effective indicators** to monitor progress toward availability, accessibility and quality;
- b. **Making key processes**, such as budgeting and policy making on SRHR, **accessible and transparent; collecting and making widely accessible the best possible data on public SRH services and on other public sector activities central to achieving SRHR**, beginning with accurate, confidential records on each person, and **improved MIS as well as epidemiological surveillance capacity**; and
- c. **Establishing and using quality assurance mechanisms** to redress shortfalls in both public and private sector SRHR services and other activities.



EIGHT RECOMMENDATIONS ON SPECIFIC ELEMENTS OF SRHR



The eight recommendations below represent priorities agreed by consensus during the Mexico meeting. They are tightly interconnected and, therefore, all of them must be addressed by every country and by the international community, while also addressing the three overarching recommendations above.

Recommendations 4 through 9 relate to transforming the health sector and health services to focus on persons, to improve equity in access as well as the quality of care, and to strengthen accountability mechanisms and processes.

Recommendations 10 and 11 address areas central to the SRHR of women and adolescents: comprehensive sexuality education and violence against women and girls.

Integration of SRH Services

As indicated above, the health system needs to be reoriented and reorganized to focus on the health of persons, not simply on the quantity of services provided. In addition, participants stressed that pendulum swings and fads in donor and government health interests, currently including emphasis on project-based financing and vertical services must end. These are counter to the commitment to serve the person in a holistic way and also miss opportunities for synergies and cost savings over time. In particular, such approaches inhibit sustained and consistent support for integrated provision of SRH services, comprehensive sexuality education, and protection of reproductive and sexual rights.

New initiatives in SRHR should aim to strengthen and improve the quality of ongoing SRH services, including their integration with each other. At least some funds provided for “vertical” services (e.g., family planning or HIV and AIDS) should be made available to help integrate these services with other SRH services, to share technical resources (e.g. laboratory equipment and personnel) and to develop collaborative monitoring systems.

Recommendation 4: Prioritize and effectively deliver, throughout the health system, the essential set of sexual and reproductive health services required across the life course

- a. **Invest in mid-level cadres, such as midwives** who can be trained in both technical skills and respect for human rights to provide the several essential SRH services;
- b. **Undertake sustained and systematic planning and actions to provide SRH services that are integrated** physically with each other or through effective referral.
- c. **The post-2015 agenda should include a target under the health goal** for “universal access to and protection of sexual and reproductive health and rights, especially for women and adolescents particularly girls”.

Specific recommendations are made below for each of the essential set of SRH services (contraception, maternity care, safe abortion, STIs and HIV), and for breast and cervical cancers, followed by recommendations on comprehensive sexuality education and on adding prevention and mitigation of violence against women to SRHR services.

Contraceptive Information and Services

Contraceptives are a vital means for women and adolescents to maintain health and are necessary for women and girls to enjoy all human rights. In the ICPD Programme of Action, governments recognized that providing family planning together with other key SRH services and with human rights protections would be most effective, especially to reach dramatically changing clientele. The persons requiring information and services are increasingly married women who want smaller family sizes, young couples who want to delay their first birth, unmarried persons and many others, such as women and adolescents living with HIV and AIDS or with disability, quite different from the original clients of national family planning programs.

Such changes mean that women will use contraceptives for many more years than earlier generations and need access to several different types over their life course. They must have information, support and male and female condoms to prevent STIs and HIV infection. They have a right to maternity care, to PAC and to safe abortion under at least some conditions in most countries.

In the last two years, however, donors, the UN system, and some countries have returned to an emphasis on vertical family planning exemplified by the “FP 2020” initiative.⁵ Such initiatives can offer a major opportunity to institutionalize practices and deliver information and services that meet human rights norms, as well as medical ethics and public health standards, provided that governments and donors make these a priority.

Recommendation 5: Governments, with the support of donors, should design and strengthen contraceptive services so that they respect each person’s (especially woman’s and girl’s) right to choose freely the method that is best for her at a particular time, based on full and accurate information and specifically:

- a. A mix of contraceptive methods must be available and accessible to meet women’s and adolescents’ needs across the life course:** At minimum, methods that work in different ways, not just several versions of the same type of method, must be made available so that women and girls can choose the type of method that is best for their circumstances at the time. Decisions about contraceptive mix, particularly contraceptive sterilization, IUDs and hormonal implants, must also be carefully calibrated with the capacities of the health system

5 The core partners of Family Planning 2020 (FP2020) are the United Kingdom’s Department for International Development (DFID), The Bill & Melinda Gates Foundations, the United Nations Population Fund (UNFPA) and the United States Agency for International Development (USAID). To learn more about FP2020 visit familyplanning2020.org.

and the skills of service providers to ensure the highest quality clinical care, including removal of LARCs on request.^{6,7}

- b. Contraceptive service providers must be trained and supervised to meet human rights standards for quality care:** Synchronous with the above standards, it is essential that contraceptive service providers are able to provide information sufficient for the client to understand the methods offered and available by referral, how to use the method she chooses if she chooses one, what effects might occur and how to manage them, and to encourage return for follow-up, including to switch to another contraceptive method.

- c. Outreach strategies and communications content must be designed to facilitate free and informed decision making about contraception:** The content and its delivery must support and facilitate free and informed choices about whether and what kind of contraception to use, not “persuade” or “motivate”. Similarly, especially in areas where fertility is high, communications initiatives, messages and materials are commonly framed to “create demand” for family planning. Rather, such programmes and messages

6 Cates, Willard Jr. and Baker Maggwa for the FHI 360 Team, “Family planning since ICPD – how far have we progressed?”, paper prepared for the ICPD Beyond 2014 Expert Meeting on Women’s Health – rights, empowerment and social determinants, Mexico City, 30th September – 2nd October 2013.

7 Germain, Adrienne. “Meeting human rights norms for the quality of sexual and reproductive health information and services”, discussion note prepared for the ICPD Beyond 2014 Expert Meeting on Women’s Health – rights, empowerment and social determinants, Mexico City, 30th September – 2nd October 2013.

should, as elsewhere aim to facilitate free and informed decision-making about contraception.

- d. **Monitoring, evaluation and accountability indicators and processes must track and assess service quality, not only the quantity** of methods delivered, including special attention to actions disallowed by ICPD and human rights standards, such as targets, incentives to persons or to providers, and force. Effective accountability requires that indicators monitor performance of personnel, as well as the wider service delivery and legal systems, in line with human rights norms.

Maternity Care

As with contraceptive services, maternity care requires priority attention to the cadres of primary health care workers who are most likely to be close to women. But saving women's lives and health also requires strong capacity at the secondary level to address complications of delivery and unsafe abortion, with effective referral from the primary level – i.e., a strong and functioning health system.

As maternal mortality continues to sharply decrease in most countries, increasing attention must be given to preventing and treating maternal morbidities such as obstetric fistula and uterine prolapse. The five priority actions recommended below are intended to significantly increase access to quality care for the women and girls currently least likely to receive it.

Recommendation 6: Good quality maternity care, free of violence and discrimination, must be made universally available and accessible as a matter of priority, to reduce both maternal deaths and morbidities.

- a. Investments should be increased in developing midwives and primary health care workers with midwifery skills** since they are the health workforce closest to women. They should be empowered and provided with the necessary medicines and equipment and must be supported by a functioning health system which includes emergency obstetric and newborn care at any time but in particular during pregnancy, childbirth and the post-partum/natal periods.
- b. Outreach to first time young pregnant women,** especially those who married very early, have been subjected to female genital mutilation, have had unsafe abortions, and use the opportunity to offer other sexual and reproductive health information and services including information about family planning, prevention of STIs including HIV, and violence against women.
- c. Financing:** The current high interest in “demand side” financing (social insurance, conditional cash transfers, incentives to give birth in facilities) pays too little attention to distortions that such payments can introduce (such as unnecessary C-sections) and to the simultaneous need to increase and improve the quality of services and eliminate financial barriers to

the poor. As women have better access to services, especially the poorest, they should be empowered with information on their right to be free of pressure from doctors to have a medically unjustified C section.

- d. Give increased Attention to Preventing and Treating Maternal Morbidities** For every woman who dies of a pregnancy-related complication, 20 women suffer serious and often life-long morbidities such as obstetric fistula, uterine prolapse, incontinence, severe anemia and mental illness. Governments should give increased attention to preventing and treating maternal morbidities. Moreover, morbidity indicators should be used for assessing quality of care and progressive realization of human rights.
- e. Monitoring, Evaluation and Accountability to improve maternity care should** strengthen oversight, civil registration, resource tracking and routine reporting of a limited set of indicators, as proposed by the WHO convened Commission on Accountability for Resources and Results. Special attention should be given to high risk groups, including adolescents, migrants, women in conflict and post-conflict situations, women with HIV, indigenous and poor women, whose access to quality services, including EmOC must be measured and improved. Governments are urged to conduct third party independent maternal death reviews which do not rely exclusively on medical records and which enable the participation of civil society. The WHO/CDC Maternal

Death and Surveillance and Response (MDSR) strategy provides the means to understand and respond to the underlying causes of preventable maternal deaths and should be progressively implemented in all countries both in the public and private sectors.⁸

Access to Safe and Legal Abortion

Unsafe abortion, one of leading causes of maternal death and injuries, is entirely preventable because technologies and safe procedures are well known. Nonetheless, WHO's technical and policy guidelines for access to safe abortion⁹, available since 2003, have been widely underutilized or ignored.

Laws restricting access to safe abortion do not reduce or end recourse to abortion. Rather, they make induced abortion, one of the safest medical procedures when properly provided, dangerous, with severe consequences for public health, equity and the human rights of women. The majority of those who die or are injured are low-income women and adolescent girls who have neither money nor the knowledge needed to find a safe provider. Legal revisions in the past two decades have predominantly been in directions that would enable increased access to safe abortion services. However, in these countries and even in countries where abortion is legal on request at least through the first trimester, the availability and accessibility of safe services are highly

8 WHO, Implementing the Maternal Death Surveillance and Response, technical guidance Maternal Death and Partnership for Maternal, Newborn and Child Health, (MDSR) Strategy Brief 02, Geneva: WHO, 2013.

9 World Health Organization, *Safe abortion: technical and policy guidance for health systems*, 2nd ed. (2012).

constrained. Although access to post-abortion care (PAC) for treatment of the complications of unsafe abortion has increased, including through NGOs and the private sector, women in many countries still do not have access to this life-saving care and or are mistreated when they seek it.

Participants fully endorsed the WHO Guidance, and urged that:

Recommendation 7: Actions, especially by governments and international partners, must be taken to increase access to safe and legal abortion:

- a. **All governments should remove abortion from their criminal law, and align laws, policies, regulations, training and service protocols, and service delivery monitoring with the WHO Guidance**, including reviewing and revising, or creating, clear laws, and eliminating regulatory and other barriers (such as conscientious objection, or donor restrictions) so that safe abortion and good quality post abortion care are available and accessible, without discrimination by age, marital status or other factors, in public and other institutions, affordable or free of charge, free of stigma, discrimination, or requirements to report women who seek these services to the authorities.
- b. **Mid-level providers, including midwives, nurses and others as appropriate, not only medical doctors must be trained, equipped and widely dispersed** through the primary health care system to provide PAC, medical abortion, vacuum aspiration and other

methods of safe abortion, with nonjudgmental and non-directive information and support including for contraception.

- c. **Information about abortion laws and regulations, methods of abortion and their use must be made widely available** to women and adolescents, to service providers and managers, and to the public to facilitate access to services, including medical abortion at home, and to reduce stigma.
- d. **With full respect for women's confidentiality and privacy, monitoring and evaluation of services must be strengthened and accountability for safe and unsafe abortion, as well as PAC, must be increased.**

Sexually Transmitted Infections and HIV

Paradoxically, STIs other than HIV are one of the most neglected dimensions of SRHR, even though they have very harmful consequences for women (e.g., compromised fertility, pain), for pregnancy (miscarriage) and for neonates (preterm births, low birth weight, congenital defects such as blindness). Estimated annual number of bacterial STIs has risen from 333 million in 1995 to 499 million in 2008¹⁰, even while HIV incidence has recently plateaued or declined in many countries. The growth in STIs, especially

10 Ortayli, Nuriye, Karin Ringheim and Tim Sladden, "Sexually transmitted infections: progress and challenges since the 1994 International Conference on Population and Development (ICPD)", paper prepared for the ICPD Beyond 2014 Expert Meeting on Women's Health – rights, empowerment and social determinants, Mexico City, 30th September – 2nd October 2013.

gonorrhoea, cannot be explained by population growth alone, but rather is due to lack of investment, lack of diagnostics suited to weak health systems, poor surveillance, and the fact that serious STIs such as gonorrhoea and chlamydia are asymptomatic in the majority of women. While screening for syphilis and also immediate treatment of newborns are simple and low cost, and should be routine, more than 500,000 poor pregnancy outcomes result from this STI annually.

The following recommendations aim to make STI, including HIV, prevention, screening and treatment a routine part of other ongoing SRH service delivery and information systems and programs.

Recommendation 8: Governments, donors and the international community must give much higher priority to prevention of sexually transmitted infections (STIs) and HIV, and to developing technologies and capacity for STI diagnosis and treatment.

- a. With financial, commodity and technical support from governments and the international community, all public and private SRH services, including HIV and AIDS programs, should **make existing prevention technologies widely and easily accessible** to women and adolescents, with the support necessary for their effective use:
 - I. **Female condoms** should receive much more support from commodity security programs and their funders as well as governments

need to invest much more in programs to promote and introduce them.

- II. **HPV vaccine rollout** must be done in line with ethical, medical and human rights standards and should provide a package of SRH information and referrals to SRH services, as well as promote gender equality, human rights and zero tolerance for gender based violence among both boys and girls.
- III. **Syphilis treatment and prophylaxis for newborns** should be a priority investment by governments and donors.

- b. **Governments and donors must support and give more priority to community-based information and outreach, including comprehensive sexuality education**, so that women and men, boys and girls, are knowledgeable about STIs and HIV, know how and where to seek diagnosis and treatment, and can combat stigma and discrimination.
- c. **Research and development of simple, accurate, low-cost, point-of-care STI diagnostics suited to weak health systems should be given high priority** by the international community, as a matter of urgency, for the benefit of people's health and also as the foundation for strong STI surveillance.
- d. **Surveillance for the most harmful STIs**, gonorrhoea, syphilis, chlamydia, must be strengthened and broadened, using multiple strategies such as sentinel

sites, or integration with HIV surveillance, with full protection of the safety and privacy of women and adolescents, along with support for them to inform their partners.

Cervical and Breast Cancer

The ICPD Programme of Action recognized the need to meet “changing reproductive health needs over the life cycle,” including prevention, diagnosis and treatment of reproductive system cancers. Nevertheless, the incidence of and mortality from cervical and breast cancer have increased significantly. Multiple reasons include the fact that more women live longer, they are increasingly exposed to risk factors such as unsafe sex and tobacco use as well as poor diet and obesity from a young age, and these cancers are fear-inducing and highly stigmatized. Lack of political support and resources, especially for prevention in LMICs, are also major drivers.

The global incidence of breast cancer more than doubled between 1980 and 2010, with the number of women affected in LMICs rising from about a third to just over half of the total. Mortality is also increasing, especially in LMICs, importantly because women go for diagnosis and treatment very late, if at all, inhibited by social norms and taboos, lack of information, and high costs. The increase in the number of women with cervical cancer has been slower (20 percent over three decades worldwide), but the shift of the burden toward LMICs even more pronounced. Cervical cancer is becoming a disease primarily born by poor women in poor

countries (90 percent of all cases in 2010). By contrast, in high-income countries, both incidence and mortality from cervical cancer declined by over 30%.

In the decades since the ICPD, important technological breakthroughs have been made that could, with the right investments, assist all countries, especially LMICs to expand prevention, diagnosis and treatment particularly for cervical cancer. The HPV vaccine, with recently secured public sector pricing and global purchasing, makes widespread primary prevention, and also screening and treatment of precancerous lesions, potentially feasible in countries with weak health systems. Advances for breast cancer are primarily in treatment, and identification of the BRCA1 and BRCA2 genes, which can be used for risk screening. These advances are themselves expensive, very costly to deliver, and not likely to reach many in LICs soon. Important new work is being done on ways to inform women, and to train community and primary health care workers to support women, to seek diagnosis and care early enough to cure treatable cases, and to improve the management of greatly overburdened treatment facilities in low-income countries, especially in Sub Saharan Africa.

Recommendation 9: Governments and the international community are urged to add, to their SRHR policies, plans and budgets, prevention, diagnosis and early treatment of cervical cancer and to introduce breast cancer prevention education, as well as early diagnosis and referral for treatment where possible, while also developing population-based cancer registries to help them identify needs

and priorities; plan, implement, and evaluate interventions; and monitor progress.

- a. **HPV vaccine delivery should be based on the highest standards of medical ethics, free of discrimination and coercion, and should combine vaccination with comprehensive sexuality education** to both boys and girls by collaborating with and helping to strengthen ongoing and new programs for young adolescents.
- b. **Primary health care systems should be enhanced** to make reasonably accessible, to all women, cervical cancer screening and removal of precancerous lesions, with referral to higher levels of care when needed and possible.
- c. **Begin, or continue building integrated networks for cervical and breast cancer prevention, screening, diagnosis, and care** by community outreach workers and health centers, district hospitals, and tertiary care facilities when needed.
- d. **Breast and cervical cancer education and awareness campaigns among both women and men** should be added into current health education and outreach activities, into the training of community level health workers and of all contraceptive service providers who should be able to support and encourage female and male condom use.

Comprehensive Sexuality Education (CSE)

Since the ICPD, intergovernmental and other agreements, as well as research evidence, have increasingly indicated that CSE, from an early age, is essential for everyone to be healthy and empowered. While many governments, most with assistance from local NGOs, have made some progress in policy, legislation, curriculum development and teacher training, much work remains to be done by governments, NGOs and donors.

Participants emphasized that comprehensive sexuality education provides scientifically accurate, nonjudgmental information and assists people to develop skills for decision-making, critical thinking, communication and negotiation of interpersonal relationships, including:

- Respect for human rights and the practice of gender equality;
- Human sexuality;
- Sexual and reproductive health (contraception, pregnancy, HIV and STI prevention and treatment, and abortion);
- Zero tolerance for violence against women and girls, including sexual coercion in and outside marriage, harmful practices and harassment, and
- Referrals for SRH services, for support following gender-based violence, for mental health, and information on other sources accessible to young people (e.g., pharmacies) for female and male condoms, emergency contraception, and certain

other contraceptives and commodities (e.g. pregnancy or STI/HIV tests).

Recognizing that most behaviors that underlie NCDs begin during adolescence, participants also agreed that CSE programs and curricula should increasingly include, as some already do, provision of information, support and referrals for adolescents' and youth decision making on such matters as tobacco use, other substance misuse (alcohol, drugs), diet and physical exercise; on other risk taking; and referral for mental health issues, all of which lay the foundation for healthy adulthood.

Recommendation 10: Governments, with the support of donors, the international community and other stakeholders including adolescents, must make comprehensive sexuality education (CSE), in line with the current gold standard, available to all adolescents, especially those ages 10 to 14, in and out of school.

- a. **Governments should adopt national and sub-national laws, policies, regulations and guidelines, and provide sufficient funding for CSE,** as well as referrals to health and other supportive services.

- b. **With the involvement of young people and experienced NGOs, governments should adapt, adopt and roll out nationwide curricula and teacher training materials based on interactive methodologies,** using materials in line with the above definition of content, now available in all regions in several languages, and/or use the "It's All One"

curriculum¹¹, rather than create new ones; select and supervise teachers and facilitators carefully, as well as work with parents, school principals and program managers, among others, at community level.

- c. **Implement special programs for adolescent girls, especially those ages 10-14** who face exceptionally high risk of early and forced marriage or other forms of sexual exploitation and violence, as well as poor SRH outcomes, and who tend to be concentrated in large numbers in certain low income urban and rural areas.

- d. **Include in the post-2015 agenda a target under the education goal** for “universal access to comprehensive sexuality education for all adolescents and youth, in and out of school”, using the definition above.

Violence against Women

According to a 2013 WHO report, intimate partner violence (IPV) and non-partner sexual violence affects 1 in 3 women worldwide, most at the hands of intimate partners. The report documents the tremendous loss of life and health burdens that such violence puts on women, including sexually transmitted infections, HIV, depression, unwanted pregnancies and abortions, among many others, and also on their children. Beyond perpetration of these forms of violence the UN Declaration on the Elimination of Violence

11 The Population Council, *It's All One Curriculum: Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV, and Human Rights Education*, revised 1st ed. (2011).

Against Women¹² also emphasizes that violence against women also includes threats of such acts, coercion or arbitrary deprivation of liberty in public or in private life, sexual abuse of children, violence in the general community (at work, in educational institutions, in conflict and humanitarian settings), female genital mutilation, dowry-related violence, honour killings and sex trafficking, among others.

Recommendation 11: All countries should institute comprehensive laws, national policies and frameworks, protocols and guidelines, capacity building and systems strengthening initiatives for all sectors, emphasizing that violence against women is a violation of human rights, imposes enormous health burdens on individuals, families and society, and will not be tolerated.

- a. Governments should develop **carefully interlinked, multi-sector primary prevention programs and strategies** to challenge social norms and gender inequalities that perpetuate violence against women and girls, as well as violence on the basis of gender identity and/or sexual orientation including comprehensive sexuality education; school- and community-based interventions; public education campaigns; and outreach through new technology (e.g. internet, mobile phones, twitter) and other mechanisms.

¹² Article 2.

- b. The health sector, particularly SRH services,** programs and information activities, should:
- I.** Ensure that health services **meet the minimum requirements for addressing violence against women and girls in accordance with WHO guidance**¹³, including policies, training and support for health care providers to recognize and respond to VAW and to provide psycho-social support and mental, not only physical, health care;
 - II. Provide post-rape care** including, at a minimum, emergency contraception, safe abortion, and STI and HIV prophylaxis, in line with WHO clinical and policy guidelines.
- c. All countries should enhance data collection and research** including:
- I. Population-based** specialized surveys that describe the magnitude, risk factors and consequences of the main forms of violence against women and girls;
 - II. Monitoring and evaluation of prevention and response** programs, with the involvement of academics, researchers and advocates; and

¹³ Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013 (<http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>).

- III. WHO should convene a meeting to define and determine how to study violence perpetrated by health care providers** against women in sexual and reproductive health services, including during labor and delivery, and in the provision of abortion and PAC, among others.
- d. A specific target to significantly reduce VAW and increase access to the critical health and other supportive services in the post-2015 agenda.**

Appendix



List of Background Papers for the ICPD Beyond 2014 Expert Meeting on Women's Health – rights, empowerment and social determinants

30 September – 2 October 2013, Mexico City

AbouZahr, Carla, “Trends and projections in mortality and morbidity”, paper prepared for the ICPD Beyond 2014 Expert Meeting on Women's Health – rights, empowerment and social determinants, Mexico City, 30 September – 2 October 2013.

Cates, Willard Jr. and Baker Maggwa for the FHI 360 Team, “Family planning since ICPD – how far have we progressed?”, paper prepared for the ICPD Beyond 2014 Expert Meeting on Women's Health – rights, empowerment and social determinants, Mexico City, 30 September – 2 October 2013.

Garcia-Moreno, Claudia, “Violence against women: too prevalent to ignore”, paper prepared for the ICPD Beyond 2014 Expert Meeting on Women's Health – rights, empowerment and social determinants, Mexico City, 30 September – 2 October 2013.

Germain, Adrienne. “Meeting human rights norms for the quality of sexual and reproductive health and information services”, discussion note prepared for the ICPD Beyond 2014 Expert Meeting on Women's Health – rights, empowerment and social determinants, Mexico City, 30 September – 2 October 2013.

Knaul, Felicia and Andrew Marx. “Cervical and breast cancer: progress, challenges, priorities, and prospects since ICPD” paper prepared for the ICPD Beyond 2014 Expert Meeting on Women’s Health – rights, empowerment and social determinants, Mexico City, 30 September – 2 October 2013.

Ortayli, Nuriye, Karin Ringheim and Tim Sladden, “Sexually transmitted infections: progress and challenges since the 1994 International Conference on Population and Development (ICPD)”, paper prepared for the ICPD Beyond 2014 Expert Meeting on Women’s Health – rights, empowerment and social determinants, Mexico City, 30 September – 2 October 2013.

Radcliffe Lattof, Samantha and others, “Improved maternal health since the ICPD: 20 years of progress”, paper prepared for the ICPD Beyond 2014 Expert Meeting on Women’s Health – rights, empowerment and social determinants, Mexico City, 30 September – 2 October 2013.

Shah, Iqbal H., Elisabeth Åhman and Nuriye Ortayli, “Access to safe abortion: progress and challenges since the 1994 International Conference on Population and Development (ICPD)”, paper prepared for the ICPD Beyond 2014 Expert Meeting on Women’s Health – rights, empowerment and social determinants, Mexico City, 30 September – 2 October 2013.

PHOTO CREDITS

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ICPD =

International Conference on
Population and Development
Beyond 2014

RIGHTS
+
DEVELOPMENT

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