CHAPTER 5

RECOMMENDATIONS

This chapter combines the recommendations of the writers, the reviewers and recommendations from the national partners of the ICPD+20 project.

The recommendations are focused on four major areas where urgent improvement is necessary in order to press forward to fulfil the commitments to the ICPD PoA: policy change with respect to reproductive rights and sexual rights; universal access to optimal sexual and reproductive health; continued, committed and sustained governmental and donor investment in women's sexual and reproductive health; and the concretisation of sexual and reproductive health and rights for adolescents and other marginalised groups.

Furthermore, the recommendations seek to voice needs that should be addressed in the post 2015 framework which were neglected in the ICPD PoA.

POLICY CHANGE UNDERPINNED BY COMMITMENT TO THE ICPD POA, WITH RESPECT TO REPRODUCTIVE RIGHTS AND SEXUAL RIGHTS

The political will of governments is essential to improving the status of women's sexual and reproductive health and rights.

In all areas where progress has been noted, government policies and implementation were critical for success. Now, nearly 20 years after Cairo and Beijing, it is imperative that governments become more cognizant of their women citizens and their needs and aspirations. Women are disproportionately affected by sexual and reproductive health issues, and improving sexual and reproductive health outcomes should be viewed as critical to government efforts to improve women's status and eliminate gender inequality.

1. Population policies continue to be driven by demographic norms rather than by meeting women's needs. Policies pertaining to women's sexual and reproductive health need to be underpinned by the PoA and the underlying concepts of reproductive rights and sexual rights. Policies on sexual and reproductive health and rights need to be mainstreamed into already existing national machineries, national policies and national plans in a cohesive manner.

2. Policies that determine sexual and reproductive health and reproductive rights should be aligned to provide access to a range of contraceptive methods, abortion services, pregnancy-related mortality and morbidity interventions, addressing STIs and HIV/AIDS, reproductive cancers, and male responsibility in sexual and reproductive health. Policies should also enunciate measures against stigma and discrimination.

3. Policies should be implemented and backed by functional health systems, adequate budgets, trained human resources and updated training and curriculum for health professionals. Policies

that determine SRHR must recognise the need for inter-sectoral coordination and cooperation. Existing policies which are progressive must be publicised, especially to service providers and to women, and must be translated into programme and project implementation.

4. Policies and policy review should be informed by robust data, should measure new indicators of reproductive rights, should include groups (beyond the traditional one of married women aged 15-49 years) such as unmarried single women, and include input from qualitative research in order to ensure that these policies are continually relevant. Intersectional analysis would enable governments to understand differences in policy implementation for different marginalised groups.

5. Policies and policy reviews that determine SRHR need to be created and implemented in secular spaces, free from the influence of fundamentalisms and other doctrines that restrict human rights.

6. Policy review efforts should be integrated into CEDAW, ICCPR and ICESCR reporting mechanisms in order to put pressure on governments to meet international commitments to ICPD, since ICPD itself does not have a reporting mechanism. NGO cross-movement collaborative efforts would help initiate policy review. ICPD national action plans have not materialised in any concrete manner in most countries.

7. Policy reviews should be underpinned by human rights paradigms. These can build on the 2009 call by the UN Human Rights Council to recognise preventable maternal mortality and morbidity as human rights violations, and on the 2009 NGO Berlin Call to Action by the SRHR community to address deaths resulting from unsafe abortions also as a human rights issue. This would ensure that sexual and reproductive health are framed and treated as issues of human rights, and that governments are held accountable for fulfilling them, regardless of economic climate or political change. Legislative initiatives that expand the grounds for abortion, for instance, or which repeal laws that punish women for procuring an abortion, should be introduced.

8. Policy review efforts should integrate the good practices of neighbouring countries as performance benchmarks, and engage in knowledge-sharing and learning between countries.

After these last 18 years, there is a new cadre of policy-makers who are unfamiliar with the ICPD PoA and the commitments that their governments have made. There is a dire need to reintroduce the PoA into the mindsets and agendas of the policy-makers.

REALISATION OF THE HIGHEST STANDARD OF SEXUAL AND REPRODUCTIVE HEALTH

Lack of access to SRH services and information contributes to high levels of morbidity and mortality for largely preventable SRH problems, particularly in developing countries. Every year, half a million women die during childbirth because they are not able to access life-saving emergency obstetric services. Lack of information and education on HIV/AIDS and condoms, as well as insufficient provision of condoms have contributed to the spread of STIs, including HIV. Restricted access to abortion services, contraceptives, and information on sexuality and reproductive health has led to unwanted pregnancies, botched abortions, women's impaired health and wellbeing and women's deaths. Policy formulation must be backed up by service provision ensuring universal access to sexual and reproductive health.

1. Comprehensive SRH services need to be made available, affordable, and acceptable at all levels starting from the primary healthcare level. The primary healthcare level is the one which is most

accessible to most of the population and, hence, the essential sexual and reproductive health services should be made available at this level. There needs to be renewed commitment to making available the full range of contraceptive methods (including emergency contraception and the promotion of condoms as a dual protection method); the full range of abortion services and post-abortion care; the full range of services that prevent maternal deaths, especially emergency obstetric care services and adequately equipped facilities; and the full range of services to identify and to treat victim-survivors of violence including counselling. Counselling services, especially to ensure informed choice, should also be provided. Contraceptives, anti-retroviral drugs, antibiotics, and other supplies ought to be adequately stocked in health facilities or other centres where younger and older women and men are able to gain access to them. Information and education campaigns are important, but behavioural change communication strategies have been shown to alter health-seeking behavior significantly in many cases.

2. There needs to be renewed commitment to staffing health facilities with skilled and trained human resources. Special attention should be paid to the practice of conscientious objection. While it is important to recognise the right of an individual to conscientiously object to performing a certain medical procedure based on religious, moral or philosophical objections, the occurrence of this practice is increasing and largely unregulated, especially in the field of reproductive health care. There is a need to balance the right of conscientious objection of an individual not to perform a certain medical procedure with the responsibility of the profession and the right of each patient to access lawful medical care in a timely manner. With regards to the practice of conscientious objection, we need to:

- Oblige countries to develop comprehensive and clear regulations that define and regulate conscientious objection with regards to health and medical services, including reproductive health services, as well as to provide oversight and monitoring, including an effective complaint mechanism, of the practice of conscientious objection.

3. There is a dire need to integrate services, especially RH and HIV services, which have generally been funded separately and operated vertically, meaning that clients see a different provider for each health service. Yet, with the growing number of HIV infections being sexually transmitted, addressing RH and HIV together would better serve the needs of clients and health care providers in a more comprehensive, cost-effective, and efficient manner. Integration is a feasible means to achieve multiple key goals: prevent new HIV infections among women and girls; reduce HIV transmission from mother to child; prevent more AIDS orphans; and support HIV-positive women's reproductive rights and fertility choices. From the perspective of ethics and programme operations, women and girls who access HIV testing, counseling, and treatment through HIV/AIDS programmes have a compelling need for RH and FP services, especially relating to their fertility choices, just as much as women and girls accessing RH and FP services have a critical need for HIV information and services. In this aspect we need to:

- Develop more effective strategies to help HIV-positive women prevent unwanted pregnancies and access contraception. This underscores the need for comprehensive SRH services where providers do not judge their clients and for the provision of safe spaces for young, HIV-positive women to access services. Responses are needed to address negative, judgmental attitudes of service providers toward HIV-positive women, especially those wanting children.

- Strengthen the ability of local government units and NGOs to reach adolescent girls, including married adolescents, with RH and HIV information and services. Adolescent girls have poor access to confidential and affordable reproductive health and HIV services, making it difficult for them to protect themselves from HIV and unwanted pregnancy. This is an area that demands greater innovation and attention, both through facility-based approaches and other activities to reach young people.

- Develop programmes that integrate RH/FP programmes in HIV/AIDS prevention strategies. This is critical: programmes that help prevent women from acquiring HIV but do not help women prevent pregnancy are not sufficient. Women need to use dual protection – contraception and condoms – to prevent unwanted pregnancy and HIV.

4. Service providers should incorporate gender-sensitive approaches and be receptive to differences in sexual orientation and gender identities. Service providers should also mitigate misconceptions on all aspects of sexual and reproductive health. Service provision should also include accountability mechanisms and redressal mechanisms for patients and clients.

ENSURE CONTINUED, COMMITTED AND SUSTAINED INVESTMENTS IN WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS BY GOVERNMENTS AND DONORS

Until 2011, aid had been steadily increasing for more than a decade and net official development assistance (ODA) rose by 63% from 2000 to 2010.

However, a drop in ODA registered in 2011 shows that donor countries need to move more aggressively to meet the 0.7% aid target by 2015.

1. There needs to be advocacy for political support and to encourage donors and governments to meet the agreed funding requirements to ensure universal access to sexual and reproductive health services by 2015:

    - At the global level – by influencing the allocation of ODA to sexual and reproductive health and rights (SRHR) by forging partnerships with global inter-government agencies and international NGOs;

    - At the regional level – by impressing the central role of SRHR in the achievement of the ICPD and, by extension, the MDGs upon EU institutions, UN agencies and regional offices of other UN agencies such as UNDP and UNAIDS;

    - At the national level – by prioritising SRHR in national development plans and legislative initiatives, by ensuring that SRHR is supported by funds stipulated in the national budget, and by incorporating SRH service components, especially important country specific SRH issues.

    - At the sub-national or local level – by prioritising SRHR in local or provincial investment health plans at the local level, i.e., local government units, and by ensuring that funds are invested in interventions and activities that support and sustain efforts to achieve the ICPD PoA.

2. It is important to advocate that governments track expenditure on SRH. There is a compelling need to create national health accounts' (NHA) sub-accounts on RH programmes. This is a crucial tool for setting priorities, allocating budgets, and advocacy as well as for increasing transparency

and drawing accountability from governments tasked with providing RH services.

3. The capacity of partners and their constituencies needs to be strengthened, to engage effectively in policymaking and political decision-making processes. They need to: appreciate the context and understand the processes of policymaking such as setting priorities and drafting policies and engaging in health sector-wide approaches; to strategically apply political and technical tools, e.g., national health accounts' sub-account for RH to influence priorities and budgetary allocations; to forge alliances and coalitions; and to demonstrate results.

4. Donors should fulfill their commitments to the vision set out by the PoA, by funding all components of SRHR and health system strengthening from primary healthcare levels. Vertical funding mechanisms for components of SRH services need to be reviewed, putting them under the same umbrella. Shifting the agenda from ICPD to MDGs has resulted in the loss of the rights-based approach, so crucial to the full realisation of sexual and reproductive health. With the shift in agenda, the push from donors to governments to adopt women's rights, reproductive rights and sexual rights, is waning in strength.

CONCRETISE THE RIGHTS TO SEXUAL AND REPRODUCTIVE HEALTH AND THE SEXUAL AND REPRODUCTIVE RIGHTS, ESPECIALLY THOSE OF ADOLESCENTS, MARGINALISED GROUPS OF WOMEN AND THOSE WITH DIVERSE SEXUAL ORIENTATION AND GENDER IDENTITIES

Across the region, there is a tendency to restrict women's access to SRHR services and supplies.

Moreover, women who are poor, less educated, who live in remote areas, rural areas, and less developed parts of the country face greater difficulties in accessing services and realising the autonomy of their bodies. This happens regardless whether the service they require access to is contraception, maternal health services, safe abortion services, prevention and treatment of reproductive cancers, HIV testing and anti-retroviral therapy or sexual health services. Sexual and reproductive health and rights are issues of socio-economic equity as well as gender equity.

1. Adolescent-friendly policies and services need to be created, because this group faces the greatest barriers in accessing information, education and services for sexual and reproductive health. Barriers of consent and discrimination which prevent adolescents from accessing all sexual and reproductive health services including contraception, abortion and post-abortion care and counseling need to be eliminated.

2. It is important to ensure that comprehensive sexuality education is available, to inform and

empower adolescents with choices regarding safe-guarding their sexual and reproductive health and enable them to realise their sexual and reproductive rights.

3. Comprehensive programmes need to be created, with policies and plans to address marginalised groups. Ethnic minorities, elderly, disabled, and migrants will require more than one intervention to improve their sexual and reproductive health and rights. Barriers that impede their access must be understood, and these must be deliberately and systematically removed. It is important to ensure that national resources are also allocated to these marginalised groups. Sexual and reproductive health needs of these groups must be understood in a non-judgemental manner, and service provisions created if previously non-existent.

4. Policies need to be created which will include sex-workers and people with diverse sexual orientation and gender identities within service provision, which will ensure they are entitled to equal, fair, non-discriminatory sexual and reproductive health services, care and treatment. Legislation needs to be created and enacted, which will enable these groups to also realise their sexual and reproductive rights to the fullest.

5. Communities must be empowered, especially marginalised communities, to recognise their rights to sexual and reproductive health, and build their capacities to claim these rights from duty-bearers. Spaces need to be created for the participation of different marginalised communities in policy and programme formulation, encouraging their leadership at all levels.

6. Policies and programmes need to be implemented with an understanding of the different aspects of vulnerability: exposure to risks and danger as well as lack of the capacity to cope with the negative consequences of risks and threats of these marginalised groups. In situations of emergencies and disasters, it is important to fully understand the increased risk for marginalised groups and incorporate SRH into the formulation and implementation of disaster-preparedness, response and recovery plans.

In conclusion, we urge governments, donors and international organisations in the region to understand the critical need for pressing forward on the agenda of sexual and reproductive health and rights in this region. Full implementation of the ICPD PoA is fundamental for achieving the MDGs and for the advancement of women in the region.

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