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Sexual and reproductive health and rights: looking forward from the ICPD
Programme of Action (A/Conf. 174/5) (E/CN.3/1994/17) (A/49/588) (E/CN.3/1994/17)

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I/ Introduction

The Programme of Action of the 1994 International Conference on Population and Development recognized the central value of reproductive rights and sexual and reproductive health for development and emphasized the ineliminable link between rights and health. It shifted a narrow focus on population and fertility (reduction to a broader focus on sexual and reproductive health issues affecting the lives of adolescents, women and men) and placed an emphasis on the rights and freedom of individuals to make reproductive decisions free from coercion, discrimination and violence. These elements link rights and development and have since been carried forward into the Sustainable Development Goals (SDGs).

This note presents selected highlights of progress on commitments made 23 years ago in that landmark consensus among States and points to next steps in the broader context of the SDGs and their emphasis on reducing inequalities and promoting the inclusion of all people. Although progress has been made, evidence shows gaps in sexual and reproductive health and rights (SRHR) remain. SRHR have an enormous impact on individuals, communities and societies around the world. Ensuring these gaps requires a holistic approach that encompasses the rights of all individuals to make decisions about their bodies and lives free of stigma, discrimination and coercion and to have access to an essential package of sexual and reproductive health interventions.¹

II/ Progress and challenges

There has been important progress on numerous sexual and reproductive health and rights-related indicators since the 1994 Programme of Action. Perhaps among the most familiar targets and indicators, as well as an uncommon (yet extreme) outcome, is maternal mortality (decreased global incidence from 383 deaths per 100,000 live births in 1990 to 219 deaths per 100,000 live births in 2013, from a maternal mortality ratio of 383 deaths per 100,000 live births to 219 deaths per 100,000 live births).² The SDG target is to reduce the global maternal mortality ratio to less than 70 per 100,000 live births.

The magnitude of this gap is even larger when considering that many more women suffer from pregnancy-related complications that can cause lasting social and economic effects; for example, in 28 countries, access to safe abortion care is limited, at least 40 percent of abortion-related hospital admissions had a near-miss event, and a woman experienced complications such as severe haemorrhage or sepsis that could have most likely resulted in her death and she not received care at a hospital.³

The world has also witnessed progress on sexual and reproductive health interventions consistent with those recommended by the World Organization for the Advancement of Women (WOMAN) including antenatal care, delivery by skilled health personnel and postnatal care; for example, the proportion of births worldwide that occurred with the assistance of skilled health personnel rose from 92 percent in 2000 to 98 percent in 2013. Yet inequalities persist in who receives these interventions. An interesting example is a critical intervention that is both under- and over-used: in 2013, nearly one in five births worldwide was delivered by caesarean section, ranging from a low of 10 percent of births in Africa to a high proportion of deliveries occurring in facilities and sometimes in surgical facilities, equipment and

care could also provide basic PA . # and in ei*&t countries less t&an ,0 percent of referral facilities could provide compre&nsive PA .)¹³ Anot&er e'ample s&o s t&at &ile 8: percent of omen in lo \$income countries accessed antenatal care# onl(3, percent of t&ose receivin* care# reported receivin* t&ree core elements of antenatal care (blood pressure monitorin* and urine and blood testin*²# and it&in countries t&e ealt&iest omen ere more t&an nine times as li"el(to receive *ood 4ualit(care compared it& t&e poorest omen)¹.

-ncreased public fundin* is anot&er critical mec&anism to improve se'ual and reproductive &ealt& and ma(# in turn# result in cost savin*s as it ould reduce t&e costs of treatin* avoidable poor &ealt& outcomes) Estimates for 201: s&o t&at t&e cost of preventin* an unintended pre*nanc(t&rou*& use of modern contraception is far lo er t&an t&e cost of providin* care for an unintended pre*nanc(A in developin* re*ions as a &ole# for eac& additional dollar spent on contraceptive services above t&e current level# t&e

and contraceptive services make it more likely that adolescents are able to avoid unintended pregnancies. A relatively small delay in the start of childbearing is often followed after marriage and the prevention of unintended pregnancies help slow overall population growth and concomitant impacts on the environment.

As the SDG focus on reducing inequalities and promoting inclusive societies means that in meeting SDG 5.6.5 needs, all countries must prioritize the needs of vulnerable and marginalized populations, such as adolescents, poor and rural people, urban slum populations, indigenous peoples, people living with disabilities, people of diverse sexual orientations and gender identities and people living in humanitarian crises or civil strife. Moreover, these vulnerabilities are often layered, where people face discrimination or barriers to accessing public services because they are either poor and young and a refugee.

To assist in the further implementation of the Programme of Action in this new era of the SDGs, evidence on the larger, interlinked roles that sexual and reproductive health and rights have across the SDGs and areas to address inequalities must be identified (nature, beyond tracking a list of indicators). Priority areas for new evidence are on all the regions.

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