

Families and sexual and reproductive health over the life course



ICPD
International Conference on
Population and Development
Beyond 2014



Highlights

Achieving universal access to sexual and reproductive health remains a top priority

Sexual and reproductive health (SRH) services are not luxuries: they are components of basic health care services which governments are obliged to provide. Yet political, cultural and social barriers to universal access still exist, and a total package of SRH services and commodities is still not available through all public health care systems.

Today's realities call for a life-course approach to SRH

People have different and changing SRH needs throughout their lives; therefore policies need to address the whole life course – from birth to old age. Although many countries achieved improvements in areas such as maternal health, family planning and preventing sexually transmitted infections (STIs), much remains to be done to ensure continuity of services and equity in health access. Applying a life-course approach to SRH is key for addressing these gaps: it improves access through integration of services, facilitates behaviour change at community level, and enables health systems to strengthen measures to prevent chronic disease in old age.

The region still faces a rising HIV epidemic

Most (but not all) countries in the region have HIV prevention measures in place, and universal access to antiretroviral therapy. Rates of some STIs, such as syphilis, have dropped dramatically. There has been good progress in decriminalizing same-sex practices, especially in former Soviet countries, which is vital for prevention. Yet Eastern Europe and Central Asia is the only region in the world where new HIV infections are on the rise, and only about 11 per cent of HIV-related investment and programmes are aimed at the key populations that are at higher risk of HIV infection.

There have been improvements in SRH data collection, but not in all countries

Twenty years after the ICPD, basic data collection on SRH is a reality. A large amount of data available, and some governments are committed to high-quality monitoring and evaluation. However, many countries have limited capacity to undertake good data collection and analysis, and reproductive health research overall suffers from a lack of coordination. Better data is absolutely vital to developing evidence-informed policies and ensuring that legislation and programmes support people's well-being and SRH choices.

THE ICPD BEYOND 2014 REVIEW

Two decades after the landmark International Conference on Population and Development (ICPD) held in Cairo in 1994, governments, parliamentarians, civil society, academics and youth representatives around the world have taken part in the ICPD Beyond 2014 review.

This has involved taking stock of what has been achieved since the ICPD, and agreeing on priorities for the future. The process has renewed political support for the ICPD Programme of Action, which has been extended beyond 2014 by the UN General Assembly, and will continue to inform the post-2015 development agenda.

In the UNECE region (comprising Europe, Central Asia, North America and Israel) the review has been led by the UN Population Fund (UNFPA) and the UN Economic Commission for Europe (UNECE). It has consisted of a series of national consultations, three regional expert meetings, and regional forums involving youth representatives and parliamentarians. The process will culminate in the high-level conference "Enabling Choices: Population Priorities for the 21st Century" in Geneva on 1-2 July 2013.

This brief is part of a series summarizing key issues and recommendations from the review leading up the July 2013 conference in Geneva. The briefs are meant to inform discussions on how to move ahead with implementing the ICPD agenda in the region in light of recent trends and developments.

Note: This brief captures highlights from the region and is therefore not exhaustive. The views expressed do not necessarily represent those of UNFPA, the United Nations, or any of affiliated organizations. All data presented is taken from the report "Population Trends and Policies in the UNECE Region", prepared by the International Institute for Applied Systems Analysis (IIASA) and the Wittgenstein Centre for Demography and Human Capital, and the regional report on the *Global ICPD Beyond 2014 Survey*.

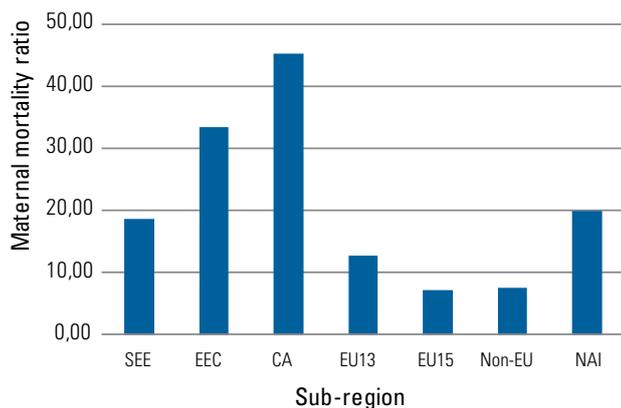
The regional picture

All governments in the UNECE region must ensure universal access to SRH in their countries, and have agreed to this by ratifying international agreements and treaties, including the ICPD Programme of Action.

While access to SRH services has generally improved in the past 20 years, there remain political, cultural and social barriers preventing vulnerable and disadvantaged population groups from accessing and utilizing such services and exercising their reproductive rights. Limited access to SRH services is not always evident in regional or national statistics, which mask existing inequalities between and within countries. Nevertheless, it is useful to analyse key SRH indicators to understand trends and differences among the different sub-regions.

For example, maternal mortality has remained low in Western Europe, and has dropped in Eastern Europe and the Caucasus. It is higher in Central Asia than in other parts of the UNECE region, but has declined in the past 20 years due to significant investments in maternal health programmes (Figure 1).

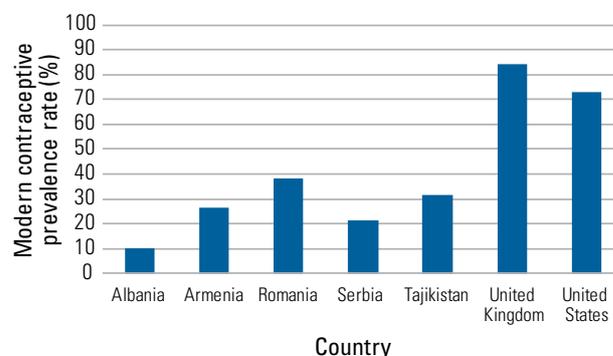
Figure 1: Maternal mortality ratio (number of deaths per 100,000 live births, 2010)



Use of modern contraceptives is high in Western Europe, North America and Israel, and comparatively lower in Eastern Europe, the Caucasus and Central Asia, where women more frequently utilize traditional methods (Figure 2). The striking differences in contraceptive use, however, are not between countries, but within countries. For example, a number of groups including adolescents, poor people living in urban areas, rural communities, and people living with HIV face additional barriers to accessing contraception and other SRH services and commodities in many countries.

Adolescent birth rates are high in many parts of the UNECE region, especially in North America, as well as in Central Asia and Eastern Europe (rates remain low in Western Europe) (Figure 3). Teenage pregnancy is often linked with lower rates of contraceptive use and a lack of youth-friendly services and

Figure 2: Modern contraceptive prevalence rate (% of women aged 15-49)



Note: UNDESA estimates, selected countries, latest available figures, age brackets vary slightly

Figure 3: Adolescent birth rate (number of births per 1,000 girls aged 15-19 years, 2010)

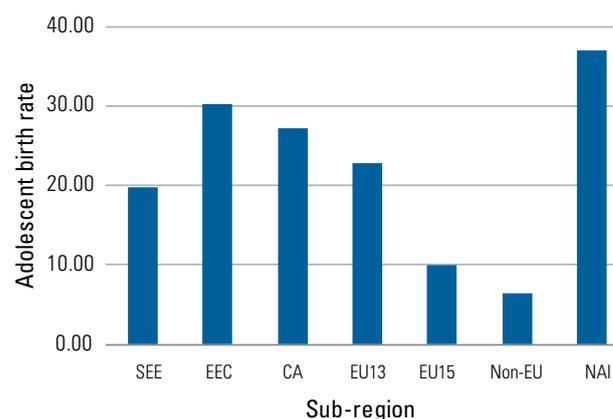
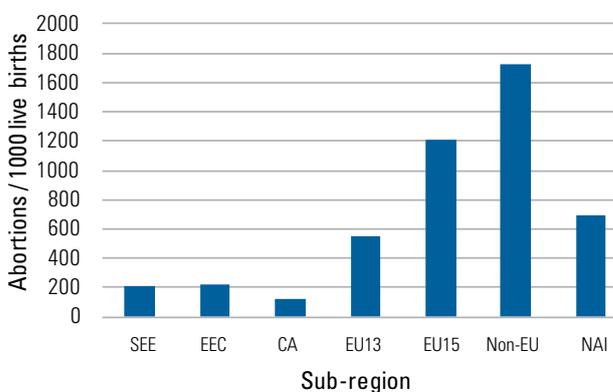


Figure 4: Adolescent abortions (per 1000 live births, women aged below 20, 2010)

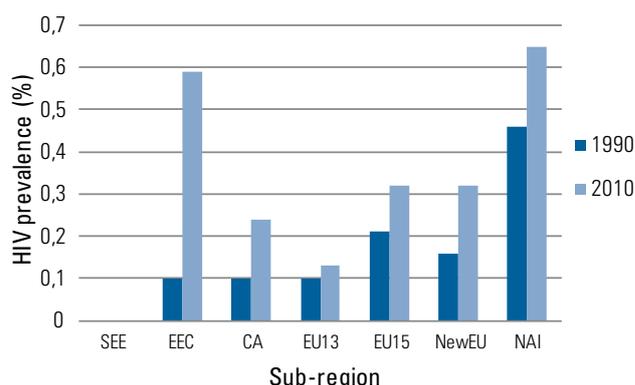


comprehensive sexuality education. Adolescent abortion rates are high among EU member states and in North America and Israel, but are reportedly rare in Eastern Europe, the Caucasus, South-Eastern Europe and Central Asia (Figure 4).

While populations in the UNECE region are ageing, health providers and the SRH sector have largely neglected the needs of older persons. Even the ICPD Programme of Action gave little attention to SRH among older persons, and there is limited data available about the SRH needs of this population. For example, surveillance of STIs and HIV usually involves data collection on people up to age 49, but not those 50 and older. Clearly, sexuality does not end at age 49, even though social and cultural pressures may prevent older persons from having a sexual life if they choose.

Wide variation is seen in the prevalence of HIV across the region (Figure 5). In all countries, stigma and discrimination against people living with HIV and key populations affected by HIV remain the biggest drivers of infection. Within Western Europe, HIV primarily occurs among men who have sex with men, but infection rates are relatively low in this group. Across Eastern Europe and Central Asia, explosive but concentrated epidemics have occurred, primarily associated with the sharing of injection equipment by people who inject drugs. Sexual transmission is increasingly occurring across the whole of Eastern Europe and Central Asia, which has also led to an increase in transmission of HIV from mothers to their children. Moreover, mobility and migration significantly influence patterns of HIV infection across the region. There is a lack of government investment in HIV services within Eastern Europe and Central Asia and most HIV programmes are run by non-governmental organizations.

Figure 5: HIV prevalence (% , 1990, 2010)



Note: No data available for SSE

KEY FOR INCLUDED GRAPHS:

CA - Central Asia: Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan

EU13 - EU new member-states: Bulgaria, Croatia, Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia, Slovenia

EU15 - EU older member-states: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Italy, Ireland, Luxembourg, Netherlands, Portugal, Sweden, Spain, United Kingdom

EEC - Eastern Europe and Caucasus: Armenia, Azerbaijan, Belarus, Georgia, Moldova, Russian Federation, Ukraine

SEE - South-Eastern Europe*: Albania, Bosnia & Herzegovina, the Former Yugoslav Republic of Macedonia, Montenegro, Serbia, Turkey *includes Kosovo

Non-EU - Western Europe Non-EU members: Andorra, Iceland, Norway, Switzerland

NAI - North America and Israel: Canada, Israel, United States

Priorities for action

Take a life-course approach to SRH and human capital development

Policymakers need to apply a life-course approach to developing and revising national health policies and other development policies addressing SRH needs and rights, especially those of women and young people.

Ensure universal access to sexual and reproductive health

SRH services and commodities must be affordable (or free), acceptable, appropriate, available, of high quality, and physically accessible. To achieve this, governments must remove barriers to access (e.g., based on age or marital status, or prohibitions on contraceptive methods such as emergency contraception). Comprehensive SRH service packages, including commodities should be an integral part of national health plans and budgets, and accessible to all groups of population and at all ages.

Address the specific needs of young people

Make comprehensive sexuality and health education for adolescents accessible and delivered in a systematic manner through the national education system; ensure it meets international standards for quality; and consider additional

modes of education, such as peer education, delivered by NGOs or others using evidence-based methods, for young people in and out of schools. Consider introducing or scaling up parenting programmes that educate parents on SRH issues relating to adolescents and youth and the importance of sexuality and health education. Integrate comprehensive sexuality education training fully into teacher training curricula. Governments also need to strengthen youth-friendly SRH services (affordable, accessible, confidential, and sensitive to young people's needs) that offer a wide range of contraceptive options.

Ensure access to sexual and reproductive health for migrants and their families

People who migrate need information and services in their own language, in places that are accessible to them. Irrespective of their legal status in the country, they need a safe, non-judgemental place to receive services where they do not fear being reported to the authorities. These efforts should be complemented through sharing of information, coordination and cooperation between governments of sending and receiving countries.

Provide sexual and reproductive health service in humanitarian settings

Access to SRH services is absolutely vital in humanitarian settings. So national preparedness plans must include comprehensive SRH care as a component of essential health services, and must ensure that services and support are also available for victims of gender-based violence.

Involve men and boys

Men need access to the full spectrum of SRH services and commodities, including infertility prevention and treatment, and support. Engaging men and boys through social and cultural institutions, in schools, and through media and awareness-raising can help to fostering healthier, more equitable gender attitudes, including zero tolerance towards gender-based violence.

Improve responses to sexually transmitted infections, including HIV

All governments need to take full ownership of their response to STIs, including HIV and AIDS, rather than relying on NGOs and donors. There also needs to be more funding for prevention and treatment of STIs, including but not limited to HIV, particularly for: people living with HIV; people who inject drugs and their sexual partners; sex workers and their clients and partners; prisoners; most-at-risk adolescents and young people; men who have sex with men; migrants and mobile workers and their sexual partners; internally displaced people; refugees; ethnic minorities; and transgender people. Funding and attention are especially needed in Eastern Europe and Central Asia. HIV and AIDS should be approached through a rights perspective, with a focus on protecting the human rights of people living with HIV and prohibiting all discrimination and violence against them.

Create enabling legislative and judicial environments

Enact laws and policies that respect and protect reproductive rights and enable all individuals to know about their rights and exercise them without discrimination, regardless of age, sex, race, ethnicity, class, caste, religious affiliation, marital status, occupation, disability, HIV status, national origin, immigration status, language, sexual orientation or gender identity, among other factors. This also requires removing trade obstacles and barriers to development of new SRH commodities, as well as barriers to legalization of medicines; removing age-of-consent laws related to sexual activity, laws that require parental consent for accessing services, and laws that enable parents to prevent their children from receiving sexuality education; and ending practices that violate the reproductive rights of women and

adolescent girls, such as spousal consent requirements to receive health services, forced sterilization and forced abortion.

Update and streamline research agendas

Strengthen countries' capacities for doing good research and ensure that national interests – rather than donor or private-sector interests – drive national research agendas. Consistently update research agendas, so that new research fills the gaps in what we know about SRH across the lifespan, about people's needs, and about the effectiveness (or otherwise) of policies and interventions. Research in Europe needs to look at the socio-cultural and economic determinants of health, and to find out what works for whom. Data gathering and analysis, including from private-sector health care facilities, need to be strengthened in order to ensure effective oversight mechanisms to ensure high standards of care in public and private health care.

Ensure access to SRH and other critical services for survivors of gender-based violence

Ensure that all women and girls who experience gender-based violence have prompt access to critical services and support for their safety, health, housing, legal and other needs and rights. This includes high-quality post-rape care with psychosocial support, emergency contraception, post-exposure prophylaxis to prevent HIV, access to safe abortion for all survivors of rape and incest, and diagnosis and treatment of STIs. Responses to gender-based violence should be systematically integrated into SRH programmes and services, and governments should be held accountable for fulfilling the commitments made.

Protect the human rights of lesbian, gay, bisexual and transgendered people

Governments and civil society need to protect the human rights of LGBT people and ensure they have full access to SRH information and services, free of discrimination.

Tailor policies and ensure they reach those most in need

Evidence-informed policymaking should assess the impact of contextual factors such as gender norms, welfare systems and levels of social support, and other socio-cultural and economic dynamics in considering the adoption of policies. For example, policies that are found to be effective in urban areas or with the general population should not be assumed effective among marginalized or ethnic minority groups. With respect to HIV and AIDS, funding should be spent on developing evidence-informed interventions that explicitly support the human rights of the people infected and affected, particularly sex workers, people who use drugs, and men who have sex with men.



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Eastern Europe and Central Asia Regional Office

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