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Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014[1]

Executive summary

This Report has been prepared pursuant to General Assembly Resolution 65/234 of December 2010. The resolution requested an operational review of the implementation of the Programme of Action on the basis of the highest-quality data and analysis of the state of population and development, taking into account the need for a systematic, comprehensive and integrated approach, responding to new challenges and to the changing development environment, and reinforcing the integration of the population and development agenda in global processes related to development.

The Programme of Action of the International Conference on Population and Development in 1994 represented a remarkable consensus among 179 governments that individual human rights and dignity, including the equal rights of women and girls and universal access to sexual and reproductive health and rights, are a necessary precondition for sustainable development, and it set forth objectives and actions to accelerate such development by 2015. Achievements over the ensuing 20 years have been remarkable, including gains in women's equality, population health and life expectancy, educational attainment, and human rights protection systems, with an estimated 1 billion people moving out of extreme poverty. Fears of population growth that were already abating in 1994 have continued to ease, and the expansion of human capability and opportunity, especially for women, which has led to economic development, has been accompanied by continued decline in the population growth rate from 1.52 per cent per year in 1990-1995 to 1.15 in 2010-2015. Today, national demographic trajectories are more diverse than in 1994, as wealthy countries of Europe, Asia and the Americas face rapid population ageing, while Africa and some countries in Asia prepare for the largest cohort of young people the world has ever seen, and the 49 poorest countries, particularly in sub-Saharan Africa, continue to face premature mortality and high fertility.

Our greatest shared challenge is that our very accomplishments, reflected in ever greater human consumption and extraction of the earth's resources, are increasingly inequitably distributed, threatening inclusive development, the environment and our common future.

The evidence of 2014 overwhelmingly supports the ICPD consensus that respect, protection, promotion and fulfilment of human rights are necessary preconditions for improving the dignity and well-being of women and adolescent girls and for empowering them to exercise their reproductive rights; and that sexual and reproductive health and rights and understanding the implications of population dynamics are foundational to sustainable development. Safeguarding the rights of young people and investing in their quality education, decent employment opportunities, effective livelihood skills, and access to sexual and reproductive health and comprehensive sexuality education strengthen young people's individual resilience and create the conditions under which they can achieve their full potential.

[1] [Report of the Operational Review of the Implementation of the Programme of Action of the International Conference on Population and Development and its Follow-up Beyond 2014]

The path to sustainability, outlined in this framework, will demand better leadership and greater innovation to address critical needs: to extend human rights and protect all persons from discrimination and violence, in order that all persons have the opportunity to contribute to and benefit from development; invest in the capabilities and creativity of the world's young people to assure future growth and innovation; strengthen health systems to provide universal access to sexual and reproductive health to enable all women to thrive, and all children to grow in a nurturing environment; build sustainable cities that enrich urban and rural lives alike; and transform the global economy to one that will sustain the future of the planet and ensure a common future of dignity and well-being for all people.

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Introduction: A new framework for population and development beyond 2014

Development is the expansion of human opportunity and freedom, a definition inherent in the commitment by all United Nations Member States to universal human rights and the dignity of all persons. It represents the shared aspiration of governments and citizens to ensure that all persons are free from want and fear, and are provided the opportunity and the social arrangements to develop their unique capabilities, participate fully in society, and enjoy well-being.[2]

The 1994 Programme of Action of the International Conference on Population and Development (ICPD) reflected remarkable consensus among diverse countries that increasing social, economic and political equality, including a comprehensive definition of sexual and reproductive health and rights[3] that reinforced women's and girls' human rights, was and remains the basis for individual well-being, lower population growth, sustained economic growth and sustainable development.

The evidence of the Operational Review, mandated by General Assembly Resolution 65/234, overwhelmingly supports the vision of that consensus. Between 1990 and 2010 the number of people living in extreme poverty fell by half as a share of the total population in developing countries (from 47 per cent in 1990 to 22 per cent in 2010), a reduction of 0.7 billion people.[4] Women gained parity in primary education in a majority of countries,[5] maternal mortality fell by 47 per cent,[6] and over the same period, the global total fertility rate fell by 23 per cent.[7]

Yet the Review also makes clear that progress has been unequal and fragmented, and new challenges, realities and opportunities have emerged.

Unequal progress

Research suggests a significant positive correlation between female education, healthier families, and stronger Gross Domestic Product growth.[8] The entry of women into Eastern and Southern Asia's export manufacturing sector, among other factors, has been a key driver of economic growth and contributed to a shift in the concentration of global wealth from West to East.[9] Gains in girls' educational attainment is contributing to both Asia's and Latin America's success in the knowledge-based economy.[10]

Yet belief in and commitment to gender equality is not universal,[11] and gender-based discrimination

[2] Sen, A (1999), *Development as Freedom,* New Delhi: Oxford University Press.

[3] Para 7.2 of the Programme of Action defines reproductive health as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life..." Para 7.4 states that, "The implementation of the Programme of Action is to be guided by the comprehensive definition of reproductive health, which includes sexual health." Based on this and para 7.3 which states that "…reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents," sexual and reproductive health and rights derive from rights under the definition of reproductive health.

[4] United Nations, *Millennium Development Goals Report 2013*.

[5] UNESCO, World Atlas of Gender Equality in Education, 2012; UNFPA, 2012, Marrying too Young: End Child Marriage; United Nations, Department of Economic and Social Affairs, Population Division (2011), World Fertility Policies 2011, quoted in UN DESA, Population Division, Population Facts--World Marriage Patterns, December 2011, http://www.un.org/en/development/desa/population/publications/pdf/popfacts/PopFacts_2011-1.pdf.

[6] UNFPA, UNICEF, WHO, World Bank. (2012). Trends in Maternal Mortality: 1990-2010. World Health Organization, Geneva, 2012. Retrieved from: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf.

[7] The decrease in the global total fertility rate is calculated using the point estimates for the years 1990 and 2010 from the United Nations, Department of Economic and Social Affairs, Population Division (2013) *World Population Prospects: The 2012 Revision*

[8] The UN Millennium Project. (2005). Taking action: Achieving gender equality and empowering women, Achieving the Millennium Development Goals. Task Force Gender Equality. United Nations Development Programme.

[9] National Intelligence Council, Office of the Director of National Intelligence, United States of America. (2008). *Global Trends 2025: A Transformed World.* NIC 2008-003. US Government Printing Office: Washington D.C.

[10] National Intelligence Council, Office of the Director of National Intelligence, United States of America. (2008). *Global Trends 2025: A Transformed World.* NIC 2008-003. US. Retrieved from: http://www.aicpa.org/research/cpahorizons2025/globalforces/downloadabledocuments/globaltrends.pdf.

[11] United Nations, 2010. *World's Women 2010. Trends and Statistics*. Department of Economic and Social Affairs, Statistics Division; Data Analyzed from the World Values Survey http://www.worldvaluessurvey.org/

and violence continue to plague most societies.[12] Beyond the discrimination experienced by women and girls are persistent inequalities faced by those with disabilities, indigenous peoples, racial and ethnic minorities, and persons of diverse sexual orientation and gender identity, among others. While a core message of the ICPD was the right of *all persons* to development, the rise of the global middle-class[13] has been shadowed by persistent inequalities both within and between countries. While we have made important gains in health and longevity, these gains are neither equally shared, nor accessible for many.

Advances in maternal and child health and family planning in the past two decades have been considerable, yet 800 women a day died from causes related to pregnancy or childbirth in 2010,[14] and an estimated 8.7 million young women aged 15 to 24 in developing countries resorted to unsafe abortions in 2008.[15] The advent of anti-retrovirals (ARVs) has averted 6.6 million HIV and AIDS related deaths – including 5.5 million in low- and middle-income countries – but new infections continue to rise, or declines have stalled, in far too many countries.[16] In general, fewer and fewer gains can be expected from technical "silver bullets" without serious improvements to the health systems of poor countries,[17] and addressing structural poverty and human rights violations.

Many of the estimated 1 billion people living in the 50-60 countries caught in "development traps" of bad governance, wasted natural resource wealth, lack of trading partners, or conflict have seen only limited gains in health and well-being since 1994, and some are poised to become poorer as the rest of the global population anticipates better livelihoods.[18] It is in these countries, and among poorer populations within wealthier countries, [19] that women's status, maternal death, child marriage, and many other concerns of the ICPD have seen minimal progress since 1994, and life expectancies continue to be unacceptably low.[20] In conditions of structural poverty, the threats to women's survival are especially acute, due to the lack of access to health services, particularly sexual and reproductive health services, and the extreme physical burdens of food production, water supply and unpaid labor that fall disproportionately on poor women.

New challenges, realities and opportunities

The dramatic decline in global fertility since the ICPD has led to a decrease in the population growth rate, but due in part to demographic inertia the world's population crossed the 7 billion mark in late 2011, and UN medium variant fertility projections anticipate a population of 8.4 billion by 2030.[21]

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[12] Garcia-Moreno C., Jansen H.A.R.M., Ellsberg M., Heise L., Watts, C. (2005). *WHO multi-country study on women's health and domestic violence against women: Initial results on prevalence, health outcomes and women's responses.* World Health Organization, Geneva. Retrieved from: http://whqlibdoc.who.int/publications/2005/924159358X_eng.pdf.; Garcia-Moreno C et al. *WHO global* World Health Organization (2013). G*lobal and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. Geneva, World Health Organization. 2013. World Health Organization, Geneva.

[13] Kharas H. (2010). The emerging middle class in developing countries. OECD Development Centre Working Paper No. 285. Retrieved from: http://unpan1.un.org/intradoc/groups/public/documents/UN-DPADM/UNPAN044413.pdf; Ferreira FHG, Messina J, Rigolini J, Lopez-Calva LF, Lugo MA, Vakis R. (2012). Economic Mobility and the Rise of the Latin American Middle Class. The World Bank, Washington, D.C. Retrieved from: http://siteresources.worldbank.org/LACEXT/Resources/English_Report_midclass.pdf

[14] WHO, UNICEF,UNFPA and The World Banks estimates: Trends in maternal mortality 1990 to 2010. Geneva: WHO, 2012; UNFPA Factsheet Dec. 2012. "Giving birth should not be a matter of life and death."
http://www.unfpa.org/webdav/site/global/shared/factsheets/srh/EN-SRH%20fact%20sheet-LifeandDeath.pdf.

[15] Shah I., Ahman E, Unsafe abortion differentials in 2008 by age and developing country region: High burden among young women: Reproductive Health Matters 2012;20(39):169–173

[16] Joint United Nations Programme on HIV/AIDS (UNAIDS). (2013). UNAIDS Report on the Global Epidemic 2013. Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf.

[17] World Health Organization. (2007). Everybody's business: Strengthening Health Systems to Improve Health Outcomes, WHO's Framework for Action. Retrieved from: http://www.who.int/healthsystems/strategy/everybodys_business.pdf

[18] Collier P., (2007) *The Bottom Billion: Why the poorest countries are failing and what can be done about it,* New York City: Oxford University Press.

[19] Collier P., (2007) *The Bottom Billion: Why the poorest countries are failing and what can be done about it,* New York City: Oxford University Press.; United Nations Population Fund. (2002). State of the World's Population 2002. Retrieved from: http://www.unfpa.org/swp/2002/english/ch5/page3.htm

[20] UNFPA, Marrying too Young. End Child Marriage, 2012; UNFPA, UNICEF, WHO, World Bank. (2012). Trends in Maternal Mortality: 1990-2010. World Health Organization, Geneva, 2012. Retrieved from:
http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf

[21] Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, *World Population Prospects: The 2012 Revision*, http://esa.un.org/unpd/wpp/index.htm

Population trends today are characterized by considerable diversity between different regions and countries. Most developed countries and several developing countries are already characterized by ageing populations, with declining proportions of young people and working age adults. Even in poor countries, declining fertility rates will eventually lead to population ageing, and the high proportion of older persons so evident in Europe and developed countries of Asia today will characterize much of world by 2050.[22]

At the opposite extreme, high total fertility rates of more than 3.5 children per women are now confined to just 49 poor countries, mostly in Africa and South Asia, which make up less than 13 per cent of the world population. These and other developing countries are still characterized by increasing proportions of young and working-age persons, which under the right circumstances, including fertility decline, can lead to a temporary demographic bonus, but at the same time challenge governments to ensure adequate access to education and employment. [23]

Declining fertility rates are providing low- and middle-income countries with a window of opportunity because the proportion of the population that is in the young working years is historically high, relative to the number of children and working people. Young people can – if provided with education and employment opportunities – support higher economic growth and development. Sub-Saharan Africa will experience a particularly rapid increase in the coming decade, and an even more rapid increase in the population aged 25-59.[24]

Access to cell phones and the internet has raised aspirations of young people today for lives previously unimagined and informed many of them of their human rights and the inequalities they experience.[25] Capitalizing on the aspirations of young cohorts will require deep investments in education and reproductive health, enabling them to delay childbearing and acquire the training needed for long, productive lives in a new economy. And because they will be part of ageing societies, they will need systems for life-long learning and opportunities for social, economic and political participation throughout their lives. They will also need the skills to be responsible stewards of the planet and the environmental legacy left to them.

We are in a time of relative global peace, with the world experiencing a precipitous decline in interstate warfare since the end of the cold war.[26] Yet in the two decades since 1994 deeply-held distinctions in religious and political values have become increasingly apparent, with the human rights and autonomy of women and girls a frequent touchstone of ideological difference.[27] In no country are women fully equal to men in political or economic power, yet while most states are progressing (albeit slowly) towards gender equality,[28] in a number of states the rights and autonomy of women are being curtailed.[29]

The scale of internal migration – a common response to structural inequality and an integral part of the development process – was far smaller in 1994, but more than half the human population became urban by 2008,[30] and cities and towns are now growing at an estimated 1.3 million persons per

[22] United Nations, Department of Economic and Social Affairs, Population Division, 2013. World Population Prospects: The 2012 Revision, DVD Edition.
[23] United Nations, Department of Economic and Social Affairs, Population Division (2013). *World Population Prospects: The 2012 Revision, Highlights and Advance Tables.* ESA/P/WP.228. Retrieved from: http://esa.un.org/wpp/Documentation/pdf/WPP2012_HIGHLIGHTS.pdf.
[24] United Nations Department of Economic and Social Affairs, Population Division, *World Population Prospects*, 2013.
[25] Halewood N and Kenny C. (2008). Young People and ICTs in Developing Countries. The World Bank, Washington D.C. Retrieved from: http://www.cto.int/wp-content/themes/solid/_layout/dc/k-r/youngsub.pdf
[26] Themnér, Lotta and Peter Wallensteen 2013. 'Armed conflict, 1946-2012.' *Journal of Peace Research*. Vol. 50 (4): 509-521.
[27] UNRISD Research and Policy Brief 11. (2011). Religion, Politics and Gender Equality. Retrieved from: http://www.af.boell.org/web/Democratization-Religion_Politics_and_Gender_Equality_334.html
[28] United Nations Department of Economic and Social Affairs. (2010). The World's Women 2010: Trends and Statistics. Retrieved from: http://unstats.un.org/unsd/demographic/products/Worldswomen/WW_full%20report_color.pdf
[29] Human Rights Watch. (2013). World Report 2013: Events of 2012. Retrieved from: https://www.hrw.org/sites/default/files/wr2013_web.pdf.
[30] United Nations Department of Economic and Social Affairs, Population Division, Population Estimates and Projections Section. (2011). World Urbanization Prospects, the 2011 Revision. Retrieved from: http://esa.un.org/unup/.

week,[31] a result of both natural increase and migration. Intensifying mobility, both within and between countries, means that people are living in an increasingly interconnected and interdependent world. The rapid growth of the urban population is one of the major population transformations of the century – one for which international, national and sub-national leadership is sorely needed if cities are to be places of innovation, economic growth and well-being. And while the growing internal migration of young people into urban areas[32] represents gains in agency, freedom and opportunity, migrants experience a host of vulnerabilities, often living under appalling conditions, without secure housing , social support or access to justice. Migration also bears unique opportunities and risks for young women, providing them with access to higher education and the labour market, while residential insecurity can lead to higher risks of sexual violence and reproductive ill-health.[33]

International migration has become a key feature of globalization in the 21st century. Attracted by better living and working conditions and driven by economic, social and demographic disparities, conflict and violence, some 230 million people, 3 per cent of the world's population, currently live outside their country of origin. Migrants whose rights are protected are able to live with dignity and security and, in turn, are better able to contribute to their host and origin societies both economically and socially than those who are exploited and marginalized.

Finally, with global economic growth has come a massive increase in greenhouse gas emissions. Earlier this year the concentration of CO_2 in the atmosphere surpassed a long-feared milestone of 400 parts per million for the first time in 3 million years,[34] suggesting that our chances of keeping the warming of the climate below 2 degrees Celsius above pre-industrial levels is fading quickly[35]. The need for global leadership on environmental sustainability grows more pressing each day.

Fragmented implementation of ICPD

A hallmark of the 1994 ICPD was its inclusivity, enabling an unprecedented level of participation from civil society, both in preparatory committees, the NGO forums and in the conference itself, and transforming the range of issues addressed in the resulting Programme of Action. The Programme of Action included 16 chapters that defined objectives and actions for more than 44 dimensions of population and development, including the interests of distinct population groups, calls for investments in young women's capabilities, concern for the implications of demographic phenomena, and recommended governance actions.

This range offered the potential for a comprehensive, integrated agenda, but in practice governments and development agencies were selective and sectoral about implementation. Programmes promoting reproductive rights, for example, ignored quality of care and inequalities in access to services. Similarly, investments in cities failed to effectively account for and embrace urban population growth, and in doing so left large numbers of the urban poor and other marginalized groups without land and housing security or access to critical services. And despite decades of attention to international migration, large numbers of migrants, both documented and irregular, continue to be excluded from full participation in their societies of destination. In numerous examples across multiple sectors, development efforts lack the fundamental message of the ICPD: investing in individual human rights, capabilities and dignity – across multiple sectors and through the life-course

[31] Estimated average weekly growth of the total urban population between 2005 and 2010, derived from United Nations, Department of Economic and Social Affairs, Population Division (2012) *World Urbanization Prospects, 2011 Revision*

[32] Bell M and Muhidin S. (2009). Cross-national comparison of internal migration. Queensland Centre for Population Research, School of Geography, Planning and Environmental Management, at the University of Queensland. Retrieved from: http://mpra.ub.uni-muenchen.de/19213/1/MPRA_paper_19213.pdf.

[33] Temin M, Montgomery MR, Engebretsen S, Barker KM. (2013). Girls on the Move: Adolescent Girls & Migration in the Developing World. A Girls Count Report on Adolescent Girls. Population Council.; Gaetano AM, Jacka T, eds. (2004) On the Move: Women in Rural-toUrban Migration in Contemporary China. New York: Columbia University Press.

[34] U.S. Department of Commerce | National Oceanic & Atmospheric Administration. Earth System Research Laboratory, Global Monitoring Division. Up-to-date weekly average CO_2 at Mauna Loa. Retrieved from: http://www.esrl.noaa.gov/gmd/ccgg/trends/weekly.html on 08 December 2013.

[35] World Bank (2012). Turn Down the Heat: A Report for the World Bank by the Potsdam Institute for Climate Impact Research and Climate Analytics.

– is the foundation of sustainable development.

Foundation for population and development beyond 2014

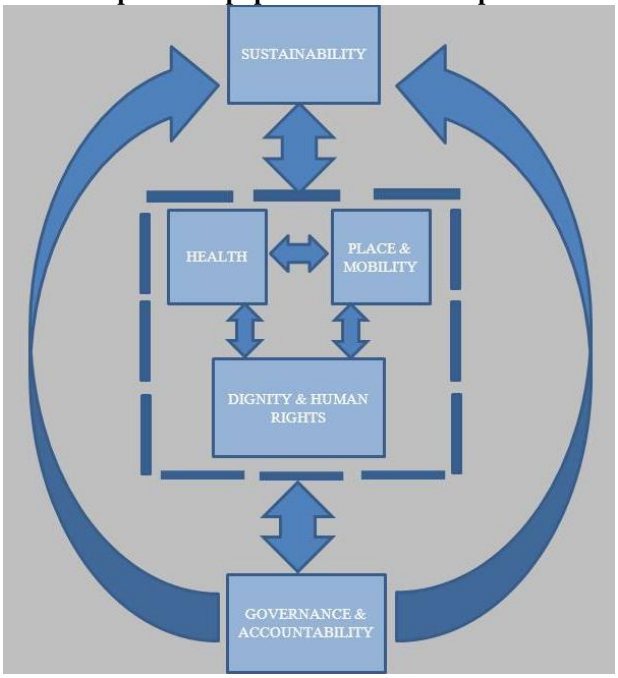
General Assembly Resolution 65/234 on the review of the implementation of the Programme of Action of the ICPD and its follow up beyond 2014 underscored the need for a systematic, integrated and comprehensive approach to population and development, one that would respond to new challenges relevant to population and development and to the changing development environment, as well as reinforce the integration of the population and development agenda in global processes related to development. The findings and conclusions of the Operational Review, in the context of the resolution, suggest a new framework for population and development beyond 2014, built on five thematic pillars: **Dignity and Human Rights, Health, Place and Mobility, Governance and Accountability, and Sustainability.**

The new framework acknowledges that the motivations for development are generated by human aspirations for dignity and human rights, for good health, and for both security of place and mobility. While these aspirations are interlinked and re-affirm one another, they offer distinct organizing thematic pillars for reviewing the numerous principles, objectives and actions contained within all chapters of the Programme of Action (see Annex III). While the objectives of the ICPD touched on many different dimensions of well-being across the life-cycle, and many domains of population and development, they each contribute, in the main, to the fulfilment of dignity and human rights, good health, a safe and secure place to live, and mobility. Because the respect, protection, promotion and fulfilment of human rights are *necessary preconditions* for realizing all of the unfulfiled objectives of the Programme of Action, the elaboration and fulfilment of rights are a critical metric for determining whether, for whom, and to what extent aspirations have been achieved.

Furthermore, the framework acknowledges that governments are accountable, as duty-bearers and vital actors, for the realization of all development goals and the fulfilment of the aspirations of the Programme of Action.

Finally, consistent with objectives stated within the Programme of Action, as well as the call of the General Assembly Resolution 65/234 to respond to new challenges relevant to population and development, the framework highlights the special concerns raised by the environmental crises of today, and the threat that current patterns of production, consumption and emissions pose for equitable development and sustainability. The figure below (Figure 1) is designed to re-affirm the core message of the Programme of Action that the pathway to sustainable development is through the equitable achievement of dignity and human rights, good health, security of place and mobility, and achievements secured through good governance, and that governance responsibilities extend to the national and global promotion of integrated social, economic and environmental sustainability in order to extend opportunity and well-being to future generations.

Figure 1
Thematic pillars of population and development



The primary attention to **Dignity and Human Rights** is motivated by the assertion that completing the unfinished agenda of the ICPD will require a focused and shared commitment to human rights, to non-discrimination, and to expanding opportunity for all persons. Any development agenda that aims at individual and collective well-being and sustainability has to guarantee dignity and human rights to all persons. Principle 1 of the Programme of Action affirmed that all human beings are born free and equal in dignity and rights, and are entitled to the human rights and freedoms set forth within the Universal Declaration of Human Rights without distinction of any kind. This is similarly affirmed and elaborated in international treaties, regional human rights instruments and national constitutions and laws. As those rights are guaranteed without distinction of any kind, a commitment to **non-discrimination and equality in dignity** lies at the core of all human rights treaties. This was reinforced in the regional review outcomes as well as in ICPD Beyond 2014 global thematic meetings. The Review afforded the opportunity to focus on the recurrent question of whether achievements since 1994 have expanded opportunities and rights across all segments of society, and across diverse locations. Recognizing that poverty is both the cause and the result of social exclusion, and that quality education is a path to individual agency, both income inequality and education gains since the ICPD are addressed in the chapter on Dignity and Human Rights.

The right to the highest attainable standard of **Health**, the significance of good health to the enjoyment of dignity and human rights, and the importance of healthy populations to sustainable development are undeniable. The ICPD recognized the centrality of sexual and reproductive health and rights to health and development. The impact of sexual and reproductive health and rights spans the life course for both women and men, offering individuals and couples the right to have control over and decide freely and responsibly on matters related to their sexual and reproductive health (SRH) and to do so free from violence and coercion. Sexual and reproductive health and rights are essential for all people, particularly women and girls, to achieve dignity and to contribute to the enrichment and growth of society, to innovation and to sustainable development. The past decades have seen important changes in the global burden of disease towards non-communicable diseases (NCDs) and injuries, including due to ageing. At the same time, communicable, maternal, nutritional and neonatal disorders, many of which are preventable, have persisted in developing countries, especially in sub-Saharan Africa and Southern Asia. Despite aggregate gains in SRH indicators, marked disparities persist across and within countries, which further highlight the persistent

inequalities inherent in a development model that continues to leave many behind. The achievement of universal access to sexual and reproductive health and rights will depend on holistically strengthening health systems by expanding their reach and comprehensiveness.

Place and Mobility encompasses the social and spatial environment that we live in and move between. The importance of place and mobility as a thematic pillar is in bringing the large-scale trends and dynamics of population – household formation and composition, internal mobility and urbanization, international migration and land and displacement – to the achievement of both individual dignity and well-being and sustainable development. This chapter reviews the changing social and spatial distributions of the human population since 1994, and puts forward approaches to integrating these changes into public policies so they can support human needs for both a safe and secure place and for mobility. This chapter also highlights the need to ensure dignity and human rights for those whose security of tenure and freedom of movement are threatened.

Governance and Accountability is the primary means of achieving these goals. The world has seen important shifts in the diffusion of authority and leadership since 1994, with a growing multiplicity of national, municipal, civil society, private sector and other non-state actors. The ICPD generated momentum at the national level for the creation and renewal of institutions to address population dynamics, sustainable development, sexual and reproductive health, the needs of adolescents and youth, and gender equality. The past 20 years has also seen a measureable increase in the formal participation of intended beneficiaries in the planning and evaluation of population and development-related investments, and in the elaboration of common indicators to measure development. As the world re-appraises goals for the future, progress in participation is at the core, along with the generation and use of knowledge, adequate resources and cooperation, and the critical and continuing need for global leadership to implement population and development beyond 2014. International human rights protection systems have gained in authority, jurisdiction, and monitoring power, and the formal participation of civil society as a political force has grown measurably since 1994, yielding important shifts in rights-based investments. Yet the political power of private wealth has never been more promising, nor more threatening, to global development – demanding more representative, public-sector, accountable global leadership.

Finally, **Sustainability** reaffirms the intrinsic linkages between the goals elaborated in the preceding chapters on dignity, health, place and governance, and underscores that discrimination and inequality must be prioritized within both the Beyond 2014 and Post-2015 agendas for the well-being of the human population and our common home – the planet. The current development model has improved living standards and expanded opportunity for many, yet the economic and social gains have been distributed unequally and have come at great cost to the environment. Environmental impacts, including climate change, affect the lives of all people, but particularly the poor and marginalized, who have limited resources to adapt while contributing the least to human-driven environmental change. This chapter addresses the linkages between increasingly diverse population dynamics, the environment and inequality, and then builds on the prior four thematic pillars to put forward a set of paths to sustainability that can help to deliver dignity and human rights for all beyond 2014. The integrated and comprehensive approach to population and development set forth in this Review is essential for achieving sustainable development, as envisaged by the Post-2015 development agenda.

ICPD Beyond 2014: Building global sustainability on a foundation of individual dignity and human rights

As the debates and policies on population before the 1994 ICPD demonstrate, large-scale global fears have too often been prioritized over the human rights and freedoms of individuals and communities, and at worst have been used to *justify* constraints on human rights. Debates over environmental sustainability, and about stimulating economic growth following the crisis of 2008,

risk the same consequences. The imperative of the post-2015 development agenda is to bring social, economic and environmental sustainability, together within one set of global aspirations; the findings and conclusions of the ICPD Beyond 2014 Review argues for integrating these often disparate aims.

The vital importance of the paradigm shift of the ICPD – subsequently affirmed by progress in the two decades since – was precisely in demonstrating that individual *and* collective development aspirations benefit from a central focus on individual dignity and human rights. By updating and advancing the implementation of such principles, governments can achieve the goals set forth in 1994, while accelerating progress towards a resilient society and a sustainable future for all. Central to this update are laws and policies to ensure respect and protection of the sexual and reproductive health and rights of all individuals, a condition for individual well-being and for sustainability.

As elaborated in the following findings from the ICPD Beyond 2014 Review, the ideals of equitably expanding human rights and capabilities, especially for young people, are shared by most Member States, and most governments report having addressed efforts at reducing poverty, raising the status of women, expanding education, eradicating discrimination, improving sexual and reproductive health and well-being, and embracing sustainability. Progress is nonetheless uneven, and the persistence of inequalities is evident throughout. Much work will be needed in the decades ahead.

The Millennium Development Goals have been the unifying global framework for development for almost 15 years. As the United Nations considers the Post 2015 development agenda, the goals and principles of the ICPD Programme of Action and the findings of the Review contribute important elements to fulfil human rights, equality and sustainable development.

The realization of human rights

In analyzing the situation regarding individual well-being envisaged in the Programme of Action an underlying question has been the extent to which progress has been equitable across diverse segments of society, and the extent to which human rights affirmed in the ICPD have been realized. Consistent with the fundamental commitment of the Programme of Action to create a more fair and equitable world, one in which security, education, wealth and well-being would be shared by all persons, this Review explicitly examines social and spatial inequalities wherever possible.

Pre-1994

The shared vision of development, human rights and a world order based on peace and security was at the foundation of the United Nations since its conception with the Charter of the United Nations in 1945. Article 1(3) of the Charter states a main purpose of the UN is to "achieve international co-operation in…promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion." The Universal Declaration on Human Rights (1948) and the two binding International Covenants on Human Rights (1966) lay out an expansive list of civil and political, as well as social, economic, and cultural rights that members state are obliged to respect, protect and fulfil. Since 1948, the human rights protection system has evolved substantially, incorporating numerous international covenants, as well as resolutions, declarations, decisions and principles. A growing regional human rights protection system has emerged to complement international efforts, providing rights protections responsive to the contexts of each region.

While all human rights are indivisible and interconnected, a variety of treaties and policy guidance elaborate specific areas of rights. The Convention on the Elimination of All Form of Discrimination against Women (1979) and the Convention on the Rights of the Child (1989) clarify specific rights and obligations, articulate the rights of women and children more completely, and provide guidance on how these rights are to be respected, protected and fulfilled.

Subsequent to the World Conference on Human Rights (1993), which affirmed both that "All human rights are universal, indivisible and interdependent and interrelated" and that "women's rights are human rights and human rights are women's rights", the ICPD brought together development and human rights in a compelling and operational way.

1994

The ICPD affirmed the application of widely acknowledged international commitments to human rights to all aspects of population and development policies and programmes. Building on the World Conference on Human Rights, a major achievement of the conference was the explicit recognition of the connection between human rights, population, and development. The Programme of Action affirmed that "the right to development is a universal and inalienable right, and an integral part of fundamental human rights and the human person is the central subject of development." Already looking forward to the challenges and obligations of sustainability, the agreement acknowledges that "development must be fulfilled so as to equitably meet the population, development and environmental needs of present and future generations."

The Programme of Action also affirmed that all human beings are born free and equal in dignity and rights, as set forth within the Universal Declaration of Human Rights, and guaranteed without distinction of any kind, such as race, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

In affirming the centrality of human rights with regard to population, the Programme of Action acknowledged "that reproductive rights embrace certain human rights that are already recognized" (Para 7.3), and that these rights rest on the recognition of "the basic right of all couples and individuals to decide freely and responsibly the number, timing and spacing of their children, and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health," as well as the "right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents" (Para 7.3).

The Programme of Action also reaffirmed civil rights of direct relevance to migration, mobility, and human security. It called on all countries to "guarantee to all migrants all basic human rights as included in the Universal Declaration of Human Rights" (Principle 12), and "the right to seek and enjoy in other countries asylum from persecution." (Principle 13) Further, it provides protections for mobility, elaborating that "population distribution policies should ensure that the objectives and goals of those policies are consistent with...basic human rights." (Para 9.3) Regarding human security, the Programme of Action reaffirms for all persons "the right to an adequate standard of living for themselves and their families, including adequate food, clothing, housing, water and sanitation" (Principle 2).

Post-ICPD (1994 to 2013)

The 19 years following the ICPD have seen the expansion of both international and regional human rights protection systems, with specific advances related to many of the population and development objectives proposed in the Programme of Action. Notably, the 1995 Fourth World Conference on Women in Beijing marked an important milestone for women's empowerment, gender equality and human rights globally. The Platform of Action adopted by United Nations Member States outlines objectives and key actions regarding women's gender equality including poverty eradication, education and training, health, eliminating violence against women, promoting women's economic participation, and protecting women's human rights.

The elimination of violence against women has also received substantial attention in regional commitments since 1994, with the African, inter-American, and European human rights systems all developing instruments that address violence against women.

Human rights laws related to mobility, in particular the rights of migrant populations, have also gained attention since the ICPD. The Programme of Action urged states to ratify the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990). Less than a decade later, the Convention entered into force in 2003.

Particular advances are also noted in extending the human right to dignity and non-discrimination to all persons, and affording rights protections to population groups that endure persistent stigma, discrimination and/or marginalization. For example, the Programme of Action affirmed the rights of persons with disabilities, and in 2006 the Convention on the Rights of Persons with Disabilities formally acknowledged those rights. In 2007 the Declaration on the Rights of Indigenous Peoples was adopted by the General Assembly recognizing the right to self-determination of indigenous peoples as well as the principle of free, prior and informed consent on all matters affecting their rights. In 1997, the International Guidelines on HIV and AIDS and Human Rights presented a framework for promoting the rights of persons living with HIV and AIDS.

Despite such developments the human rights principles related to equality and non-discrimination are woefully unrealized for many; principal among these are girls and women, and persons of diverse sexual orientation or gender identity. In some countries, laws continue to ban consensual adult sexual behaviour and relationships, including relations outside of marriage.

Regionally, the African human rights system has made notable developments since 1994, through the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (1995) and the African Youth Charter (2006). The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa makes important advances in protecting and promoting women's rights and gender equality, elaborating international commitments within the specific cultural and political contexts of the region. In addition to affirming rights to development, education, employment and socio-economic welfare, the Protocol highlights the specific impact of many issues for women in Africa, including land rights and inheritance; harmful practices; HIV and AIDS and reproductive health; as well as marriage, divorce, and widowhood. Globally, the African Youth Charter and the Ibero-American Convention on the Rights of Youth (2005) represent the only youth-centred, binding regional instruments to date that explicitly aim to respect and fulfil the rights of youth. These expansive documents promote youth empowerment, development, and participation, and protect and promote youth rights to non-discrimination, freedom of expression, health, work and professional training.

Despite the numerous advances in human rights conventions and charters in the past two decades elaborated throughout this Report, significant gaps remain in the equitable application of these rights to all persons, as well as in the development of systems of accountability.[36] Prospects and needs for accountability systems are foreshadowed throughout the Report, and reviewed in greater depth under Governance, with specific recommendations.

Methodology, data sources, and structure of the Report

The methodology and activities of the Review were jointly developed based on consultation and agreement with Member States, the UN System and other relevant partners, identified in 65/234, including civil society and other institutions. The Review was based on the highest quality data generated by Member States, including the ICPD Beyond 2014 Global Survey (2012) and Country

[36] International Conference on Population and Development Beyond 2014, International Conference on Human Rights, Chair's Reflections, "All Different, All Human, All Equal," pp. 4-5.
http://humanrights.icpdbeyond2014.org.php53-3.dfw1-2.websitetestlink.com/uploads/browser/files/human_rights_conference_chair_reflections_final_version.pdf

Implementation Profiles (CIP), designed in consultation with all partners, principally Governments. In addition, global thematic conferences or meetings were held on a number of issues where more in-depth examination and multi-stake holder discussion was required beyond the Global Survey: youth, women's health, human rights and an ICPD Beyond 2014 monitoring framework.

The results of these activities as well as regional reviews by the United Nations Regional Commissions and ministerial regional reviews on the ICPD Beyond 2014 and the following data and source material provided the basis for the analyses and recommendations of this Report mandated by 65/234:

- Country Implementation Profiles
- The ICPD Beyond 2014 Global Survey on the Programme of Action implementation
- Outcome Document of the Global Youth Forum and technical papers prepared in the context of the meeting
- Report of the ICPD Beyond 2014 International Conference on Human Rights and technical papers prepared in the context of the meeting
- Recommendations of the Expert Consultation on Women's Health: Rights, Empowerment and Social Determinants and technical papers prepared in the context of the meeting
- Recommendations of the International Meeting on ICPD Monitoring and Implementation Beyond 2014
- Reports prepared by the Regional Commissions based on the regional analyses of the Global Survey data and the outcomes of the Regional Conferences
- Data and analysis from peer-reviewed sources and related inter-agency processes such as Special Ad-Hoc consultations organized by the Thematic Groups and the ICPD Beyond 2014 Secretariat on the ICPD Programme of Action implementation
- Data, analyses and reports on ICPD financial resource flows, including available cost estimates for implementation up to 2015
- Review reports for the ICPD at 10 and the ICPD at 15 Reviews
- Relevant Post-2015 documents to the ICPD Review, in particular the Global Consultation on Population Dynamics outcome report and Dhaka declaration; the UN Task Team paper on population dynamics; as well as papers and outcome documents from the global thematic consultations on health, education, inequalities and governance.

The Global Survey was completed by 176 member states and 7 territories and areas, representing all regions, and provides new data on the elaboration of government institutions to address key concerns related to the ICPD, on the extent to which governments have addressed select related issues in the preceding 5 years, and on government priorities in related domains for the coming 5-10 years.

Data on health outcomes, population change, gender values, socio-economic status, and education are based on evidence reported by countries through censuses, household surveys (such as the Demographic and Health Surveys and the Multiple Indicator Cluster Surveys), from trends and projections generated by the UN Population Division, from UN-based surveillance systems (WHO; UNAIDS; UNICEF), and other surveys, including the World Values Survey, which result from academic collaborations that require research approval by Member States; and enriched by analyses drawn from technical reports commissioned as part of the ICPD Beyond 2014 Review. Methods of analysis are provided in detail in the Annex of the Report (see Annex III).

For analytical purposes, data presented in this Report have been aggregated or grouped into geographic regions and sub-regions, income groups, and more developed and less developed regions.

The geographical regions or sub-regions used are based on the M49[37] classification of the United Nations, but they may vary slightly within the Report, depending on the distinct groupings used by the international organizations from which data have been drawn, and/or the statistical clustering of countries according to selected characteristics. Classification of countries by income group is as provided by the World Bank, based on GNI per capita.[38] The "more developed countries" include all European countries, Australia, Canada, Japan, New Zealand and the United States of America. Countries or areas in Africa, Latin America and the Caribbean, Asia (excluding Japan) and Oceania (excluding Australia and New Zealand) are grouped under "less developed regions".
Review of the alignment between the thematic pillars and the ICPD Programme of Action is included in Annex II, Section A. The orange boxes at the outset of each chapter list key principles, objectives and actions affirmed in the Programme of Action that are representative of the thematic pillar.

The human rights mapping throughout this Report was conducted through a review of the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, and the seven additional core international human rights treaties; key international and regional human rights instruments; general comments and recommendations of the human rights treaty bodies; Special Rapporteurs' reports; select General Assembly resolutions; and outcome documents from intergovernmental processes that reaffirm human rights commitments.

Elaborations since 1994 in international and regional human rights instruments relevant to key topics are listed in boxes throughout the Report corresponding to three levels:[39]

a) **Treaties, covenants, and conventions** that are legally binding for states that have ratified them and that enter into force once they have received a sufficient number of ratifications;
b) **Intergovernmental human rights negotiated outcomes and consensus**, such as resolutions and declarations that elaborate human rights commitments related to specific topics. Several **other intergovernmental negotiated outcomes** were chosen selectively for their importance to the Review of the ICPD, including conference outcome and consensus documents, which are not human rights instruments, but contain human rights standards;
c) **Other soft law instruments**, such as general comments and recommendations of the human rights treaty monitoring bodies that offer interpretations on the content of human rights provisions included in the core international treaties.

How to read the human rights boxes:

1. Binding Instruments Conventions, Covenants, Treaties
2. Intergovernmental Human Rights Outcomes Declarations, Resolutions **2a. Other Intergovernmental Outcomes** Conference Outcome and Consensus Documents
3. Other Soft Law Documents Guiding Principles, General Comments, Recommendations,

[37] Composition of macro geographical (continental) regions and geographical sub-regions are available at http://unstats.un.org/unsd/methods/m49/m49regin.htm
[38] As of 1st July, 2012. For further details see World Bank, http://data.worldbank.org/about/country-classifications
[39] The human rights documents reviewed in this report are non-exhaustive. Our review focuses on international human rights instruments relevant to the ICPD Beyond 2014 review, and does include ILO Conventions, nor does it review instruments of international humanitarian law. The list of "Other Intergovernmental Outcomes" is selective and abbreviated, representing only several documents that were critical to this review.

Concluding Observations of the Treaty Monitoring Bodies

Table 1 (see Annex I) summarizes the principal human rights instruments that appear throughout the Report in boxes. As such, these instruments define the foundational and underlying rights upon which the principles, objectives and actions of the Programme of Action are based, and the mechanisms through which they have evolved over the past 20 years.

The bolded text throughout the Report provides recommendations to address specific issues raised within each thematic pillar. At the end of each chapter, Key Areas for Future Action synthesize the main findings and recommendations of the thematic pillar. The final chapter concludes with seven Paths to Sustainability that define the contributions of the new framework for ICPD Beyond 2014 to the achievement of sustainable development.

I. Dignity and human rights

The principles of the Programme of Action of the International Conference on Population and Development affirm "that all human beings are born free and equal in dignity and rights", are entitled to all rights and freedoms as set forth in the Universal Declaration of Human Rights, without distinction of any kind (See box below). These principles underscore the urgent need to eradicate all forms of discrimination and assert that the principal aim of population-related goals and policies is to improve the quality of life of all people. The principles of the Programme of Action establish the link between dignity and human rights and individual well-being.

Dignity is intrinsically interlinked with human rights and fundamental freedoms. As reflected in the Programme of Action, dignity includes far more than the meeting of basic needs, as it includes the right to education; to full participation in social, economic and political life; to freedom of information; to be free from discrimination and violence; to security of residence as well as the freedom of human mobility; and it requires that individuals are provided access to opportunities to build and renew their capabilities across the life course. Dignity includes the foundational human right to sexual and reproductive health, and the freedoms to choose whom to love, whether and when to have children, and the guarantee that sex and reproduction are entered into without fear of illness or a risk to health, but as a source of human happiness. These entitlements and freedoms are a pre-condition for a thriving, inclusive society, composed of resilient individuals who can innovate and adapt, and ensure a shared and vibrant future for all persons.

This chapter of the global Review examines progress since 1994 in the achievements of equality and non-discrimination, especially among population groups at high risk of discrimination. It identifies gaps and challenges in implementing the ICPD Programme of Action as related to dignity and human rights, and provides concrete recommendations and highlights key areas for future action.

"All human beings are born free and equal in dignity and rights. Everyone is entitled to all the rights and freedoms set forth in the Universal Declaration of Human Rights, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Everyone has the right to life, liberty and security of person." (ICPD Programme of Action Principle 1)

"Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development- related programmes. The human rights of women and the girl child are an inalienable, integral and indivisible part of universal human rights. The full and equal participation of women in civil, cultural, economic, political and social life, at the national, regional and international levels, and the eradication of all forms of discrimination on grounds of sex, are priority objectives of the international community." (ICPD Programme of Action Principle 4)

A. The many dimensions of poverty

Poverty is the deprivation of one's ability to live as a free and dignified human being with the full potential to achieve one's desired goals in life.[40] Poverty has many manifestations. It is the lack of income and productive resources sufficient to ensure sustainable livelihoods, but also includes many other deprivations, such as food insecurity; lack of health care, education and other basic services; inadequate or no housing; lack of safety or means of redress; and lack of voice or access to information or political participation.[41] The experience of poverty is dynamic, with some trapped in it while others move in and out, and many are living at the threshold.

Globally, between 1990 and 2010, the number of people living in extreme poverty fell by half as a share of the total population in developing countries (from 47 per cent to 22 per cent), a reduction of 0.7 billion people.[42] Yet the significant poverty reduction that has occurred in the last two decades – at an extraordinary scale - has nonetheless been accompanied by an estimated 1.2 billion poor people who have been left behind in extreme poverty. Using a more multi-dimensional definition of poverty, for example a measure of human deprivations in health, education and standard of living, UNDP estimates that for 104 countries studied, some 1.57 billion people, or more than 30 per cent of the population, live in multidimensional poverty. In fact the number of people living in multidimensional poverty surpasses that of those living in income poverty, in many fast growing countries of the South.[43]

Poverty occurs in all countries, and women bear a disproportionate burden of its consequences, as do the children they care for. Because poverty has historically been measured at the level of the household, without measures of intra-household inequality, the differential poverty of women and men has been obscured. But when comparing households occupied by a single adult (with or without children), the greater poverty among women compared to men is irrefutable.[44] For similar reasons, poverty among specific population groups, e.g. persons with disabilities and older persons is equally difficult to measure. The eradication of extreme poverty is universally achievable, and is at the centre of realizing **dignity and human rights** for all.

Central to the other thematic pillars in this Review, **health** is vital to all conceptions of poverty. Health is necessary for the achievement of well-being and for longevity. Poverty undermines health by exposing people to poor living conditions lacking in sanitation, shelter or clean water, and by creating barriers to access to health, social and legal services, either societally through limited health systems or individually for those without the resources to access what is available to others.[45]

Each of these factors is in turn shaped by **place and mobility**. Insecurity of place, whether in the form of homelessness, limited rights to land ownership or tenure, substandard housing or heightened exposure to natural or manmade disasters, war or conflict, threatens the livelihoods of the poor and drives or traps many in poverty**.** Such insecurity combined with a lack of freedom and resources to move, is itself a critical contributor to extreme vulnerability.

[40] UN DESA World Social Situation 2010: Rethinking Poverty
[41] United Nations, 1995, Programme of Action of the World Summit for Social Development. Annex II in the Report of the World Summit for Social Development, Copenhagen, 6-12 March 1995, Para 19. United Nations A/CONF.166/9.; United Nations, 2009, Rethinking Poverty: Report on the World Social Situation 2010 New York: 2009; United Nations. (2006). Millennium Development Goals: 2006 Report: A look at gender equality and empowerment of women in Latin America and the Caribbean.
[42] United Nations, 2013. The Millennium Development Goals Report 2013. New York: 2013.
[43] UNDP, 2013, Human Development Report 2013:The Rise of the South, New York
[44] United Nations, 2010. *World's Women 2010. Trends and Statistics*. Department of Economic and Social Affairs, Statistics Division
[45] Link BG and Phelan J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*, Spec No:80-94.

Lack of participation in **governance and accountability** is a vital component of multidimensional poverty. The benefits of society go to those who are able to participate in its creation, yet poverty undermines participation and quiets the voices of the poor, especially in contexts of high inequality. Poverty is a cause and a consequence of multiple human rights deprivations for which there is often a lack of accountability. While participation is a crucial element in ensuring accountability, it also means ensuring that duty bearers are responsible, answerable, and that laws are enforceable.

Finally, poverty is fundamentally related to **Sustainability**. Economic growth is a necessary engine of poverty reduction, yet the global rise in income and wealth inequality, together with the environmental impacts of economic growth, underscore that economic growth alone is insufficient for inclusive development. Economic growth and finite environmental resources are being shunted disproportionately to the wealthy, undermining poverty reduction. At the same time, the waste and byproducts of environmentally unfriendly industry and development heavily impact the poor and compound poverty.

In responding to the ICPD Beyond 2014 Global Survey (2012), not only did an overwhelming majority of governments (93 per cent) indicate that they are addressing[46] "the eradication of poverty, with special attention to income generation and employment strategies", but "social inclusiveness, and protection of the poor" were prioritized across numerous segments of the survey. For example, when asked to identify public policy priorities for sustaining family welfare over the next five to ten years, governments were most likely to include "Social protection of the family" (77 per cent of governments), which captured all priorities pertaining to the provision of social services and/or investments for the fulfilment of basic needs.

States should develop, strengthen and implement effective, integrated, coordinated and coherent national strategies to eradicate poverty and break the cycles of exclusion and inequality as a condition for achieving development, also targeting persons belonging to marginalized or disadvantaged groups, in both urban and rural areas, guaranteeing for all people the chance to live a life free from poverty, and to enjoy protection and exercise of their human rights.

Human rights elaborations since the ICPD: Poverty

Intergovernmental human rights outcomes: The United Nations General Assembly has adopted a series of resolutions on the relationship between human rights and extreme poverty, including *Resolution 65/214 Human Rights and Extreme Poverty* (2012) which reaffirms "that extreme poverty and exclusion from society constitute a violation of human dignity" and that "urgent national and international action is therefore required to eliminate them."

Other soft law: *The Guiding Principles on Human Rights and Extreme Poverty* (2012) offer international global policy guidelines that address the human rights of people living in poverty, following international human rights norms and standards.

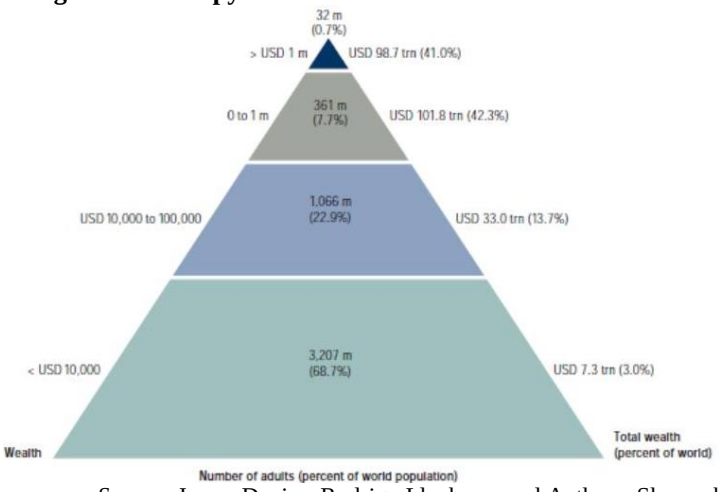
1. The economic and social cost of income and wealth inequality

Achieving equal opportunity and equitable outcomes is the basis for sustained economic and social well-being. Expanding the capabilities of diverse people – through better health, education and opportunity - expands the collective pool of creative energy, ideas and contribution in a given society. Technical, economic and social innovations thrive under conditions in which many people have the opportunity to

[46] Note: The definition of "addressed" (yes/no), is based on countries reporting 3 responses to a given ICPD-related issue: [the existence of relevant policy] + [allocation of budget] + [implementation of programmes] during the preceding 5 years. All 3 conditions must be met to classify a government as "addressing" the issue.

fully participate and succeed in society. And the reverse is true: Severe inequalities in access to health, security and high-quality education can prevent large sectors of the population from rising out of poverty and achieving social mobility, and such conditions increasingly narrow the selection of persons and ideas that contribute to society.

Figure 2
The global wealth pyramid



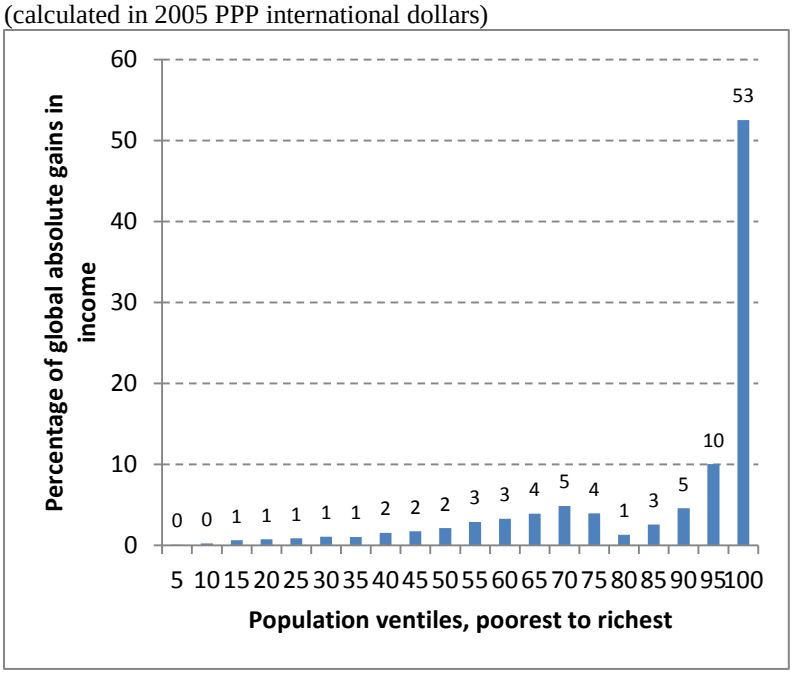
Source: James Davies, Rodrigo Llueberas and Anthony Shorrocks, *Credit Suisse Global Wealth Databook*, 2013, in *Credit Suisse Global Wealth Report*, 2013, p. 22, retrieved from https://publications.credit-suisse.com/tasks/render/file/?fileID=BCDB1364-A105-0560-1332EC9100FF5C83

The current distribution of wealth (see Figure 2), presents a serious threat to further economic growth, inclusiveness and both social and environmental sustainability. According to the Credit Suisse Global Wealth Report, global wealth was estimated at US $223 trillion in mid-2012. This works out to be an estimated US $48,500 per capita for each of the world's 4.6 billion adults. This average hides enormous inequalities. Approximately 69 per cent of all adults were found in the lowest wealth category with only 3 per cent of global wealth. The next category (US $10,000 to 100,000) had 1,066 million adults who owned 13.7 per cent of global wealth. The category from US $100,000 to US $1,000,000 included 361 million adults, or 7.7 per cent of the total who commanded 42.3 per cent of global wealth. Finally, the category of millionaires included 32 million adults, representing only 0.7 per cent of the global adults, who commanded 41 per cent of world wealth. In short, 8.4 per cent of the adult population in the world commands 83.3 per cent of global wealth, while almost 70 per cent possess only 3 per cent of global wealth.

Due to the convergence of mean incomes of developing and developed economies, global income inequality has been falling in recent years, albeit only slightly, and from a very high level. The more recent stabilization and slight narrowing of global income inequality largely reflect economic growth in China since the 1990s, growth in India, and other emerging economies and developing economies since 2000.[47] Yet, income inequality within and among many countries has been rising.[48]
Figure **3** depicts the unequal distribution of gains in global income from 1988 to 2008. More than half of the gains went to the richest 5 per cent, while 5 or less per cent of the global income went to each ventile in the bottom 90 per cent of the population.

[47] Milanovic 2012 in UN 2013 World Economic and Social Survey Report
[48] United Nations, Department of Economic and Social Affairs, World Economic and Social Survey 2013. Sustainable Development Challenges, retrieved from:
http://www.un.org/en/development/desa/policy/wess/wess_current/wess2013/WESS2013.pdf

Figure 3
Distribution of global absolute gains in income by population ventile, 1988-2008
(calculated in 2005 PPP international dollars)



Source: United Nations, Department of Economic and Social Affairs, World Economic and Social Survey 2013. Sustainable Development Challenges, p. 29, retrieved at http://www.un.org/en/development/desa/policy/wess/wess_current/wess2013/WESS2013.pdf, based on Branko Milanovic, "Global Income Inequality by the Numbers: In History and Now. An Overview," World Bank Policy Research Working Paper 6259, November 2012, pp. 12-16, retrieved at http://elibrary.worldbank.org/doi/pdf/10.1596/1813-9450-6259 on 17 December 2013. (Data downloaded and analyzed 17 December 2013)

Increasing economic inequality is disruptive and highly detrimental to sustainable development. From a social perspective, inequality impedes trust and social cohesion, threatens public health, and marginalizes the poor and the middle class from political influence. Social sustainability, which can be understood as the capacity of a given society to promote innovation and adaptability under changing economic, social and environmental conditions in a manner respectful of human rights, is directly threatened by having a large – and potentially growing – sector of the population who are caught in "development traps", and living day-to-day without real prospects for a better future.

Growing inequality also reduces prospects for grappling with emerging environmental crises, and re-balancing our economic growth with responsibility for the planet. It has been estimated that 11 per cent of the world's population accounts for half of all emissions, yet it is the poorest segments of the population who are disproportionally impacted by natural disasters due to climate change.[49]

Given the enormous environmental costs of economic growth under the current development paradigm, the world simply cannot afford current trajectories of wealth concentration while at the same time sustaining efforts to reduce poverty. Reductions in environmental impact necessary to achieve environmental sustainability only heighten this contradiction.

And last, the social and health consequences of inequality and exclusion not only hinder the human rights-based development championed by the ICPD, but they have the potential to de-stabilize societies. In today's globalized context, where information spreads throughout countries and the world in an

[49] The Worldwatch Institute, 2013. State of the World 2013: Is Sustainability Still Possible?

instant, the increasing concentration of wealth and its links with unemployment, social injustice and powerlessness of millions, have already become a touchstone for political protests, conflict and instability.

States should accord the highest priority to poverty eradication by ensuring that all persons have equal opportunities to share in the fruits of economic and social development, to find productive employment, and live in peace and dignity, free from discrimination, injustice, fear, want or disease.

As noted at the outset of this chapter, economic inequalities are both the cause and consequence of other social inequalities, including those experienced due to sex, race, disability, age and other dimensions of identity and circumstance. Given the principal message of the ICPD – i.e. that investments in individual capability, dignity, and freedom are the foundation of shared human well-being and sustainable development – the ensuing pages of this chapter are devoted to a closer look at the extent to which dignity, human rights and well-being have, or have not, been advanced for women and girls, and for numerous population groups identified in the ICPD Programme of Action as experiencing long-standing vulnerability to stigma and discrimination.

B. Women's empowerment and gender equality

Discrimination of select populations is common in many countries, but the discrimination of women is universal. Many young women are not empowered in the course of childhood. Instead, they are socialized to embrace subordination to men, and adopt gender values that hold ideal femininity to be incompatible with independence, power or leadership. In certain regions, women's agency may be further compromised by early or forced marriage, unintended pregnancy and early childbearing (particularly without adequate health system support), lack of education and lower wages than men and gender based violence. The hallmark commitment of the ICPD to women's empowerment, therefore, was not only an aspiration for dignity, but pivotal to creating the enabling conditions in which half the global population will have the possibility to define the direction of their lives, expand their capabilities, and elaborate their chosen contributions to society.

The Programme of Action drew historic and overdue attention to the intimate relationship between women's relative freedoms in marriage, sexuality and reproduction, their gendered position in society, and their lifetime health and well-being. In the years since the Conference, many governments have established institutions to promote women's empowerment and gender equality. As reported by governments in the Global Survey, since the early 1990s the world has seen an impressive proliferation of national institutions to address women's empowerment and gender equality. These institutions span countries in all income levels and all regions (see chapter IV, section A, Establishment of ICPD-related government institutions).

Worldwide, over 97 per cent of countries report having programmes, policies and/or strategies addressing "gender equality, equity and empowerment of women." At least 9 in every 10 countries across all regions have such frameworks in place (Africa, 100 per cent; Asia, 100 per cent; Europe, 94 per cent; Americas 94 per cent; Oceania, 93 per cent).

However, only three quarters of responding countries have committed to "improving the situation and addressing the needs of rural women" (76 per cent) and to "improving the welfare of the girl child, especially with regards to health, nutrition and education" (80 per cent).

Human rights elaborations since the ICPD: Women's empowerment and gender equality

Binding instruments: In 1999, the General Assembly adopted the *Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women* (1999; e.i.f. 2000), which contains a communications procedure to allow individuals and groups to submit claims of rights violations protected under the convention, and also created an inquiry procedure allowing the Committee on the Elimination of Discrimination against Women to investigate situations of women's rights violations. Regionally, the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* (1995; e.i.f. 2005) recognizes the key role of women's political, economic and social participation, and calls for the elimination of discrimination against women.

Intergovernmental human rights outcomes: Human Rights Council *Resolution 15/23 Elimination of Discrimination Against Women* (2010) "expresses concern at the fact that, despite the pledge made at the Beijing World Conference on Women and the review by the General Assembly at its twenty-third special session to modify or abolish remaining laws that discriminate against women and girls, many of those laws are still in force and continue to be applied, thereby preventing women and girls from enjoying the full realization of their human rights."

Other intergovernmental agreements: *The Beijing Declaration and Platform of Action* (1995) reaffirms a commitment to, "Ensure the full implementation of the human rights of women and of the girl child as an inalienable, integral and indivisible part of all human rights and fundamental freedoms."

1. Changing patterns in productive and reproductive roles

(a) Changing patterns of employment

The gender gap in labour force participation has narrowed slightly since 1990, but relative to men's work, women's work continues to pay less, to be more often in the informal sector, temporary, insecure and to command less authority. Women's total participation rates in the labour force remained steady at the global level, with a slight decline in the last few years, while men's rates also declined slightly throughout the period. At the regional level, change in women's labour force participation has been variable. It increased the most in Latin America and the Caribbean, and decreased slightly in Eastern Europe, and much of Asia other than South Asia – where it increased slightly.[50] The labour force participation of women aged 25-54[51] increased in all regions since 1990 except for Eastern Europe, partly due to declining fertility and a lessening impact of fertility on labour force participation.[52]

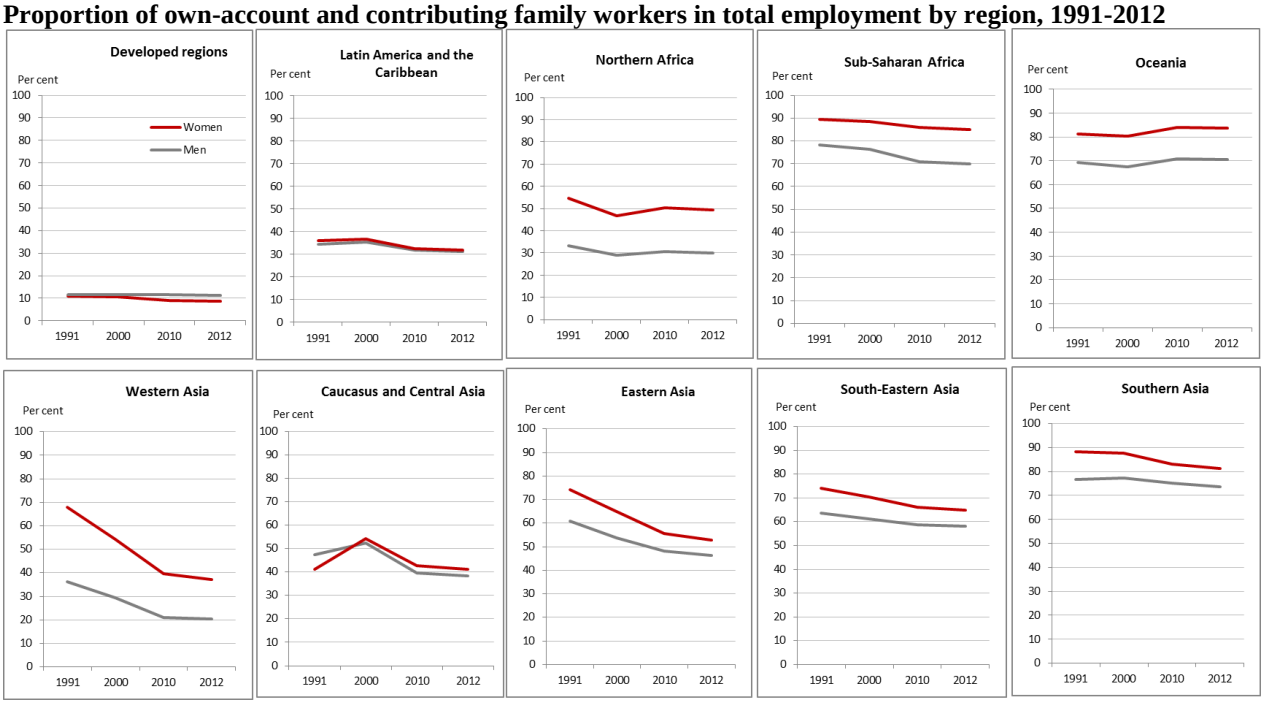
Women's share in wage employment in the non-agricultural sector and in traditionally male-dominated occupations has increased, although remained low in jobs associated with status, power and authority. In all regions, women remain significantly under-represented among business leaders and managers.[53]

Women continue to be paid less than men for equal work, as the gender pay gap is closing slowly and only in some countries.[54] And women tend to hold jobs that are less secure and with fewer benefits than men, including *vulnerable employment* (see Figure 4), which comprises contributing family workers and

[50] United Nations, 2010. *World's Women 2010. Trends and Statistics*. Department of Economic and Social Affairs, Statistics Division; ILO, 2012. *Global Employment Trends for Women 2012*. International Labour Organization: Geneva.
[51] This is a more robust indicator that mitigates labour force participation rates that are affected by changing age structures, but this indicator is not available for comprehensive number of countries.
[52] United Nations, 2010. *World's Women 2010. Trends and Statistics*. Department of Economic and Social Affairs, Statistics Division
[53] United Nations, 2010. *World's Women 2010. Trends and Statistics*. Department of Economic and Social Affairs, Statistics Division; United Nations, 2013. *The Millennium Development Goals 2013. Statistical Annex*. Available at: http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Data/Trends.htm
[54] *World's Women 2010. Trends and Statistics*. Department of Economic and Social Affairs, Statistics Division; ILO, 2012.

own account workers, as opposed to wage and salaried workers[55]. Although, the overall proportion of total employment that is *vulnerable employment* declined over the past 20 years, it remains high in many regions outside the developed countries, particularly in sub-Saharan Africa, Oceania, Southern Asia and South-Eastern Asia (See Figure 4). Women's employment continues to be more concentrated than men's employment in vulnerable jobs in all but the wealthiest countries – and this gender gap is widest in North and sub-Saharan Africa and Western Asia; the gender gap decreased in Asia and increased in sub-Saharan Africa.

Figure 4
Proportion of own-account and contributing family workers in total employment by region, 1991-2012



Source: United Nations, 2013. Millennium Development Goals Report 2013. Statistical Annex: Millennium Development Goals, Targets and Indicators, 2013: Statistical tables. Department of Social and Economic Affairs, Statistics Division.

Since 1995, women's paid employment has risen substantially, which raises the question of how this has affected women's overall work burden. Studies of Africa in particular reveal that time and money poverty may be inter-related, and that women in particular suffer from both. In one country for example, while the average man worked 38.8 hours per week, women on average worked 49.3, and at least a quarter of women reported working 70 hours per week, a clear sign that time poverty is a problem[56]; similar patterns have been found in Latin America.[57]

The Programme of Action called on governments to take steps to eliminate inequalities between men and women by:

- Adopting appropriate measures to improve women's ability to earn income beyond traditional occupations, achieve economic self-reliance, and ensure women's equal access to the labour market and social security systems.
- Eliminating discriminatory practices by employers against women.

[55] United Nations, 2013. *The Millennium Development Goals 2013*. New York: United Nations; United Nations, 2010. *World's Women 2010. Trends and Statistics*. Department of Economic and Social Affairs, Statistics Division; ILO, 2012. *Global Employment Trends for Women 2012*. International Labour Organization: Geneva.
[56] Bardasi, E., and Q. Wodon. 2010. Working Long Hours With No Choice: Time Poverty in Guinea, Feminist Economics, 16(3), 45-78.
[57] Gammage, Sarah, 2010. Time Pressed and Time Poor: Unpaid Household Work in Guatemala. Feminist Economics 16(3), 79–112.

The member states in the regional review conferences of the ICPD Beyond 2014 acknowledged that increasing women's access to paid employment has many advantages, both for women themselves, and for economic development more generally. By pulling women into paid employment, not only does national income rise, but societies can draw more extensively on the many talents and skills women have to offer. Additionally, women's increased engagement with the monetary economy creates a positive feed-back loop in terms of job creation.

States should enact or review, strengthen and enforce, laws against workplace discrimination of women, guaranteeing women the same access as men to formal and secure employment, with equal pay for equal work. Guaranteeing equal employment opportunities for women and men advances equality, and is also beneficial for economic growth. Gender equality in education, skill development, and equal access to all sectors of employment can result in broad productivity gains and increased profitability; improved well-being of women and their families; and more inclusive institutions and policy choices.[58]

Companies that invest in women's employment often find that it benefits their bottom line by improving staff retention, innovation, and access to talent and new markets.[59] A recent report by the IMF estimates that closing the gender gap in the labour market would raise Gross Domestic Product in the United States of America by 5 per cent, in the United Arab Emirates by 12 per cent, and in Egypt by 34 per cent,[60] and that economic benefits of women's empowerment and gender equality are particularly high in rapidly ageing societies, where women's labour force participation can help to offset the impact of an otherwise shrinking workforce.

On the issue of enhancing women's income-generation ability, 85 per cent of all countries report having budgetary policies and programmes to address the issue of "increasing women's participation in the formal and informal economy", and this does not vary by the wealth of countries. Eighty-five per cent of countries report that they currently have a law in place (with an enforcement provision) against gender discrimination at work in hiring, wages and benefits.

(b) Support for Working Parents

The Programme of Action of the ICPD encouraged countries to create policies and programmes to support work-life balance, and enable parents to participate in the workforce without compromising the well-being of children and households by making it possible, through laws, regulations and other appropriate measures, for women to combine the roles of child-bearing, breast-feeding and child-rearing with participation in the workforce.

Ninety per cent of countries reporting in the Global Survey state that they have a law in place with an enforcement provision for paid maternity leave (of any length). Yet only 54 per cent have such an instrument in place for paid paternity leave, constituting a major barrier to men's participation in parenting. Europe is the region with the highest proportion of countries with a law guaranteeing such paternity-related benefit (81 per cent), followed by the Americas (53 per cent), Africa (52 per cent), Asia

[58] ILO, 2012. *Global Employment Trends for Women 2012*. International Labour Organization: Geneva; World Bank, 2011. World Development Report 2012. Gender Equality and Development. Washington DC: The International Bank for Reconstruction and Development / The World Bank..; International Finance Corporation, 2013. Investing in Women's Employment. Good for Business, Good for Development. World Bank Group: Washington DC.

[59] International Finance Corporation (IFC), 2013. Investing in Women's Employment. Good for Business, Good for Development. World Bank Group: Washington DC.

[60] International Monetary Fund (IMF), 2013. Women, Work and the Economy; Katrin Elborgh-Woytek, Monique Newiak, Kalpana Kochhar, Stefania Fabrizio, Kangni Kpodar, Philippe Wingender, Benedict Clements, and Gerd Schwartz, 2013. Women, Work, and the Economy: Macroeconomic Gains from Gender Equity. IMF Staff Discussion Note, September 2013 SDN/13/10.

(43 per cent) and Oceania (29 per cent).

Fewer than half of responding countries report having enforced laws guaranteeing daycare centres and facilities for breastfeeding mothers in the public (41 per cent) or private sectors (39 per cent). These limitations can make it impossible for women to rejoin the labour market after childbearing, or to sustain breastfeeding after doing so, with negative implications for both women's productivity and child health. In fact, only one in four African countries - the region where most of the population growth will occur in the next decades - have laws in place to ensure the compatibility between breastfeeding and work responsibilities (25 per cent for both public and private sectors).

If a composite indicator is created for the five family-work balance issues described above (promulgated and enforced laws against workplace discrimination against women; facilitating compatibility between labour force participation and parental responsibilities; promulgated and enforced laws that enable maternity leave; promulgated and enforced laws that enable paternity leave; promulgated and enforced laws that enable breastfeeding in the workplace), of 113 countries with complete information, only 26, or 19 per cent, have addressed all 5 dimensions.

States should ensure universal access to paid parental leave for both mothers and fathers, including adoptive parents; universal access to high-quality infant and child care for working parents, including extended after-school care; and establish and enforce laws that require that public and private workplaces accommodate the needs of breastfeeding mothers.

(c) Co-responsibility

Women continue to bear most of the responsibilities at home, caring for children and other dependent household members, preparing meals, cleaning or doing other housework. It is estimated that, in all regions, women spend at least twice as much time as men on unpaid domestic work; and when paid and unpaid work are combined together, women's total work hours are longer than men's. Balancing work and family is particularly challenging for employed parents with young children and often women are the ones to discontinue their employment or take on part-time jobs while their partners keep a full-time job.[61]

The Programme of Action recognized that the full participation of and partnership between both women and men is required in productive and reproductive life, including co-responsibility for the care and nurturing of children and maintenance of the household.

Gender equality in the home and the workplace demands changes in the involvement of men and boys in reproductive roles and household chores; without such task shifting, women take on an inordinate double-burden of responsibility, and are unlikely to realize their full and fair participation in both productive and reproductive life and to enjoy equal status in society.

While many countries have made substantial advances in enhancing women's participation in the labour force since 1994, gender inequalities in the balance of work and family life have not garnered the same level of support. For example, fewer than two-thirds of countries (64 per cent) reporting to the Global Survey have addressed the issue of "facilitating compatibility between labour force participation and parental responsibilities", making it easier for women to combine child-rearing with participation in the workforce. This issue has been prioritized by a smaller proportion of countries in the Americas (53 per cent) and in Africa (55 per cent) compared with those in Asia (74 per cent) or Europe (92 per cent). In

[61] United Nations, 2010. *World's Women 2010. Trends and Statistics*. Department of Economic and Social Affairs, Statistics Division.

fact, a higher proportion of richer countries and countries marked by slow population growth have addressed these issues when compared to poorer countries and countries marked by high population growth.

Two-thirds of countries reporting to the Global Survey have "engaged men and boys to promote male participation, equal sharing of responsibilities such as care work*"* during the past 5 years (63 per cent). Although no major regional variations are observed, grouping countries by income shows that this is a higher concern for high-income OECD countries (81 per cent), while the proportion of countries addressing this issue in the four other income groups is just above or below the world average (low-income: 69 per cent; lower middle-income: 58 per cent; higher middle-income: 57 per cent; high-income non-OECD: 67 per cent).

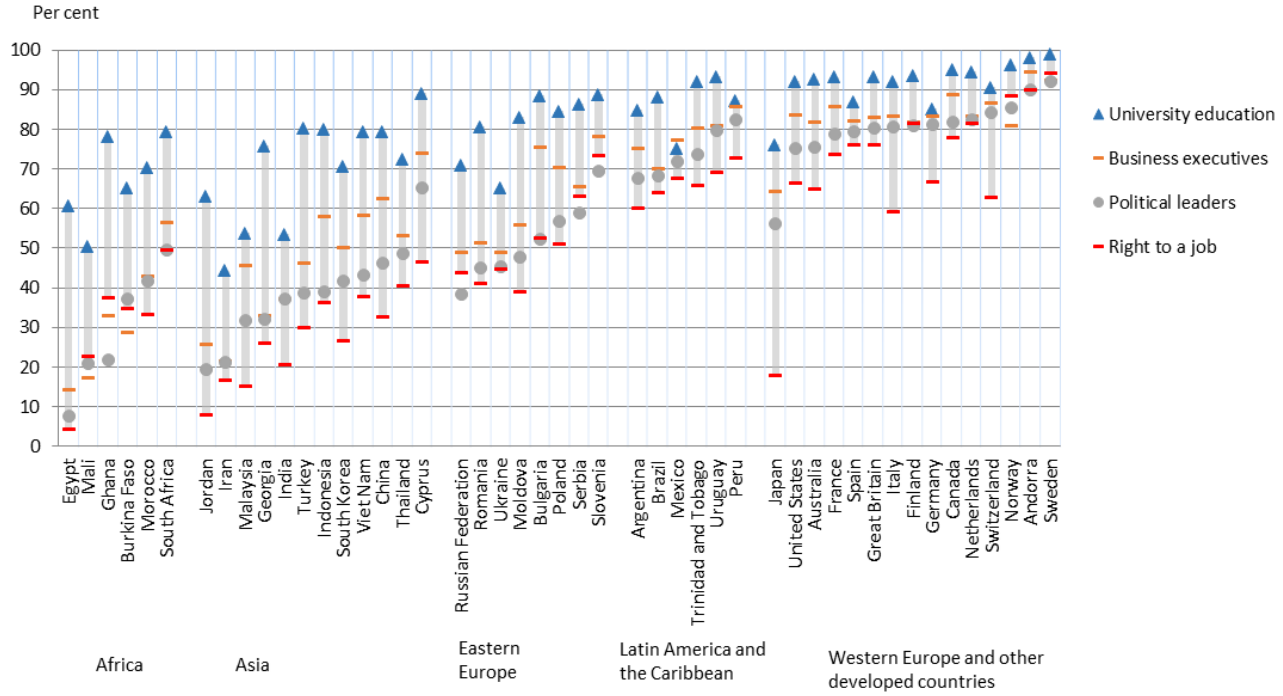
2. Uneven progress in attitudes towards gender equality

Public attitudes support women's empowerment and gender equality in a majority of the population in most of the countries for which there is data, but the extent of support depends on the specific gender value under consideration. The most recent available data from the World Values Survey (2004-09) in 47 countries, provides evidence that public values are most gender equitable regarding who should have access to higher education, highly variable with regard to men's and women's equal access to jobs, and consistently more modest with regard to women's effectiveness (relative to men's) as leaders in business or politics (see Figure 5). Currently, there is a large consensus with regard to the importance of tertiary education for both girls and boys; in most countries, the majority of people no longer believe that a university education makes a difference only for boys. However, with regard to other public spheres, distinct gender roles that give advantage to men are still valued in countries from Africa and Asia and in some of the countries from Eastern Europe. For example, men are considered better business and political leaders by 50 per cent or more people in almost half of countries, with perceptions of male superiority in political leadership more pronounced than in business.

The trend data suggests that values of gender equality have been trending upwards in most countries since the mid-1990s (see Figure 5a-c), with the exception of the value "when jobs are scarce, men should have more right to a job than women" – which is highly variable between countries, and over time.

Figure 5

Support for gender equality in university education, business executives, political leaders, and women's equal right to employment by region, 2004-2009



Source: World Values Surveys 2004-2009 data (downloaded and analyzed 20 August 2013).

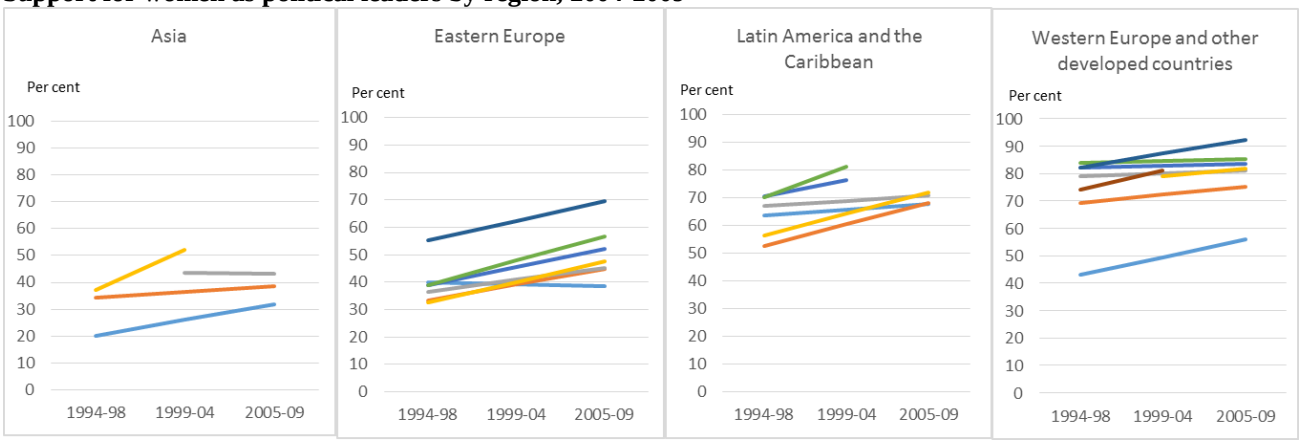
Note: Support for gender equality is measured as the proportion of respondents who *disagree* with the following statements: (a) "a university education is more important for a boy than for a girl"; (b) "on the whole, men make better business executives than women do"; (c) "on the whole, men make better political leaders than women do"; and (d) "when jobs are scarce, men should have more right to a job than women.

The regional and development gap in gender values has been getting smaller, as countries from Western Europe and wealthy non-OECD countries have already reached a high degree of social consensus, while countries from Latin America and the Caribbean, as well as countries from Eastern Europe, are catching up.

Some countries showed no significant change in support for gender equality values. These countries are from all regions, and they vary depending on the issue in question. No progress was observed for one eighth of countries (3 out of 25 with available data) with regard to tertiary education; a quarter of countries (6 out of 25) with regard to political leadership; and a third of countries (8 out of 25) with regard to access to the job market.

Figure 5.a

Support for women as political leaders by region, 2004-2009

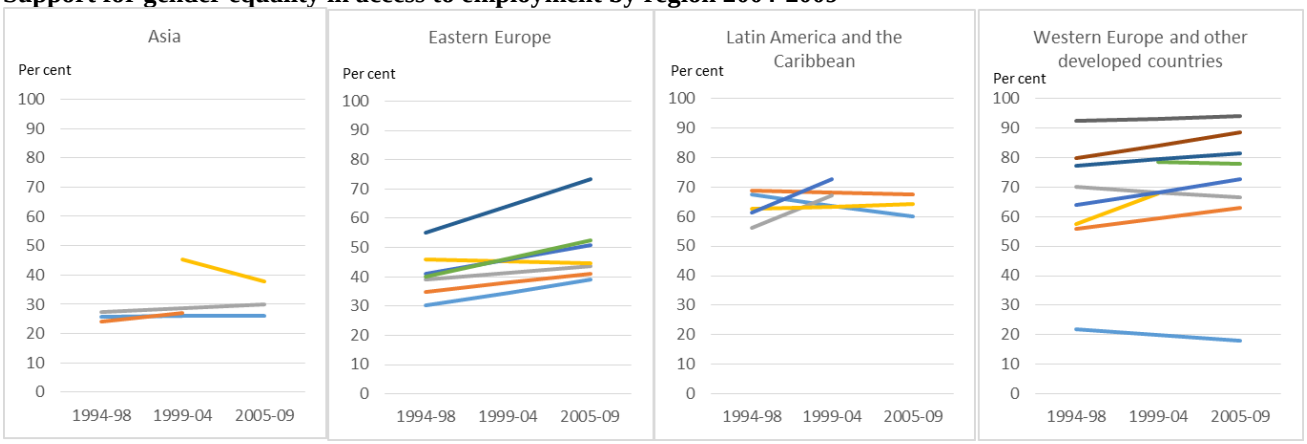


Source: World Values Surveys 2004-2009 data. (downloaded and analyzed 20 August 2013).

Note: Measured as the proportion of respondents who ***disagree*** with the following statement: (a) "on the whole, men make better political leaders than women do"

Figure 5.b

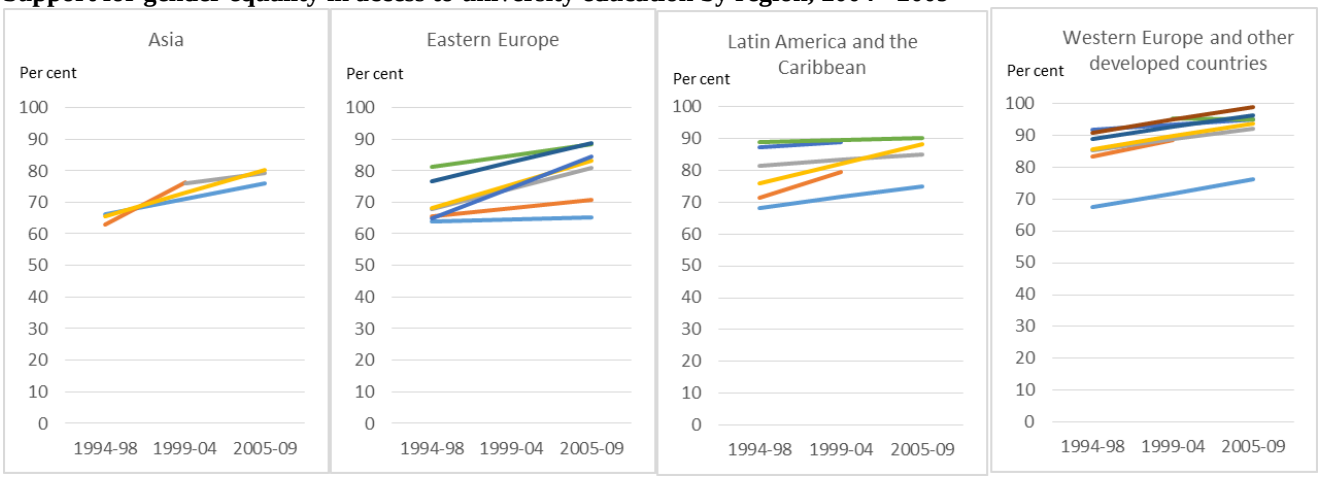
Support for gender equality in access to employment by region 2004-2009



Source: World Values Surveys 2004-2009 data. (downloaded and analyzed 20 August 2013).

Note: Measured as the proportion of respondents who ***disagree*** with the following statement: "when jobs are scarce, men should have more right to a job than women.

Figure 5.c
Support for gender equality in access to university education by region, 2004 - 2009



Source: World Values Surveys 2004-2009 data. (downloaded and analyzed 20 August 2013).
Note: Measured as the proportion of respondents who disagree with the following statement: "a university education is more important for a boy than for a girl". Source of data: World Values Surveys (data downloaded and analyzed 20 August 2013).

There is greater support for gender equality among women than men (see Annex I, Figure 1). This is the case for all four issues explored, and in the majority of countries. The gender gap is not marginal, and becomes larger in countries with less overall support for gender equality. Overall, the gender gap is smaller on the issue of access to tertiary/university education, and larger on men's favoured access to jobs, and women's leadership in politics and business. For all four issues, the gap is lowest in Western European countries and other developed countries, where men have reached similar or only slightly lower levels of recognition of gender equality as women.

Although women are stronger supporters of gender equality, there have been positive changes in gender attitudes and values for both women and men. The overall differences in gender values and attitudes between women and men have increased in some countries, for example, concerning values related to women as political leaders in Ukraine, Moldova, and Argentina, and values related to education in the Russian Federation. In those cases, the proportion of women supporting gender equality has increased significantly, while the proportion of men remained at the same lower levels as in the previous surveys. Conversely, in some other countries, it is men who progressed more than women, for example, regarding values related to tertiary education in Turkey and Brazil. While women remain stronger in their support to gender equality, in select cases men are getting closer to the higher level of support shared by women (see Annex I, Figure 2).

Younger generations also tend to be more positive towards gender equality than older cohorts, although the intergenerational gap is significant only in a few countries (see Annex I, Figure 3). In about half of the countries surveyed in 2005, younger generations give a significantly stronger support to gender equality related to political and managerial leadership and higher education. With regard to rights to a job, young people more strongly support gender equality in about three quarters of countries.

Countries from Western Europe have the highest intergenerational consensus with regard to politics, while countries from Eastern Europe and Africa have the highest intergenerational consensus with regard to rights to a job.

The results suggest that changes in attitudes and values regarding gender are taking place across whole societies over time, rather than only among younger generations. For some countries with available data

on trends, the cross-sectional differences over ten years were larger than differences between older cohorts of above 50 years and younger cohorts of 15-29 years. This is the case of some Eastern and Western European countries. For example, regarding attitudes towards women and men as political leaders in 2005, there were no significant differences between older and younger cohorts in Bulgaria, Romania, Ukraine, Finland, or Sweden, while all of those countries had increased their support for gender equality between 1995 and 2005.

States should ensure equal opportunities for women to contribute to society as leaders, managers, and decision-makers, granting them access to positions of power that is equal to those of men in all sectors of public life. As part of these efforts, it is important to address public views and values regarding sexism or other forms of discrimination, including through creative communication and education campaigns, and monitor these on a regular basis as indicators of social development.

3. Gender based violence

An estimated one in three women worldwide report they have experienced physical and/or sexual abuse, mostly at the hands of an intimate partner, making this form of violence against women and girls one of the most prevalent forms of human rights violations worldwide.[62]

The first multi-country study (2005) estimating the extent of domestic violence found that the proportion of adult women who had ever suffered physical violence by a male partner ranged widely across 10 study countries – from 13 per cent to 61 per cent.[63] The proportion of women who had experienced *severe physical violence* by a male partner, defined as "being hit with a fist, kicked, dragged, threatened with a weapon or having a weapon used against her" ranged from 4 per cent to 49 per cent across countries, with most countries falling between 13 per cent and 26 per cent.[64] The first global and regional prevalence estimates (2013) on sexual and physical intimate partner violence (IPV), and non-partner sexual violence, show that 30 per cent of ever-partnered women age 15 and older worldwide have experienced some form of IPV, with as many as 38 per cent of women having experienced IPV in certain regions.[65]

Metrics to measure non-partner sexual violence are less clearly defined, highlighting a general lack of data on non-partner sexual violence. Yet, current estimates are that globally 7 per cent of women have experienced sexual violence by someone other than an intimate partner. Combined estimates show that 36 per cent of women globally have experienced either IPV, non-intimate partner violence, or both forms of gender based violence.[66]

A recent (2013) UN multi-country study on Men and Violence in Asia and the Pacific found that nearly half of the 10,000 men interviewed reported using physical and/or sexual violence against a female

[62] World Health Organization (2013). G*lobal and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. World Health Organization, Geneva. Retrieved from: http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf.

[63] Garcia-Moreno C et al, Jansen H.A.R.M., Ellsberg M., Heise L., Watts, C. (2005). *WHO multi-country study on women's health and domestic violence against women: Initial results on prevalence, health outcomes and women's responses.* Geneva, World Health Organization, 2005.Geneva. Retrieved from: http://whqlibdoc.who.int/publications/2005/924159358X_eng.pdf.

[64]Garcia-Moreno C., Jansen H.A.R.M., Ellsberg M., Heise L., Watts, C. (2005). *WHO multi-country study on women's health and domestic violence against women: Initial results on prevalence, health outcomes and women's responses.* World Health Organization, Geneva. Retrieved from: http://whqlibdoc.who.int/publications/2005/924159358X_eng.pdf.

[65] World Health Organization (2013). G*lobal and regional estimates of violence against women:Prevalence and health effects of intimate partner violence and non-partner sexual violence*. Geneva, World Health Organization. 2013. World Health Organization, Geneva. Retrieved from: http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf.

[66]World Health Organization (2013). G*lobal and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. World Health Organization, Geneva. Retrieved from: http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf. .

partner, ranging from 26 per cent to 80 per cent across sites.[67] Nearly a quarter of men interviewed reported perpetrating rape against a woman or girl, ranging from 10 per cent to 62 per cent across the sites. Men begin perpetrating violence at young ages, with half of those who admitted to rape reporting a first perpetration when they were teenagers, and some even younger than 14. Of those men who admitted to rape, the vast majority (72-97 per cent in most sites) had experienced no legal consequences, confirming that impunity remains a serious issue in the region. Across all sites, the most common motivation that men cited for rape related to sexual entitlement - a belief that men have a right to sex with women regardless of consent. Over 80 per cent of men who admitted to rape in sites in rural parts of two countries gave this response. Overall, 4 per cent of all respondents said that they had perpetrated gang rape against a woman or girl, ranging from 1 to 14 per cent across the various sites. This is the first data from such a large sample of men on the perpetration of gang rape.[68]

The health effects of IPV are substantial, with IPV contributing to numerous direct and indirect negative health outcomes among women and their children. Thirty eight per cent of all murders of women globally are committed by intimate partners. Beyond non-fatal and fatal injuries, experiences of IPV among women are associated with an increased risk of HIV and other sexually transmitted infections. Further, women who have experienced sexual or physical IPV show higher rates of induced abortion, and poor birth outcomes, including low birth weight and preterm birth. Gender based violence also has serious short- and long-term social and economic costs for societies, including direct costs through health expenditures, indirect economic costs on workforce participation, missed days of work, and lifetime earnings, as well as indirect costs to the long-term health and well-being of children and other people living in a violent household.[69]

In 12 countries, the Demographic and Health Surveys (DHS) collected data on attitudes towards "wife-beating" during at least two time points, based on the percentage of men and women aged 15–49 who agreed that a husband/partner is justified in hitting or beating his wife/partner for at least one of the following reasons: if she burns the food, argues with him, goes out without telling him, neglects the children or refuses sexual relations. As displayed in Figure 6 (below), there has been a measurable decline in the proportion of males who endorse any of these justifications for this particular form of physical intimate partner violence. While these trends suggest positive change in men's respect for women's dignity it must be noted that in five countries, despite these trends, more than 40 per cent still endorsed justifications for domestic violence.[70]

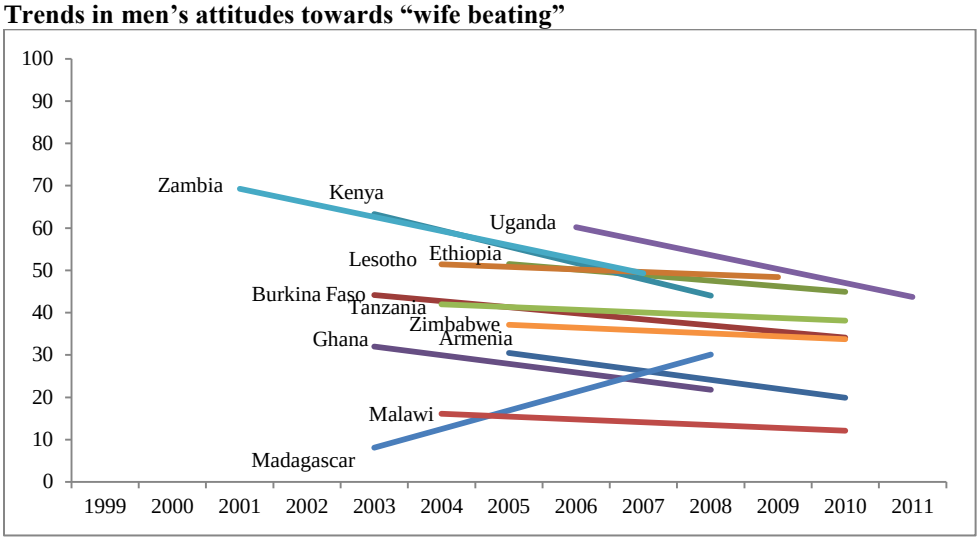
[67] UNDP, UNFPA, UN Women and UNV. (2013). Why do some men use violence against women and how can we prevent it? Quantitative findings from the United Nations Multi-Country Study on Men and Violence in Asia and the Pacific. Partners for Prevention. A UNDP, UNFPA, UN Women and UNV Regional Joint Programme for Gender-Based Violence Prevention in Asia and the Pacific. Retrieved from: http://www.partners4prevention.org/node/515.

[68] UNDP, UNFPA, UN Women and UNV. (2013). Why do some men use violence against women and how can we prevent it? Quantitative findings from the United Nations Multi-Country Study on Men and Violence in Asia and the Pacific. Partners for Prevention. A UNDP, UNFPA, UN Women and UNV Regional Joint Programme for Gender-Based Violence Prevention in Asia and the Pacific. Retrieved from: http://www.partners4prevention.org/node/515.

[69] Jewkes, RK., Dunkle, K., Nduna M., Shai, N. (2010). Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: A cohort study. *Lancet*, 376(9734): 41-48.; Morrison, AR., Orlando, MB. (2004). The costs and impacts of gender-based violence in developing countries: Methodological considerations and new evidence. Background paper prepared for *The Development Implications of Gender-Based Violence* Workshop. World Bank. Retrieved from: http://siteresources.worldbank.org/INTGENDER/Resources/costsandimpactsofgbv.pdf. ; Weiss, HA., Patel, V., West, B., Peeling, RW., Kirkwood, BR., Mabey, D. (2008). Spousal sexual violence and poverty are risk factors for sexually transmitted infections in women: a longitudinal study of women in Goa, India. *Sexually Transmitted Infections*, 84(2): 133-139.; World Health Organization (2013). G*lobal and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. World Health Organization, Geneva. Retrieved from: http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf.

[70] Demographic and Health Survey Data from 12 countries with available data: Zambia, Kenya, Uganda, Ethiopia, Lesotho, Burkina Faso, the United Republic of Tanzania, Zimbabwe, Armenia, Ghana, Malawi, Madagascar. Data retrieved from: Measure DHS (http://www.measuredhs.com/) and UNICEF Global Database Childinfo: Monitoring the Situation of Children and Women (http://www.childinfo.org/attitudes.html).

Figure 6
Trends in men's attitudes towards "wife beating"



Sources: Demographic and Health Surveys, all countries with available data for at least 2 timepoints, retrieved from www.measuredhs.com on 15 November 2013.

Similar trends are noted in women's attitudes, with an overall decline between survey time points. Yet despite these positive trends, as many as 70 per cent of women surveyed in some countries continue to agree that wife-beating is justified under certain circumstances (See Annex I, Figure 4).[71]

Government accountability and community-supported policies to promote women's empowerment and gender equality are key to preventing and responding to gender based violence, alongside social and economic interventions that challenge social norms and promote women's economic rights and gender empowerment.[72] Agreed conclusions for preventing and eliminating violence against women from the 57th Commission on the Status of Women urge strengthening legal and policy frameworks, and monitoring and ensuring accountability, while addressing structural causes of violence and promoting multi-sector responses.[73]

WHO guidelines urge a strengthened multi-pronged health systems response to IPV and sexual violence, improving access to critical treatment services such as emergency contraception, abortion in cases of pregnancy from rape, prophylaxis for HIV and other STIs, and mental health support.[74]

A growing number of Security Council resolutions are recognizing and responding to the extent of violence against women and girls, including 2122 (2013) highlighting the need for humanitarian aid to include a full range of health services for women who become pregnant as a result of rape in conflict, which would include access to abortion; 1325 (2000) on the impact of conflict on women and their role in resolution and peace-building; 1820 (2008) acknowledging sexual violence against women in conflict

[71] Demographic and Health Survey Data from 12 countries with available data: Zambia, Kenya, Uganda, Ethiopia, Lesotho, Burkina Faso, the United Republic of Tanzania, Zimbabwe, Armenia, Ghana, Malawi, Madagascar. Data retrieved from: Measure DHS (http://www.measuredhs.com/) and UNICEF Global Database Childinfo: Monitoring the Situation of Children and Women (http://www.childinfo.org/attitudes.html).
[72] Sen G. *Sexual and reproductive health and rights in the post 2015 development framework*. Provisional Discussion Paper, ICPD Beyond 2014 International Conference on Human Rights. 26 June 2013. World Health Organization (2013). G*lobal and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. World Health Organization, Geneva. Retrieved from: http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf.
[73] The Fifty-seventh Session of the Commission on the Status of Women. Agreed conclusions on the elimination and prevention of all forms of violence against women and girls: agreed conclusions. In: *Commission on the Status of Women*, Fifty-seventh session,. E/2013/27; E/CN.6/2013/11. 4-15 March 2013., New York, United Nations, 2013. (http://www.un.org/womenwatch/daw/csw/57sess.htm).
[74] World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines.* Geneva, World Health Organization, 2013. Retrieved from:
http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf.

as a war crime; and 1888 (2009) that explicitly charges peacekeeping missions with the job of protecting women and children from sexual violence in conflict.[75]

Violence against children takes many forms, is perpetrated by both adults and peers, and can lead to greater risk of suicide, depression and other mental illness, substance abuse, a reduced ability to avoid other violent relationships, and for some, a heightened risk of perpetrating violence.[76] While girls are especially vulnerable to sexual violence and abuse, new multi-country data[77] is drawing attention to the violent experience of boys during childhood, which is treated too often as normal for boys, but which can have long-term effects no less traumatic than for girls.

Recent data from a collection of six diverse countries[78] affirm the longstanding observation that men are more likely to use violence against women and children if they have less gender equitable attitudes, if they witnessed or experienced household violence during childhood, are under acute economic stress, or experiencing the disruptions of displacement or conflict.[79]

Psychologists suggest that acute fear, such as that prevalent in war or conflict, may be temporarily dissipated for some people by perpetrating aggression against others. Such a response can also lead to heightened non-combatant violence. Rape and other forms of sexual violence are used as tactics of war, but their incidence also increases within the non-combatant population during war-related instability and conflict.[80]

Recent data from eastern Democratic Republic of Congo (DRC), which has experienced sustained internecine violence for over a decade, found that almost half (48 per cent) of male non-combatants reported using physical violence against women, 12 per cent acknowledged having carried out partner rape, and 34 per cent reported perpetrating some kind of sexual violence. This heightened violence included 9 per cent of adult men having been victims of sexual violence themselves, and 16 per cent of men and 26 per cent of women having been forced to watch sexual violence.[81] All available evidence suggests that the consequences of such violence can be serious and long-term,[82] and several small-scale

[75] United Nations Security Council Resolution on *Women and peace and security:* S/RES/2122 (2013) adopted 18 October 2013; S/RES/1888 (2009) adopted 30 September 2009; S/RES/1820 (2008) adopted 19 June 2008; S/RES/1325 (2000) adopted 31 October 2000.

[76] Carrington and Scott 2008; Stewart and Simons 2010; Briere 1987; Markowitz 2001; Lichter and McCloskey 2004 United Nations Secretary-General's report of the independent expert for the United Nations study on violence against children. (2006). Retrieved from: http://www.unicef.org/violencestudy/reports/SG_violencestudy_en.pdf.; World Health Organization. (2006). Preventing Child Maltreatment: A Guide to Taking Action and Generating Evidence. World Health Organization and International Society for Prevention of Child Abuse and Neglect, (Geneva, Switzerland). Retrieved from: http://whqlibdoc.who.int/publications/2006/9241594365_eng.pdf.

[77] Representing surveys from Brazil, Chile, Croatia, India, Mexico, Rwanda (Images/Promundo) Findings from the Instituto Promundo *International Men and Gender Equality Survey* (IMAGES), presented by Dr. Gary Barker at the Dialogue on Men and Boys, Masculinity and Sexual and Reproductive Health and Rights, United Nations Population Fund, New York, 23 September 2013.

[78]International Center for Research on Women and Instituto Promundo. (2011).Evolving Men: Initial Results from the International Men and Gender Equality Survey (IMAGES). Men and Gender Equality Policy Project coordinated by the International Center for Research on Women and Instituto Promundo. Retrieved from: http://www.promundo.org.br/en/wp-content/uploads/2011/01/Evolving-Men-IMAGES-1.pdf.

[79] International Center for Research on Women and Instituto Promundo. (2011).Evolving Men: Initial Results from the International Men and Gender Equality Survey (IMAGES). Men and Gender Equality Policy Project coordinated by the International Center for Research on Women and Instituto Promundo. Retrieved from: http://www.promundo.org.br/en/wp-content/uploads/2011/01/Evolving-Men-IMAGES-1.pdf.

[80] Presentation by Dr. Ernesto Mujica at the Dialogue on Men and Boys, Masculinity and Sexual and Reproductive Health and Rights, United Nations Population Fund, New York, 23 September 2013.

[81] Slegh, H., Barker, G., Ruratotoye, B. & Shand, T. (2012). Gender Relations, Sexual Violence and the Effects of Conflict on Women and Men in North Kivu, Eastern Democratic Republic of Congo: Preliminary Results of the International Men and Gender Equality Survey (IMAGES). Sonke Gender Justice Network and Promundo-US: Cape Town, South Africa, and Washington, DC. Retrieved from: http://www.promundo.org.br/en/wp-content/uploads/2013/01/IMAGES-DRC1.pdf.

[82] Kinyanda, E., Musisi, S., Biryabarem, C., Ezati, I., Oboke, H., Ojiambo-Ochieng, R., Were-Oguttu, J., Levin, J., Grosskurth, H., Walugembe, J. War related sexual violence and it's medical and psychological consequences as seen in Kitgum, Northern Uganda: A cross-sectional study. BMC International Health and Human Rights 2010, 10:28 doi:10.1186/1472-698X-10-28; Ward J, Marsh M: Sexual violence against women and girls in war and its aftermath: Realities, responses and required resources. In *Proceedings of the Symposium on sexual violence in conflict and beyond*. Brussels, Belgium; 2006; Longombe AO, Claude KM, Ruminjo J: Fistula and traumatic genital injury from sexual violence in a conflict setting in Eastern Congo: Case studies. *RHM* 2008, 16(31):132-141; Joachim I: Sexualised violence in war and it's consequences. In *Violence against women in war: Handbook for professionals working with traumatized women*. Edited by Medica Mondiale. Cologne, Medica Mondiale; 2005::63-110;

efforts are underway in the eastern DRC to try and address the emotional trauma of victims and their families, as well as physical scarring.[83]

Of all the issues related to the ICPD listed in the Global Survey, "ending gender-based violence" was among those addressed by the highest proportion of governments (88 per cent). Regionally, this issue was addressed by 94 per cent of governments in Africa, 87 per cent in the Americas, 90 per cent in Asia, 82 per cent in Europe and 77 per cent in Oceania.

With regards to legal frameworks aimed at preventing and addressing abuse, neglect and violence, only 87 per cent of countries reported in the Global Survey that they have promulgated and enforced laws that criminalize rape and other forms of sexual exploitation, and only 53 per cent of countries have promulgated and enforced laws criminalizing marital rape (Africa: 39 per cent; Americas: 57 per cent; Asia: 48 per cent; Europe: 75 per cent; Oceania: 62 per cent).

Seventy three per cent of countries have promulgated and enforced laws criminalizing intimate partner violence, an issue that has been prioritized in the Americas (88 per cent) and Europe (84 per cent) in contrast with those in Asia (61 per cent), Africa (68 per cent) and Oceania (71 per cent).

In relation to the criminalization of sexual exploitation of young people, particularly girls, 83 per cent of countries reported that they have promulgated and enforced laws, and 77 per cent have promulgated and enforced laws preventing the use of children in pornography.

If a composite indicator is calculated for the six legal dimensions above, results show that only 28 per cent of countries have promulgated and enforced laws in all cases. Almost half of European (48 per cent) and Oceanic (46 per cent) countries have done so, but a smaller share of African (26 per cent), Asian (15 per cent) and American (14 per cent) countries have done so. **States should adopt and implement legislation, policies and measures that prevent, punish and eradicate gender based violence within and outside of the family, as well as in conflict and post-conflict situations. Laws that exonerate perpetrators of violence against women and girls, including provisions that allow them to evade punishment if they marry the victim, or are the partners or husbands of the victims should be revised. Sexual violence should also be eliminated from post-conflict amnesty provisions within the framework of strengthened legislation and enforcement to end impunity.**

States should enhance their capacity to recognize and prevent violence, ensure the provision of services that can mitigate the consequences of violence and enable the full rehabilitation of those who experience it. In addition states should strengthen routine monitoring, and extend research into important unaddressed issues such as the number of people living in conditions of sustained fear; violence within schools, prisons and the military; the causes and consequences of violence; the effectiveness of interventions, and of laws and systems for the protection and recovery of victims and/or survivors.

States should further ensure that all victims/survivors of gender based violence have immediate access to critical services, including 24-hour hotlines; psychosocial and mental health support; treatment of injuries; post-rape care, including emergency contraception, post-exposure prophylaxis for HIV prevention and access to safe abortion services in all cases of violence, rape and incest; police protection, safe housing and shelter; documentation of cases, forensic services

[83]Panzi Hospital. (2012). Annual Activity Report Panzi Hospital 2012. Retrieved from: http://www.panzihospital.org/wp-content/uploads/2013/03/0823-Panzi_ENG_v9.pdf.

and legal aid; and referrals and longer-term support.

CSO priorities regarding gender based violence

A recent survey (2013) among 208 civil society organizations[84] from three regions (the Americas, Africa, and Europe), that work in the area of gender based violence found that in Africa, 23 per cent of CSOs cited "gender norms and male engagement" as the *one (1) top priority issue* for public policy for the next 5 to 10 years. In the Americas and Europe, 31 per cent and 21 per cent of CSOs respectively identify the "development of programmes, policies, strategies, laws and the creation of institutions to eradicate gender-based violence" as a priority. Finally, the "elimination of all forms of violence", including sexual violence, rape, domestic violence and femicide, among others, is also consistently mentioned by CSOs across all regions as the *one (1) top priority issue* for public policy for the next 5 to 10 years (Africa: 20 per cent; the Americas: 22 per cent; Europe: 26 per cent).

Human rights elaborations since the ICPD: Gender based violence

Binding instruments: In the years following the ICPD, GBV emerged as a prominent human rights issue, particularly in regional binding instruments, including: *The Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women* (1994; e.i.f 1995) which has been ratified by most OAS Member States *the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* (1995; e.i.f. 2005); and *The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence* (2011, *not in force*), which will enter into force once ratified by 10 states.

Intergovernmental human rights outcomes: The Human Rights Council has adopted a series of resolutions on intensifying efforts to eliminate all forms of violence against women, including *Resolution 14/12 Accelerating Efforts to Eliminate All Forms of Violence against Women: Ensuring Due Diligence in Prevention (*2010).

Other soft law: *Concluding Observations* from various treaty monitoring bodies require states to take measures to prevent sexual violence, provide rehabilitation and redress to victims of sexual violence, and prosecute offenders.[85]

4. Female genital mutilation/cutting

Female genital mutilation/cutting (FGM/C) refers to all practices that include the "partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons."[86] FGM/C can lead to both short- and long-term health consequences and risks, which increase along with the severity of the FGM/C procedure. FGM/C offers no known health benefits to women and girls.[87]

An estimated 125 million women and girls live with the consequences of FGM/C worldwide, with

[84] Only one representative of each CSO was allowed to respond to this survey, irrespective of the size and coverage of the CSO. Thus, several CSOs that responded to the survey have a national, regional and/or global scope with large beneficiary populations.

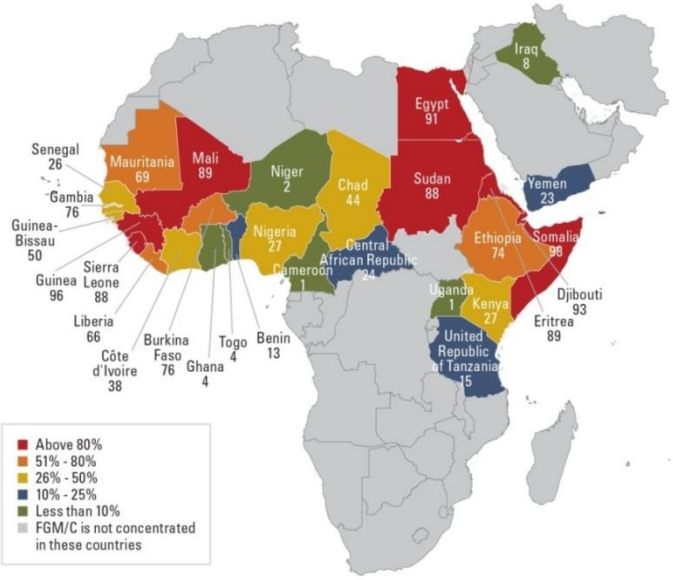
[85] CRC Committee, *Concluding Observations: Lebanon*, para. 48(d), U.N. Doc. CRC/C/LBN/CO/3 (2006); CEDAW Committee, *Concluding Observations: Tanzania*, para. 24, U.N. Doc. CEDAW/C/TZA/CO/6 (2008); Committee against Torture (CAT Committee), *Concluding Observations: Costa Rica*, para. 19, U.N. Doc. CAT/C/CRI/CO/2 (2008).

[86] World Health Organization. Female Genital Mutilation. Factsheet Number 241. February 2013. Retrieved from: http://www.who.int/mediacentre/factsheets/fs241/en/ World Health Organization. (2008). Eliminating female genital mutilation: An interagency statement. OHCHR, UNAIDS, UNDP, UNEC, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, Geneva, World Health Organization. Retrieved from: http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf.

[87] World Health Organization. (2008). Eliminating female genital mutilation: An interagency statement. OHCHR, UNAIDS, UNDP, UNEC, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, Geneva, World Health Organization. Retrieved from: http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf.

approximately 3 million girls, the majority under age 15, at risk of undergoing FGM/C each year. FGM/C is practiced widely in more than 29 countries, predominately in western, eastern, and north-eastern regions of Africa, and in countries among the Arab States.[88]

Figure 7
Percentage of girls and women aged 15-49 who have undergone FGM/C by country



Source: UNICEF, Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change, 2013

Socioeconomic factors such as educational attainment and household income influence the prevalence of and attitudes towards FGM/C within countries, while due to increased migration the prevalence of FGM/C among women and girls living outside their countries is also on the rise.[89]

Since the joint Interagency statement signed by UNICEF, UNFPA and WHO in 1997[90] much effort has been made to eliminate FGM/C and indeed the past decades have seen increased international attention and resources devoted to ending the practice. Numerous international and regional human rights instruments protect the rights of women and girls, and advocate for the eradication of FGM/C. FGM/C is a violation of the rights of the child; the rights of all persons to achieve the highest attainable standard of health; the right to be free from torture, and cruel, or inhuman treatment; and as a form of gender inequality and discrimination against women.[91] However, its persistently high prevalence coupled with

[88] United Nations Children's Fund. (2013). Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change, UNICEF, New York, 2013. Retrieved from: http://www.unicef.org/media/files/FGCM_Lo_res.pdf. ; United Nations Population Fund. (2013). UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change, Annual Report 2012. Scaling up a comprehensive approach to abandonment in 15 African countries. Retrieved from: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2013/UNICEF-UNFPA%20Joint%20Programme%20AR_final_v14.pdf; World Health Organization. (2008). Eliminating female genital mutilation: An interagency statement. OHCHR, UNAIDS, UNDP, UNECAUNEC, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, Geneva, World Health Organization. Retrieved from: http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf.

[89] United Nations Children's Fund. (2013). Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change, UNICEF, New York, 2013. Retrieved from: http://www.unicef.org/media/files/FGCM_Lo_res.pdf. ;World Health Organization. (2008). Eliminating female genital mutilation: An interagency statement. OHCHR, UNAIDS, UNDP, UNEC, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, Geneva, World Health Organization. Retrieved from: http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf.; Yoder PS, Abderrahim N, Zhuzhuni A (2004). *Female genital cutting in the Demographic and Health Surveys: a critical and comparative analysis*. Calverton, Macro International Inc.

[90] World Health Organization. (1997). Female Genital Mutilation: A Joint WHO/UNICEF/UNFPA Statement. Retrieved from: http://www.childinfo.org/files/fgmc_WHOUNICEFJointdeclaration1997.pdf.

[91] World Health Organization. (2008). Eliminating female genital mutilation: An interagency statement. OHCHR, UNAIDS, UNDP, UNEC, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, Geneva, World Health Organization. Retrieved from:

statistical projections which reveal that, at current annual reduction rates, by 2030, 20.7 million more girls born between 2010 and 2015 will likely experience some form of FGM/C,[92] further highlight the urgent need to intensify, expand and improve efforts to accelerate the annual rate of reduction and eliminate FGM/C in less than a generation. Hence the new Joint Interagency Statement written and signed by a wider group of UN agencies in 2008 calls for increased support, advocacy and resources towards the elimination of FGM/C at the community, national, and international levels.[93]

Based on the Global Survey, 46 per cent of countries have promulgated and enforced laws protecting the girl child against harmful practices, including FGM/C, with 66 per cent of countries in Africa and just 26 per cent of countries in Asia having done so.

Punitive laws that criminalize FGM/C are unlikely to succeed on their own, and must be accompanied by culturally sensitive public awareness and advocacy campaigns that create sustained change in cultural and community attitudes. Community-led approaches endorsed by national and local leaders will be critical to creating the sustained behavioural change necessary to protect the rights of women and girls by ending the practice of FGM/C.[94] Indeed, those communities that have employed a process of collective and participatory decision making have been able to abandon the practice of FGM/C.[95]

States should develop, support and implement comprehensive and integrated strategies for the eradication of FGM/C, including the training of social workers, medical personnel, community and religious leaders and relevant professionals, and ensure that they provide competent, supportive services and care to women and girls who are at risk of, or who have undergone, FGM/C, and establish formal mechanisms for reporting to the appropriate authorities cases in which they believe women or girls are at risk, and ensure that health professionals are able to recognize and address health complications arising from FGM/C.

Human rights elaborations since the ICPD: Female genital mutilation/cutting

Binding instruments: Regionally, the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* (1995; e.i.f. 2005) states, "States Parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women…States Parties shall take all necessary legislative and other measures to eliminate such practices, including: prohibition through legislative measures backed by sanctions, of all forms of female genital mutilation." Article 38 of the *Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence* (2011; *not in force)* states that, "Parties shall take the necessary legislative or other measure to ensure that the following intentional conducts are criminalised: a) excising, infibulating or performing any other mutilation to the whole or any part of a woman's labia majora, labia minora or clitoris; b) coercing or procuring a woman to undergo any of the acts listed in point a; c) inciting, coercing or procuring a girl to undergo any of the acts listed in point a."

http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf.

[92] United Nations Population Fund. (2013). *Facts, Figures and Maps.* MDG5b+Info database using Demographic and Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS) data (http://www.devinfo.org/mdg5b/). Retrieved from: http://www.unfpa.org/webdav/site/global/shared/events/2013/UNFPA-FGMC-Posters-FINAL.pdf.

[93] World Health Organization. (2008). Eliminating female genital mutilation: An interagency statement. OHCHR, UNAIDS, UNDP, UNEC, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, Geneva, World Health Organization. Retrieved from: http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf.

[94] World Health Organization. (2008). Eliminating female genital mutilation: An interagency statement. OHCHR, UNAIDS, UNDP, UNEC, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, Geneva, World Health Organization. Retrieved from: http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf.

[95] United Nations Population Fund. (2013). UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change, Annual Report 2012. Scaling up a comprehensive approach to abandonment in 15 African countries. Retrieved from: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2013/UNICEF-UNFPA%20Joint%20Programme%20AR_final_v14.pdf.

Intergovernmental human rights outcomes: The General Assembly has adopted several resolutions on eliminating harmful practices, including FGM/C, including milestone *Resolution 67/146 Intensifying Global Efforts towards the Elimination of Female Genital Mutilation* (2012).

5. Government priorities: Gender equality and women's empowerment[96]

Economic empowerment and employment	**71 per cent of governments**
Political empowerment and participation	**59 per cent**
Elimination of all forms of violence	**56 per cent**
Gender norms and male engagement	**22 per cent**
Work-life balance	**7 per cent**

Promoting and enabling the "economic empowerment" of women was the most frequently mentioned priority by at least two thirds of countries in 4 of the 5 regions: Africa (67 per cent), Asia (78 per cent), Europe (79 per cent) and Oceania (71 per cent). In the Americas, it was the second most widely mentioned priority at 59 per cent, following "Elimination of all forms of violence". These numbers are in keeping with the widespread recognition that women's participation in the work place drives economic growth and development; a phenomenon which has contributed to the recent economic growth in many Asian countries.

"Political empowerment and participation" was a priority for two-thirds of governments across Africa (63 per cent), Asia (66 per cent) and Oceania (64 per cent); in Europe and the Americas the issue was a priority among 48 per cent and 53 per cent of governments, respectively. Notably, "political empowerment and participation of women" was prioritized by only 45 per cent of governments among high-income non-OECD countries, and 41 per cent of high-income OECD countries. It was a higher priority within other income groups; among low, lower middle and upper middle countries it was prioritized by 62 per cent, 67 per cent and 62 per cent of governments, respectively.

The low support for the political empowerment of women among wealthy non-OECD and wealthy OECD countries may reflect different underlying values. The highest proportion of parliamentary seats held by women is within high-income OECD countries, suggesting the political participation of women is well advanced and may not be seen as demanding government intervention. By contrast, the lowest proportions are held in high-income non-OECD countries, suggesting lower relative support for women's political leadership – which may reflect that these countries have experienced very rapid economic development that has outpaced social and political change.

Globally, the third most widely mentioned priority for gender equality and women's empowerment, by 56 per cent of countries, was the "elimination of all forms of violence".[97] Among countries in the Americas this was the priority that garnered the highest mention, by 69 per cent of governments, well higher than the global average. While the lifetime prevalence of partner and non-partner physical and sexual violence is highest in Africa (WHO), a lower proportion of countries in the region prioritized this issue (49 per cent) compared to the Americas (69 per cent), Europe (69 per cent), or Oceania (57 per cent).

"Gender norms and male engagement" was a priority for only 22 per cent of governments globally, and was most frequently included by governments in Europe (34 per cent). This issue was not prioritized by

[96] See Annex II for full table of government priorities by region including definitions of each priority.
[97] Includes all priorities addressing the elimination of all forms of violence against any and all persons; including gender based violence (GBV), sexual violence (rape), domestic violence, trafficking, femicide, slavery and forced sterilization.

governments of most low-income and lower middle-income countries, of which only 15 per cent and 14 per cent of countries respectively included it. "Addressing Son Preference" was prioritized by only three countries (Armenia, China, India), countries where the sex ratio is significantly skewed.

In contrast to the shared global priority of promoting the economic participation of women, "work life balance"[98] was mentioned as a priority by only 7 per cent of countries worldwide, most of which are in Europe. Globally, it appears that the inclusion of women in the workplace is recognized as an obvious step forward; however, holistic policies that include parental (maternity and paternity) leave and quality child care will be necessary to ensure the well-being of children and families, and to avoid the overburdening of women.

States should initiate national campaigns, including through information and education curricula and the ability of the school/formal education and informal education/system and community groups to eliminate sexism, including violence against women and girls, and promote male and boys participation and equal sharing of responsibility, including through the establishment of special schools for men and boys and other community-based institutions, to enable awareness, exposure and behaviour change.

C. Adolescents and youth

1. The demographic importance of young people

Demographic changes in the past decades have led to the largest generation of young people (aged 10-24 years) in the world today, comprising adolescents (aged 10-19 years) and youth (aged 15-24 years). The proportion of the global population that is between ages 10 and 24 accounted for 28 per cent in 2010, slightly higher than in Asia, and more than 31 per cent of the population of Africa (see Figure 8). While this proportion will decline in most regions in the coming 25 years, it will remain above 20 per cent in all regions except Europe until 2035, and above 30 per cent until 2035 in Africa.[99]

But the centrality of adolescents and youth to the development agenda in the coming two decades is not because they represent a large cohort in absolute terms,[100] but because of four crucial conditions:

a) The decline in fertility that followed their births means they must become self-supporting and thrive, for there will be no larger, younger cohort to support them as they themselves age, and they can be expected to live to an advanced age, given increasing life expectancy;
b) They will also need to support the existing and growing population of elderly persons;
c) The majority of this cohort is growing up in poor countries, where education and health systems are of poor quality, reproductive choice and health are not guaranteed, good jobs are not abundant, and migration is constrained;
d) They have expectations – higher than the generations before them – for self-direction, freedom, and opportunity. The information age has taught them their human rights, and given them a broader vision of what their lives could be.

The declining fertility rates are also providing low- and middle-income countries with a window of opportunity because the proportion of the population that is in the young working years is historically high, and these cohorts can – if provided with learning and work opportunities - jumpstart economic

[98] Includes all priorities that address facilitating and ensuring balance in the role of women in the home and workplace, and preservation of the family
[99] United Nations, Department of Economic and Social Affairs, Population Division, 2013. World Population Prospects: The 2012 Revision. DVD Edition.
[100] Every cohort ahead of them is the largest of that age group that there has ever been, i.e. the world is currently home to the largest cohort of 40 year olds, of 50 years olds, 60 year olds, and so on.

growth and development. Therefore, as acknowledged in the Commission on Population and Development (CPD) Resolution 2012/1,[101] the well-being and the positive social participation of this cohort of adolescents and youth hinges on the commitments of governments to protect their human rights, develop their capabilities, secure their sexual and reproductive health and rights, prepare them for productive and creative activities, and reward them for their labours. Investments in human development targeting adolescents and youth are most critical to ensure that they have the capabilities and opportunities to define their futures, and spur the innovations needed for a sustainable future.

Figure 8
Trends and projections in the proportion of young people (10-24 years), worldwide and by region, 1950-2050
(medium fertility variant)

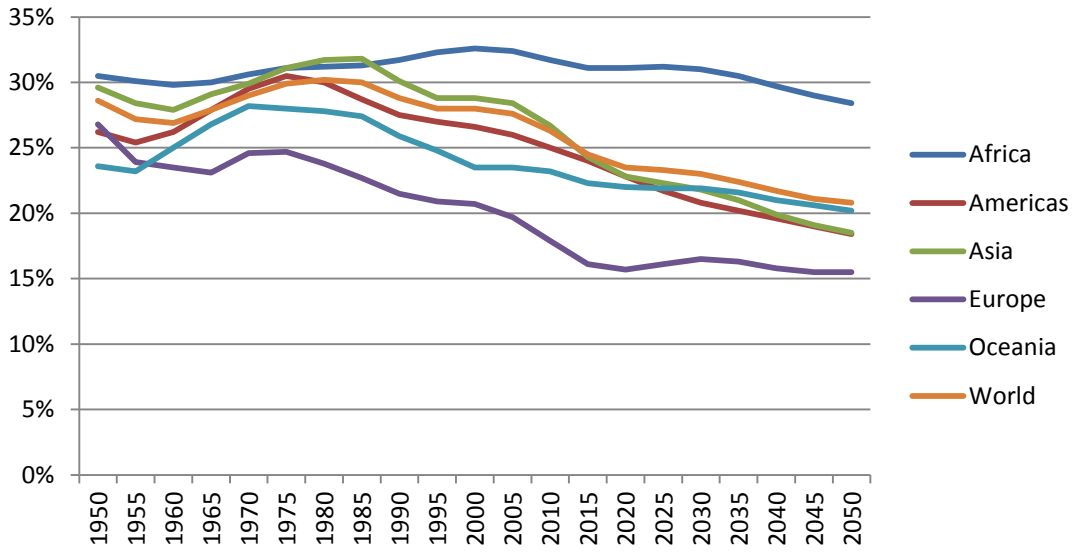
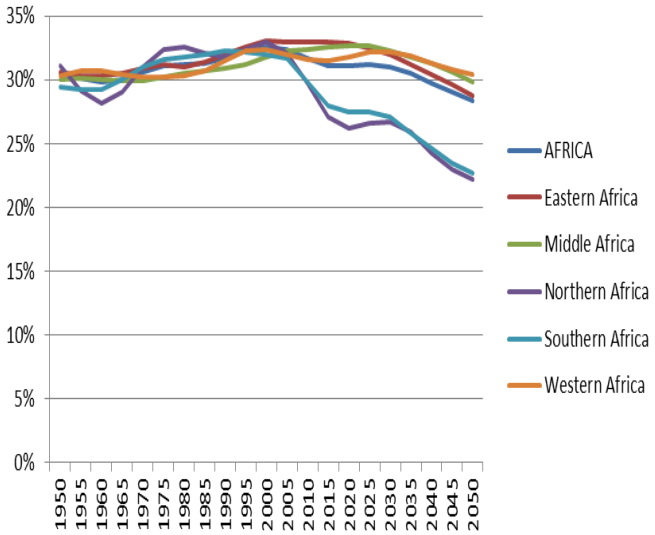


Figure 8.a
Trends and projections in the proportion of young people (10-24 years) in Africa by sub-region, 1950-2050
(medium fertility variant)



[101] Forty-fifth session of the Commission on Population and Development. Resolution 2012/1: Adolescents and Youth.

Figure 8.b
Trends and projections in the proportion of young people (10-24 years) in the Americas by sub-region, 1950-2050
(medium fertility variant)

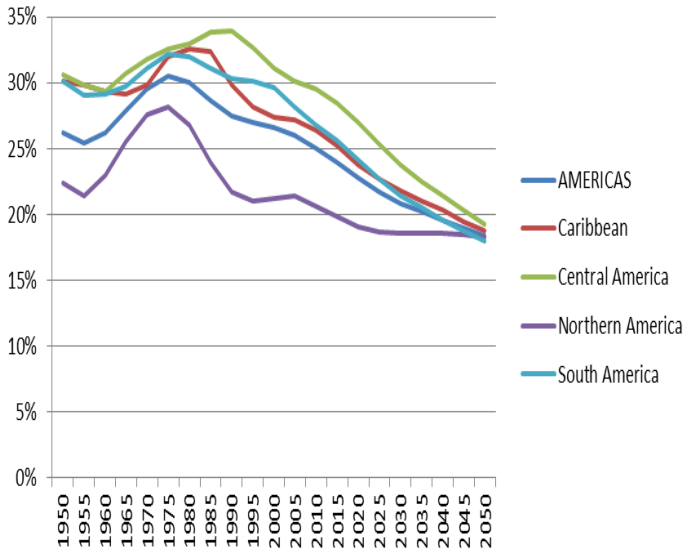


Figure 8.c
Trends and projections in the proportion of young people (10-24 years) in Asia by sub-region, 1950-2050
(medium fertility variant)

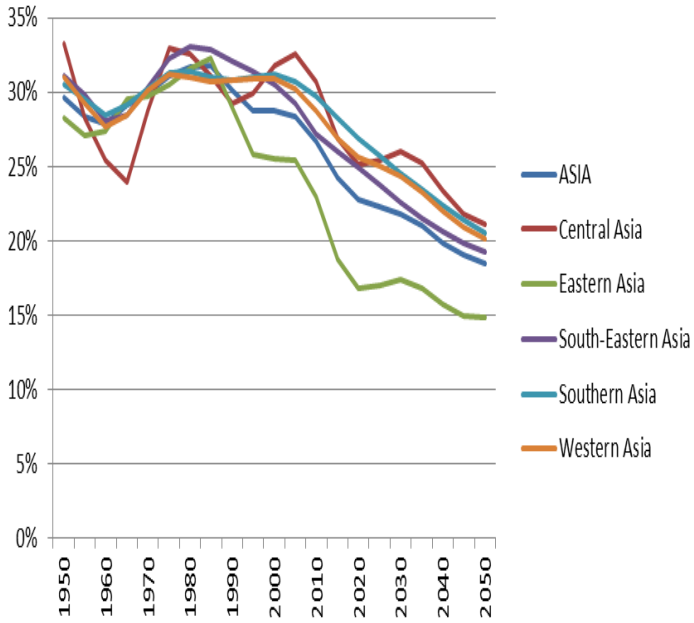


Figure 8.d
Trends and projections in the proportion of young people (10-24 years) in Europe by sub-region, 1950-2050
(medium fertility variant)

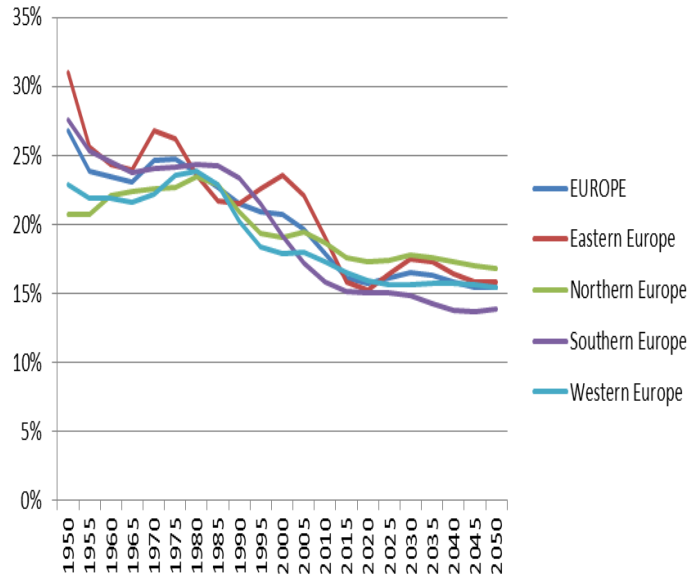
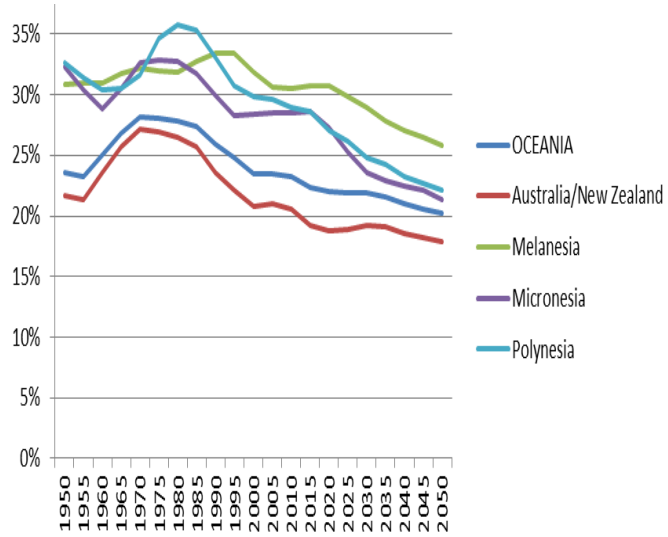


Figure 8.e
Trends in the proportion of young people (10-24 years) in Oceania by sub-region, 1950-2050
(medium fertility variant)



Source: United Nations, Department of Economic and Social Affairs, Population Division, 2013. World Population Prospects: The 2012 Revision, DVD Edition, retrieved from http://esa.un.org/unpd/wpp/index.htm, November 2013.

Sub-regional trends highlight the high proportion of young people across the sub-regions of Africa, with declining proportions in only Northern and Southern Africa. In Asia, the decline in the proportion of young people began earlier and proceeded faster in Eastern Asia than elsewhere in the region. Similarly, the proportion of young people declined rapidly in the 1980s in North America, and other sub-regions of the Americas are now converging with the North. The sub-regions of Europe all have low proportions of

young people, and Oceania displays wide variations between sub-regions, with the highest proportions in Melanesia.

For youth overall, governments responding to the Global Survey prioritize economic empowerment and employment (70 per cent), and social inclusion and education (both 56 per cent). These priorities underscore the intersections between the right to productive employment and decent work, and key links to education, training, social integration, and mobility, taking into account gender equality, as affirmed in the Commission on Population and Development (CPD) Resolution 2012/1.[102] In addition, a number of intergovernmental outcomes, including the World Programme of Action on Youth, 2012/1, and the regional review outcomes as well as the multi-stakeholder Bali Global Youth Forum Declaration highlight the importance of the full and effective participation of young people, as well as the importance of investing in young people as key agents of development and social change.

Countries that will host a large youth cohort over the next two decades have addressed over the past five years the needs of their adolescent and youth populations, in particular with regards to job creation and access to sexual and reproductive health services ("creating employment opportunities for youth", 94 per cent; "ensuring the same rights and access to sexual and reproductive health services, including HIV prevention", 94 per cent (see chapter II, section D, Sexual and reproductive health and rights and lifelong health for young people). A high percentage also have "addressed the violence, exploitation and abuse" (81 per cent), and "instituted concrete procedures and mechanisms for participation" (81 per cent). "Addressing the adverse effects of poverty on adolescents and youth" is the issue addressed by the smallest proportion of countries (75 per cent), but this proportion is still higher than that observed for any ageing-related issue.

Human rights elaborations since the ICPD: Adolescents and youth

Binding instruments: Since the ICPD, regional youth charters including the *Ibero-American Convention on the Rights of Youth* (2005; e.i.f. 2008) and the *African Youth Charter* (2006; e.i.f. 2009) promote a broad range of rights for young people. The African Youth Charter provides a framework for youth empowerment, strengthening youth's participation and partnership in development. Specific articles in the Charter affirm rights related to, inter alia, nondiscrimination; freedom of movement, expression, thought, and association; development and participation; education and skill development; employment; health; and peace and security. The Ibero-American Convention recognizes the right of all youth age 15-24 to the full realization of civil, political, economic, social and cultural rights and recognizes youth as key actors in development. The Convention recognizes youth rights related to, inter alia, peace, nondiscrimination, gender equality, family, life, personal integrity, participation, education, freedom to sexual education, health, work and working conditions, housing, and a healthy environment. Internationally, through the *Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography* (2000; e.i.f. 2002) State Parties commit, at a minimum, to ensure that such acts "are fully covered under its criminal or penal law, whether such offences are committed domestically or transnationally or on an individual or organized basis."

2. Child, early and forced marriage

Denial of the human rights of a child by the practice of child, early and forced marriage is a violation that remains commonplace in many countries and most regions worldwide -- even where laws forbid it. Vulnerability to child, early and forced marriage is related to extreme poverty, the low status of women, and community vulnerability, as much as to cultural norms. If current trends continue, by 2020, an

[102] Forty-fifth session of the Commission on Population and Development. Resolution 2012/1: Adolescents and Youth.

additional 142 million girls will be married before their 18th birthday.[103]

Girls living in rural areas of the developing world tend to marry or enter into union at twice the rate of their urban counterparts (44 per cent and 22 per cent, respectively). Girls with a primary education are twice as likely to marry or enter into union as those with a secondary or higher education. However, those with no education are three times more likely to marry or enter into union before age 18 as those with a secondary or higher education. Furthermore, more than half (54 per cent) of girls in the poorest quintile are child brides, compared to only 16 per cent of girls in the richest quintile.[104]

As of 2010, 158 countries have a legal age of marriage of 18 years. Nevertheless, for the period 2000-2011, an estimated 34 per cent of women aged 20 to 24 in developing regions had been married or in union before age 18; further, an estimated 12 per cent had been married or in union before age 15.[105]

The Global Survey shows that only 51 per cent of countries have "addressed child marriage / forced marriage" during the past five years, most likely reflecting that this practice is not a problem worldwide. When analysis was confined to the 41 "priority countries" in which marriage before age 18 affects more than 30 per cent of girls, 90 per cent of reporting countries had addressed this issue. Yet three of the poorest countries with high rates of child marriage (affecting between 39-75 per cent of girls) had not addressed it, and 11 of the 41 priority countries did not provide a response to this question.

States should preserve the dignity and rights of women and girls by eradicating all harmful practices, including child, early and forced marriages through integrated multi-sector strategies including the universal adoption and enforcement of laws that criminalize marriage below age 18, and through widespread campaigns to create awareness around the harmful health and life consequences of early marriages, supporting national targets and incentives to eliminate this practice within a generation.

Human rights elaborations since the ICPD: Child, early and forced marriage

Binding instruments: Reinforcing pre-1994 obligations enshrined in international human rights law, regionally the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* (1995; e.i.f. 2005) requires signatory states observe that a "minimum age for marriageable women shall be 18 years." The *Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence* (2011; *not in force)* requires states to "take the necessary legislative or other measures to ensure that the intentional conduct of forcing an adult or child to enter into a marriage is criminalized."

Intergovernmental human rights outcomes: The Human Rights Council adopted landmark *Resolution 24/L.34/Rev.1 Strengthening Efforts to Prevent and Eliminate Child, Early and Forced Marriage: Challenges, Achievements, Best Practices and Implementation Gaps* (2013).

Other soft law: Through *General Comments and Recommendations* Treaty monitoring bodies have agreed that 18 is the appropriate minimum age for marriage, and that states should enact legislation to increase the minimum age for marriage to 18, with or without parental consent.[106]

[103] UNFPA, 2012. Marrying too Young: End Child Marriage. UNFPA: New York.
[104] UNFPA 2012, *"Marrying too Young: End Child Marriage".*
[105] UNFPA, 2012. Marrying too Young: End Child Marriage. UNFPA: New York.
[106] CEDAW Committee, *General Recommendation No. 21: Equality in Marriage and Family Relations*, (13th Sess., 1994); CRC Committee, *General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, supra note 28, 2003.

3. Adolescent births, and the mediating role of female education

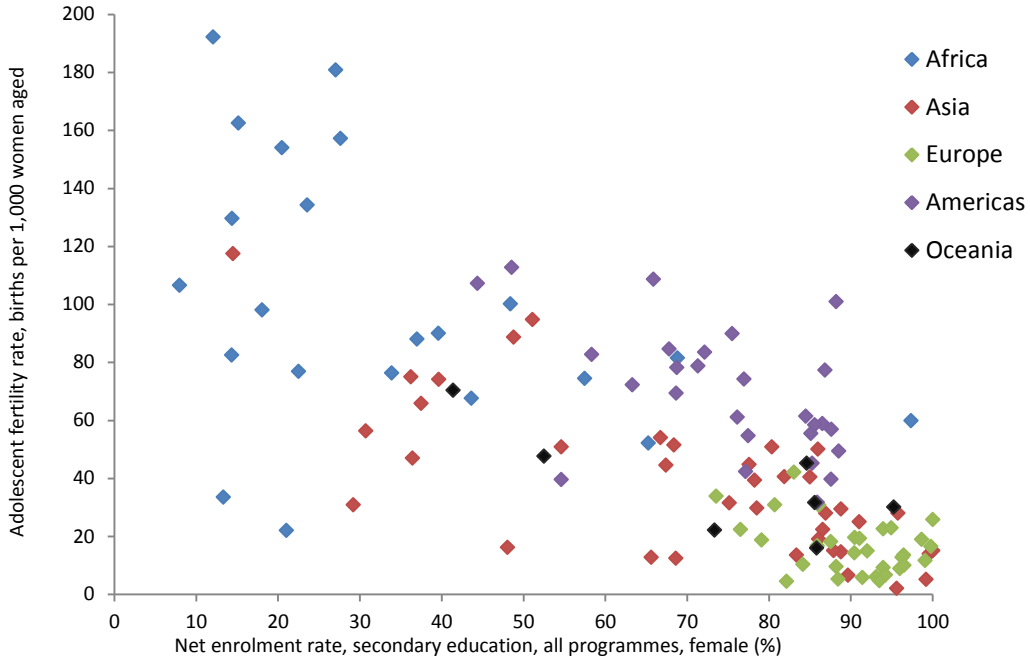
Worldwide, more than 15 million girls age 15 to 19 years give birth every year, [107] with about 19 per cent of young women in developing countries becoming pregnant before they turn 18.[108] A significant proportion of adolescent pregnancies result from non-consensual sex, and most take place in the context of early marriage.[109] Pregnancies occurring at young ages have greater health risks for mother and child, and many girls who become pregnant drop out of school or are dismissed from school, drastically limiting their future opportunities, their future earnings, and both their own health and the health of their children.[110] Globally, adolescent birth rates are highest in poor countries, and in all countries they are clustered among the poorest sectors of society, compounding the risk of poor maternal outcomes for both mother and child.[111]

Adolescent birth rates (ABRs) have been declining from 1990 to 2010 across countries in all income groups and MDG regions (see Annex I, Figure 6). Higher secondary school enrolment among those aged 15-19 is associated with lower adolescent birth rates (Figure 9). While greater literacy among young women is associated with lower birth rates in all regions, this pattern is less evident in countries in the Americas, which are characterized by high levels of adolescent fertility despite high enrolment rates. Indeed, Latin America has the second highest adolescent fertility rate in the world after Sub-Saharan Africa, and secondary school enrolment does not have the same impact on youth fertility in Latin America as it does in other regions.

[107] United Nations, 2013. The Millennium Development Goals Report 2013. New York: 2013.
[108] UNFPA, 2013, State of the World's Population: Motherhood in Childhood, Facing the Challenge of Adolescent Pregnancy.
[109] Santhya, K, Early marriage and sexual and reproductive health vulnerabilities of young women: a synthesis of recent evidence from developing countries, Current Opinion in Obstetrics and Gynecology 23:334-339, 2011
[110] Lloyd C. and Mensch, B, Marriage and childbirth as factors in dropping out of school: an analysis of DHS data from sub-Saharan Africa, Population Studies 62(1):1-13,2008; Santhya, K, Ram, U, Rajib, A, et al, Associations between early marriage and marital and reproductive health outcomes, International Perspectives on sexual and reproductive health, 36(5):132-139, 2010.
[111] UNFPA. 2010. How universal is access to reproductive health? A review of the evidence. New York: UNFPA, 2010.

Figure 9

Adolescent fertility rate and net secondary education female enrolment rate by region, 2005-2010



Source: United Nations, Department of Economic and Social Affairs, Population Division, 2013. World Population Prospects: The 2012 Revision, DVD Edition, retrieved from http://esa.un.org/unpd/wpp/index.htm, November 2013 and UNESCO, Institute for Statistics, Data Centre, Custom Table retrieved from http://stats.uis.unesco.org/unesco/TableViewer/document.aspx?ReportId=136&IF_Language=eng&BR_Topic=0

Note: Adolescent fertility rates are period estimates for 2005-2010. Net secondary education female enrolment rates reflect the latest available point estimate for the period 2005-2010.

Education of all children increases their capacity to participate socially, economically and politically, but the education of girls leads to special benefits for girls themselves, their families and communities. When girls are educated it reduces the likelihood of child marriage and delays childbearing, leading to healthier birth outcomes. Female education is consistently associated with greater use of family planning, more couple communication about family planning, and lower overall fertility.[112] A recent analysis in East Africa found that temporal fertility trends across Demographic and Health Surveys waves were associated with changes in female educational attainment, and there was an association between the proportion of females having no education and stalled fertility declines in Kenya, United Republic of Tanzania, Uganda, and Zimbabwe.[113]

Researchers have presented theories and evidence to explain why greater female education leads to lower fertility, showing that education affects girls in numerous critical domains that each affect fertility:[114] education expands opportunities and aspirations for work outside the home, it enhances girls' social status and alters the types of men they marry,[115] it increases their bargaining power within

[112] Martin, T.C. Women's Education and Fertility: Results from 26 Demographic and Health Surveys. *Studies in Family Planning*, Vol. 26, No. 4 (Jul.- Aug., 1995), pp. 187-202. ; Jeejeebhoy S.J. (1995). Women's Education, Autonomy, and Reproductive Behavior: Experiences in Developing Countries. Oxford: Clarendon Press.

[113] Alex C. Ezeh, Blessing U. Mberu and Jacques O. Emina, 2009. Stall in fertility decline in Eastern African countries: regional analysis of patterns, determinants and implications. In Philosophical Transactions of The Royal Society, Biological Sciences, 364, doi: 10.1098/rstb.2009.0166, published 21 September 2009.

[114] Diamond I, Newby M, Varle S (1999) Female education and fertility: Examining the links. In: Bledsoe CH, Casterline JB, Johnson-Kuhn JA, Haaga JG (eds0 (1999) *Critical perspectives on Schooling and Fertility in the Developing World*. Washington D.C.: National Academy Press, pp 23-48.

[115] Basu A.M. (1999) Women's education, marriage and fertility in South Asia: Do men really not matter? In: Bledsoe CH, Casterline JB, Johnson-Kuhn JA, Haaga JG (eds0 (1999) *Critical perspectives on Schooling and Fertility in the Developing World*. Washington D.C.: National Academy Press, pp 267-86.

marriage,[116] increases their use of health services, and enhances the health and survival of their children.[117] Greater educational attainment also shapes attitudes of both girls and boys to gender equality, i.e. their gender values, with greater education leading to more positive attitudes towards gender equality among both males and females.[118]

Comprehensive sexuality education (CSE), as part of in-and-out of school education, is recognized as an important strategy that empowers young people to make responsible and autonomous decisions about their sexuality and sexual and reproductive health. Evidence also suggests that rights-based and gender-sensitive CSE programmes can lead to greater gender equality. The Commission on Population and Development (CPD) in its resolutions CPD 2009/1 and 2012/1 for example called on Governments to provide young people with comprehensive education on human sexuality, on sexual and reproductive health, on gender equality to enable them deal positively and responsibly with their sexuality.

Only 40 per cent of all countries have addressed "facilitating school completion for pregnant girls". The Americas is the only region where a higher proportion of governments (67 per cent) report policies, budgets and implementation measures; in Europe and Asia only 29 per cent and 21 per cent of countries, respectively, report addressing it. Proportions remain very similar if countries are grouped by income level. Support for this issue in Latin America and the Caribbean underscores the relatively high adolescent fertility rate in the region.

States should implement their commitments to promote and protect the rights of girls through enacting and implementing targeted and coordinated policies and programmes that concretely address: a) ensuring gender parity in their access to school; b) providing comprehensive sexuality education; c) reducing adolescent pregnancy; d) enabling the reintegration of pregnant girls and young mothers into education at all levels, with a view towards empowering the girl child and young women towards achieving their fullest potential; and e) eliminating of harmful traditional practices such as child, early and forced marriage and FGM/C.

4. Uneven progress in education

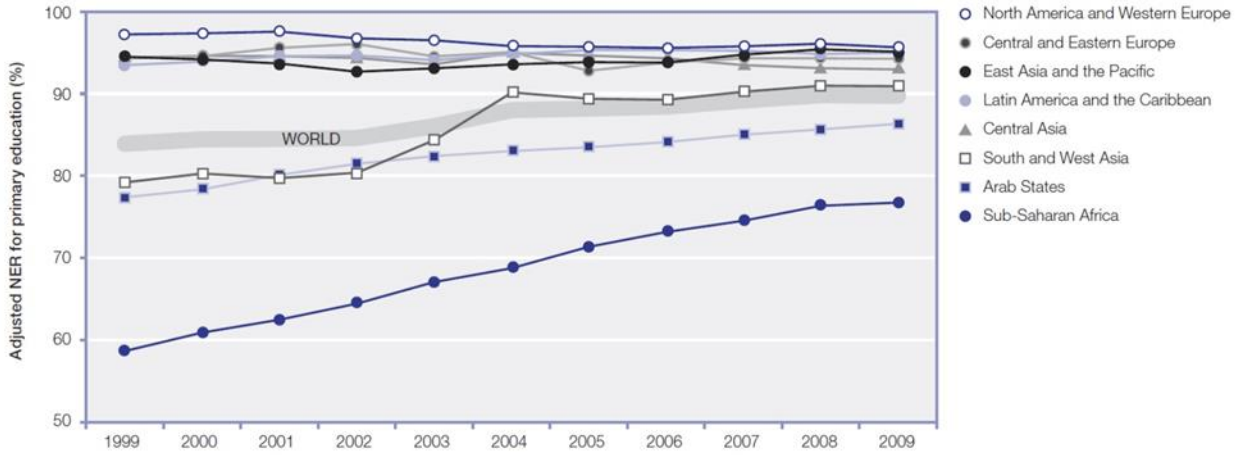
Over the past 15 years the number of children who are attending primary school worldwide has expanded to an extraordinary degree, with global enrolment now reaching 90 per cent. However, attaining universal primary education (UPE) by 2015 is far from certain, and large geographic disparities persist. Primary school enrolments have increased most dramatically in West and South Asia, the Arab States and in sub-Saharan Africa, but because of low starting levels (~60 per cent) in Africa at the turn of the millennium, nearly one in four primary school aged children in sub-Saharan Africa is still out school (Figure 10).

[116] Kishor, Sunita, and Lekha Subaiya. 2008. *Understanding Women's Empowerment: A Comparative Analysis of Demographic and Health Surveys (DHS) Data*. DHS Comparative Reports No. 20. Calverton, Maryland, USA: Macro International Inc.

[117] See, for example, Cutler DM, Lleras-Muney A., 2008. Education and health: evaluating theories and evidence. In: Schoeni RF, House JS, Kaplan GA, Pollack H, eds. Making Americans healthier: social and economic policy as health policy. New York: Russell Sage Foundation; Emmanuela Gakidou, Cowling, Krycia, Lozano, Rafael, Murray, Christopher JL, 2010. Increased educational attainment and its effect on child mortality in 175 countries between 1970 and 2009: a systematic analysis. In *The Lancet* - 18 September 2010 (Vol. 376, Issue 9745, Pages 959-974) DOI: 10.1016/S0140-6736(10)61257-3; Desai S, Alva S., 1998. Maternal education and child health: is there a strong causal relationship?. in Demography 1998; 35: 71-81.

[118] Inglehart, Ronald, and Pippa Norris, 2003. Rising Tide. Gender Equality and Cultural Change around the World. Cambridge University Press. Pp. 226; Marcel van Egmond, Baxter, Janeen, Buchler, Sandra, and Western, Mark , 2010. A stalled revolution? Gender role attitudes in Australia, 1986–2005. In J Pop Research (2010) 27:147–168 DOI 10.1007/s12546-010-9039-9.

Figure 10
Adjusted net enrolment rate for primary education by region, 1999-2009



Source: UNESCO Institute for Statistics database and Statistical Table 3, in UNESCO Institute of Statistics, Global Education Digest 2011, Comparing Education Statistics Across the World, p. 10, retrieved at http://www.uis.unesco.org/Education/Documents/ged-2011-en.pdf on 14 September 2013;

Note: East Asia and the Pacific and South and West Asia: UIS estimates based on data with limited coverage for the reference year, produced for specific analytical purposes.

Globally, primary completion rates have risen along with overall enrolments, globally as high as 88 per cent in 2009, and ranging from 67 per cent in sub-Saharan Africa to 100 per cent in Latin America and the Caribbean. The largest gains over the last decade have been in sub-Saharan Africa, South and West Asia and the Arab States.[119]

Yet numerous inequalities persist with respect to gender, residence (urban versus rural), and household wealth. Although girls have been the main beneficiaries of the trend toward higher Gross Enrolment Ratios (GER),[120] with their enrolment increasing at a faster rate than that of boys and resulting in nearly two-thirds of countries (128 of 193 countries) reporting in 2012 the achievement of gender parity in primary schools, boys continue to benefit from greater access. This is the case in 57 of the 65 countries that have not achieved gender parity in primary education.[121]

The Global Survey finds that during the past 5 years, 82 per cent of countries have addressed the issue of "ensuring equal access of girls to education at all levels", and 81 per cent have done so for the issue "keeping more girls and adolescents in secondary school". If grouping countries according to income, there are no major differences in these proportions with regard to ensuring equal access, but keeping girls in secondary school is a policy that is budgeted for and implemented by a higher proportion of poor countries.

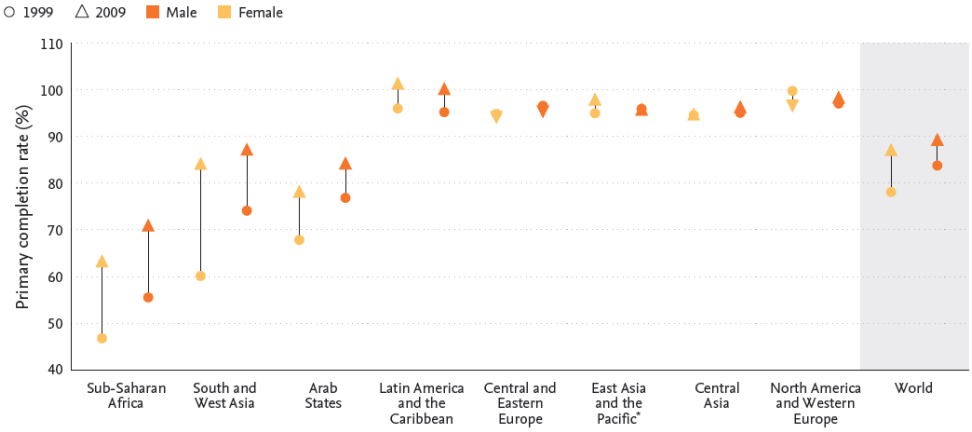
Rural to urban inequalities persist in school attendance. Lower overall attendance is clearly driven by lower attendance in rural areas, with the largest shortfalls in Africa and Asia (See Annex I, Figure 7). The majority of countries have urban-to-rural differentials close to parity, or between parity and 1.5, but a small smattering of countries have more severe urban-rural differentials coinciding with net attendance rates at 60 per cent or less.

[119] UNESCO, *World Atlas of Gender Equality in Education*, 2012, p. 48-9, p. 54.
[120] Gross Enrolment Ratio (GER): Total enrolment in a specific level of education, regardless of age, expressed as a percentage of the eligible official school-age population corresponding to the same level of education in a given school year. The Gross Enrolment Ratio can exceed 100 percent if there are significant numbers of under- or over-age children enrolled in primary schools. UNESCO Institute of Statistics (UIS), *Education Indicators, Technical Guidelines*, November 2009, p. 9; UNESCO, *World Atlas of Gender Equality in Education*, 2012.
[121] UNESCO, *World Atlas of Gender Equality in Education*, 2012.

Among the 81 countries with available data, primary school attendance is actually higher in rural areas than in urban areas in only 12 countries from the Americas, Asia and Europe. However, the urban-rural differential is small in all cases (less than 5 per cent), and most countries already present primary school net attendance rates higher than 90 per cent, with the exception of Ukraine (73 per cent) and Bangladesh (86 per cent).

In nearly half of 162 countries with comparable data, boys and girls do not have an equal chance of completing primary education. Girls generally lag behind boys, though not in all countries. As with enrolment, the largest gains in completion between 1999 and 2009 were observed among girls (Figure 11, below), yet rates are still generally lower for them. Primary school completion rates increased to 87 per cent for girls overall in the same decade, close to the 90 per cent rate for boys. Regionally, South and West Asia saw the greatest relative gains for girls.[122]

Figure 11
Primary completion rates by region and by gender, 1999-2009



Source: UNESCO Institute of Statistics, *UNESCO World Atlas of Gender Equality in Education*, 2012, p. 48, retrieved from http://www.unesco.org/new/typo3temp/pics/d7af2fe604.jpg on 11 November 2013.

Note: 2009 data for East Asia and the Pacific refers to 2007.

Regarding school-life expectancy,[123] the average number of years of instruction that a child entering the education system can expect to receive, also increased between 1990 and 2009 from 8.3 to 11 years for females and from 9.6 to 11.4 years for males. Consistent with progress in primary school completion, the greatest progress in reducing the gender gap in school life expectancy has been made in South and West Asia, where a girl who started school in 2009 can expect to receive 9.5 years of education, up from 6 years in 1990. Nevertheless, boys continue to have the advantage, with an average school-life expectancy of 10.5 years. Likewise, in sub-Saharan Africa and the Arab States, girls who started school in 2009 can expect to receive 8 and 10 years of education respectively, whereas boys in these regions still have the advantage of at least one extra year of instruction. In East Asia and the Pacific, not only did school-life expectancy for girls rise by 38 per cent between 1990 and 2009, girls enrolled in primary education can expect to spend about 12 years in school, which slightly surpasses the male average. Similarly, in Latin America and the Caribbean, a girl starting primary school can expect to receive almost 14 years of instruction, compared to 13.3 years for boys.[124]

[122] UNESCO, *World Atlas of Gender Equality in Education*, 2012.
[123] School Life Expectancy (SLE) is the total number of years of schooling which a child of a certain age can expect to receive in the future, assuming that the probability of his or her being enrolled in school at any particular age is equal to the current enrolment ratio for that age. UNESCO Institute of Statistics (UIS), *Education Indicators, Technical Guidelines*, November 2009.
[124] UNESCO, *World Atlas of Gender Equality in Education*, 2012.

Although gains in secondary education have not been as rapid as those at the primary level, countries around the world are making progress toward increased access to secondary education. Among 187 countries with data, a quarter (27 per cent) has gross enrolment ratios of 98 per cent or more, approaching universal secondary enrolment; however, in 43 per cent of countries, enrolment is less than 80 per cent.[125]

Access to secondary education remains a challenge for girls in many regions, especially in sub-Saharan Africa and South and West Asia. While the disproportionate exclusion of girls from access to education is not only greater at the secondary than at primary level, it increases from lower to upper secondary levels. Numerous factors may be the cause, which point to disadvantages girls face due to gender discrimination both inside and outside of schools, including family and social pressures for girls to devote more time to household labour, early marriage, potential increases in emotional and physical dangers as girls age and face risks of sexual harassment and assault, lack of bathrooms, families' unwillingness to pay school fees for girls, and the potentially unsafe daily journey to school for girls and young women.[126]

Regarding vocational education programmes, globally, young males are more likely than young females to enrol, though there are notable exceptions, such as Burkina Faso and Ethiopia, where females outnumber males.[127]

Gains in school enrolment mask other important inequalities, particularly in the quality of education. Access to good quality education is especially limited for those living in poverty. Schools serving poor children characteristically have teachers who are over-burdened, unsupervised, and underpaid, crowded classrooms and a lack of adequate learning materials, and therefore produce poorer outcomes, even in wealthy countries.[128] A recent comparison of the pupil-teacher ratios at primary level in Asian countries, for example, highlights the wide range between countries, from 16 pupils per teacher in Indonesia and Thailand, 17 in China, and up to 40, 41, and 43 pupils per teacher in India, Pakistan and Bangladesh.[129]

Quality education includes access to knowledge about human biology and comprehensive sexuality education (CSE), which remains under-resourced and incomplete in many schools throughout the world, in both poor and wealthy countries.

Finally, although access to higher education remains limited in many countries, the last decades have brought a major expansion of higher education in every region of the world, and women have been the prime beneficiaries. Globally, the Gross Enrolment Ratio in tertiary education was 28 per cent for females in 2009, compared with 26 per cent for males. Regionally, more women than men were enrolled in institutions of tertiary education in North America and Western Europe, Central and Eastern Europe, Latin America and the Caribbean, and East Asia and the Pacific, while in sub-Saharan Africa and South and West Asia, the Gross Enrolment Ratios favour men.[130]

Governments' priorities in education for the next 5-10 years highlight their concern for equality in access, the quality of education, and the importance of linking education to decent work opportunities. In addressing these priorities it will be important that teacher shortages be addressed. According to new

[125] UNESCO, *World Atlas of Gender Equality in Education*, 2012.
[126] UNESCO, *World Atlas of Gender Equality in Education*, 2012.
[127] UNESCO, *World Atlas of Gender Equality in Education*, 2012
[128] See, for example, J. Douglas Willms, 2006. Learning Divides: Ten Policy Questions about the Performance and Equity of Schools and Schooling Systems. Unesco Institute for Statistics Working Paper No. 5.
[129] Dreze J, Sen A 2013, An Uncertain Glory, India and its Contradictions
[130] UNESCO, *World Atlas of Gender Equality in Education*, 2012.

global projections from the UNESCO Institute for Statistics, the world will need an extra 3.3 million primary teachers and 5.1 million lower secondary teachers in classrooms by 2030 to provide all children with basic education.[131]

States should commit to and support early and life-long learning, including pre-primary education, to ensure that every child, regardless of circumstance, completes primary education and is able to read, write and count, to undertake creative problem-solving, and to responsibly exercise their freedoms. States should also ensure access to secondary education for all and expand post-secondary opportunities; enable the acquisition of new skills and knowledge at all ages; and enhance vocational education and training, and work-directed learning linked to the new and emerging economies.

Human rights elaborations since the ICPD: Education

Binding instruments: The regional human rights systems contain specific protections of the rights of young people to education. The *Council of Europe European Revised Social Charter* (1996; e.i.f. 1999) reaffirms the right of young persons to "a free primary and secondary education as well as to encourage regular attendance at schools." The *Ibero-American Convention on the Rights of Youth* (2005; e.i.f. 2008) recognizes that "youth have a right to education" and "States Parties recognize their obligation to guarantee a comprehensive, continuous, appropriate education of high quality. The *African Youth Charter* (2006, e.i.f. 2009), states that "every young person shall have the right to education of good quality" and values the "multiple forms of education, including formal, non-formal, informal, distance learning, and life-long learning to meet the diverse needs of young people."

Other soft law: *General Comment No. 13: The Right to Education* of the Committee on Economic, Social and Cultural Rights (1999) recognizes that "education is both a human right in itself and an indispensable means of realizing other human rights. As an empowerment right, education is the primary vehicle by which economically and socially marginalized adults and children can lift themselves out of poverty and obtain the means to participate fully in their communities. Education has a vital role in empowering women, safeguarding children from exploitative and hazardous labour and sexual exploitation, promoting human rights and democracy, protecting the environment, and controlling population growth. …a well-educated, enlightened and active mind, able to wander freely and widely, is one of the joys and rewards of human existence."

5. Government priorities: Education[132]

Improve quality standards in education, including the curriculum	**61 per cent of governments**
Maximize social inclusion, equal access and rights to education	**54 per cent**
Capacity strengthening (human resources in education)	**43 per cent**
Development of education programmes, policies, strategies, laws/creation of institutions	**43 per cent**
Capacity strengthening (build, expand and equip schools)	**36 per cent**

When asked to identify public policy priorities for education over the next five to ten years, over half of governments highlighted the importance of "improving quality standards in education, including the

[131] UNESCO Institute for Statistics, October 2013 "A teacher for every child; Projecting Global Teacher Needs from 2015 to 2030" http://www.uis.unesco.org/Education/Documents/fs27-2013-teachers-projections.pdf (last accessed October 22, 2013)
[132] See Annex II for full table of government priorities by region including definitions of each priority.

curriculum" (61 per cent) and "maximizing social inclusion, equal access and rights" (54 per cent). The need to improve the quality and coverage of education were in fact the top two priorities identified by governments in all regions, although Africa is the only region where a higher proportion of governments mentioned coverage (61 per cent) over quality (55 per cent), pointing towards the unfinished agenda of universal enrolment.

Two other priorities linked to labour and infrastructure investments in the educational system garnered the next tier of support and were mentioned by over a third of governments: "capacity strengthening (human resources in education)" (43 per cent) and "capacity strengthening (build, expand and equip schools)" (35 per cent). A regional breakdown shows that the proportion of countries in Africa that identify both priorities is higher than the world average (human resources: 55 per cent; infrastructure: 45 per cent), while in Europe it is lower (human resources: 31 per cent; infrastructure: 23 per cent).

While one-third of countries globally cite "training to work/education-employment linkages" (33 per cent) as their priority, this issue is of special relevance for a higher proportion of countries in Europe (58 per cent) and Oceania (46 per cent), acknowledging the need for transforming education to better suit the job market.

Facilitating the access to and improving the quality of "pre-school education" is a priority for one in every four countries in the Americas (25 per cent), acknowledging that early childhood development is key to foster the capabilities of children in their first years of life. In all other regions, 15 per cent or fewer governments identify it as a priority.

Finally, "gender parity", which captures all priorities pertaining to ensuring equality in school enrolment and completion rates between males and females, was identified as a priority by around one-fifth of governments in Asia (20 per cent) and Africa (18 per cent), while this issue is of lesser concern for governments in the Americas (9 per cent), Oceania (8 per cent) and Europe (4 per cent).

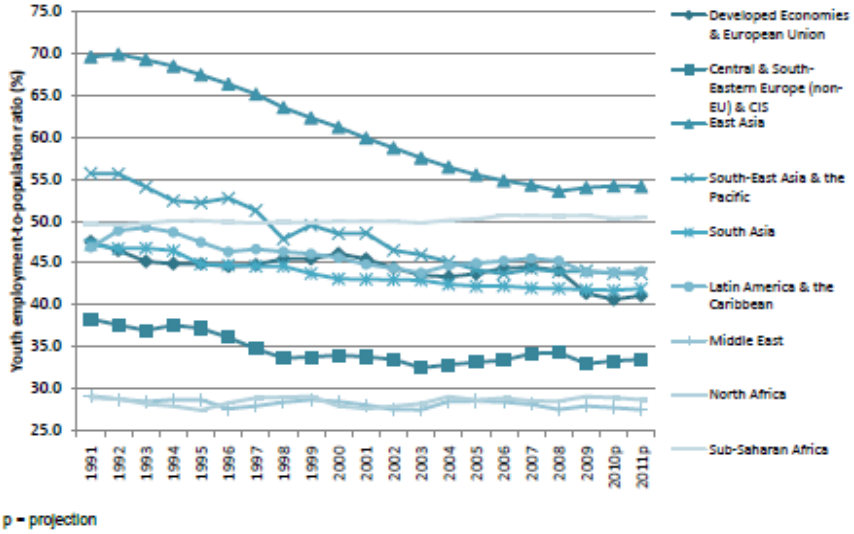
6. Youth employment

Achieving decent work for young people is crucial for the progression towards wealthier economies, fairer societies and stronger democracies. Decent work involves opportunities for work that are productive and deliver a fair income; provides security in the workplace and social protection for workers and their families; offers better prospects for personal development and empowers people by giving them the freedom to express their concerns, to organize and to participate in decisions that affect their lives.[133]

The challenge to provide decent work to young people is a concern for both industrialized and developing countries. Of the estimated 197 million unemployed people in 2012, nearly 40 per cent were between 15 and 24 years of age.[134] The economy will need to create 600 million productive jobs over the next decade in order to absorb the current unemployment levels and to provide employment opportunities to the 40 million labour market entrants each year over the next decade.[135]

[133] ILO, *Promoting youth transitions to decent work: Empowering young people through employment* A background paper for the Global Youth Forum, Bali, 4 – 6 December 2012
[134] ILO, *Global employment trends for youth*, Geneva, 2013.
[135] ILO, *Global employment trends*, Geneva, January 2012.

Figure 12
Youth Employment-to-Population Ratio by region, 1991-2011



Source: ILO, Global Employment Trends for Youth, April 2010, p. 13.

Figure 12 illustrates the overall decline in youth employment to population ratios, highlighting that job opportunities have not kept pace with the growing youth population, but also increased school enrolments. Youth (age 15-24 years) employment-to-population ratios have declined for both males and females in all regions of the world since 2000. Male youth employment remains higher (49 per cent) than females (35 per cent), reflecting the movement of many young women into early marriage and childbearing by this age, and thereby into unpaid work within the household.

Although all regions face a youth employment crisis, large differences exist across countries and regions. For example, youth unemployment rates in 2012 were highest in the Middle East and North Africa, at 28 per cent and 24 per cent, respectively, and lowest in East Asia (10 per cent) and South Asia (9 per cent). The youth unemployment rate for the Developed Economies and European Union in 2012 was estimated at 18 per cent, the highest level in this region in the past two decades.[136]

Gender differentials in youth unemployment rates are small at the global level and in most regions. Regional youth unemployment rates are lower for young women in the advanced economies and East Asia. However, large gaps between female and male rates are evident in some regions such as North Africa and the Middle East and, to a lesser extent, Latin America and the Caribbean, with young women at a disadvantage. Household wealth, investment in education and urban origins offer critical advantages to youth undertaking the transition from education into the labour market, and in countries with such data available, young males are more likely than young females to complete the transition to stable and/or satisfactory employment.[137]

In many countries, the unemployment scenario is further aggravated by the work of large numbers of young people in poor quality and low paid jobs with intermittent and insecure work arrangements, including in the informal economy. As many as 60 per cent of young persons in developing regions are either without work, not studying, or engaged in irregular employment and thus not achieving their full economic potential.[138]According to the ILO, youth account for 24 per cent of the total working poor,

[136] ILO, *Global employment trends for youth*, Geneva, 2013.
[137] ILO, *Global employment trends for youth*, Geneva, 2013..
[138] ILO, *Global employment trends for youth*, Geneva, 2013.

compared to 19 per cent of non-poor workers in the 52 countries where data is available.[139] Many of the young working poor are in countries and regions where unemployment rates are relatively low, such as in South Asia, East Asia and Sub-Saharan Africa.[140] Furthermore, where age disaggregated data on informality is available, these confirm the higher incidence of informality among young workers compared to their adult counterparts.[141]

A review of the policy frameworks of several countries shows that, since the mid-2000s, there has been an increasing commitment by countries to prioritize youth employment within national policy frameworks, as reflected in the Poverty Reduction Strategies (PRSs) of low-income countries.[142] Compared to the first generation of PRS where youth employment was absent, nearly half of the second generation prioritizes youth employment. Similar results are found in national development strategies of countries that do not have PRSs. This increased attention to youth employment is necessary to ensure young people's effective transition from school to decent jobs, but the challenge of job creation is particularly daunting for countries that face large cohorts of youth entering their productive years. The 49 poorest countries face a stark demographic challenge, as their collective population – about 60 per cent of which is under the age of 25 – is projected to double to 1.7 billion by 2050. For the coming decade these countries will have to create about 95 million jobs to absorb new entrants to the labour market, and another 160 million jobs in the 2020s.[143]

States should invest in building young people's capabilities and equip them with the skills to meet the labour demands of the current and emerging economies, and develop labour protection policies and programmes that ensure employment which is safe, secure, non-discriminatory, and which provides a decent wage and opportunities for career development. Efforts must also include a focus on productive investment in technologies, machineries, and infrastructure, and the sustainable use of natural resources to create employment opportunities for young people.

7. Government priorities: Adolescents and youth[144]

Economic empowerment and employment	**70 per cent of governments**
Maximize social inclusion, equal access and rights	**46 per cent**
Education	**46 per cent**
SRH information and services for youth, including HIV	**38 per cent**
Training to Work	**36 per cent**

Governments responding to the Global Survey regarding their priorities for adolescents and youth in the coming 5-10 years spoke strongly for their economic empowerment, preparing them for full participation in the labour market, and the importance of their social protection and rights. "Economic empowerment and employment" was especially noted among governments from poorer countries: 69 of 85 governments in the bottom two World Bank income categories, versus 16 of 33 governments in the top two income categories. Youth cohorts are larger in countries lower in the income spectrum due to higher fertility in recent years, and the challenges of providing employment, particularly employment that leads out of poverty, are very high. Still, youth unemployment has become an enormous issue in wealthier countries as well, particularly since the 2008 global economic crisis, underscoring the priority

[139] ILO, *Promoting youth transitions to decent work: Empowering young people through employment* A background paper for the Global Youth Forum, Bali, 4 – 6 December 2012
[140] ILO, *Global employment trends for youth*, Geneva, 2013.
[141] ILO, *Global employment trends for youth*, Geneva, 2013.
[142] For a review of policies and programmes for youth employment see ILO, The youth employment crisis: Time for action, Report V, Geneva, 2012 accessible at http://www.ilo.org/ilc/ILCSessions/101stSession/reports/reports-submitted/WCMS_175421/lang--en/index.htm
[143] UNCTAD, 2013, The Least Developed Countries Report 2013: Growth with Employment for Inclusive and Sustainable Development
[144] See Annex II for full table of government priorities by region including definitions of each priority.

governments assign to this issue.

The global prioritization of "maximizing social inclusion, equal access and rights" was driven in part by its frequent mention in Europe (63 per cent of governments) and the Americas (56 per cent); in Africa and Asia, approximately 40 per cent of governments highlighted it. The Programme of Action recognized the critical role of youth and the need to integrate them into society, reflected both in progress for young people, and the continued priority by governments. Social inclusion and rights also included priorities relevant to addressing neglect, discrimination and ensuring human rights protections, areas of significant focus in the Bali Global Youth Forum Declaration.

Three additional priorities were very common among governments. The first, "sexual and reproductive health information and services for youth, including HIV", was listed by 38 per cent of governments globally but was a priority for half of all countries in Africa and Asia, half of low-income and lower middle-income governments, and 40 per cent of all upper middle-income countries. However, only one of the 33 wealthiest countries included sexual and reproductive health among their top five priorities for youth, which may reflect the better existing access to health in most of the wealthiest countries.

"Political empowerment and participation", was highlighted by 38 per cent of governments, evenly distributed regionally and by income. This provides a strong complement to, and mechanisms for achieving, both social inclusion and rights and economic empowerment, and highlights the rising strength of youth in influencing social, economic and political systems. Finally, "training to work" was listed by 36 per cent of governments globally, including 52 per cent of African governments and 56 per cent of low-income governments.

Taken together, this collection of priorities – economic empowerment, education both generally and targeted for work, as well as sexual and reproductive health and political empowerment– reinforce governments emphasis on strengthening the capabilities of their young people.

D. Older persons

1. The demographic importance of population ageing

An inevitable consequence of demographic changes resulting from fertility decline and increased longevity is population ageing. One of humanity's greatest achievements is that people are living longer and healthier lives, with the number and proportion of older persons aged 60 years or over rising in all countries. Population ageing presents social, economic, and cultural challenges to individuals, families and societies but also opportunities to enrich entire households and the larger society. During 1990 to 2010, the population aged 60 years or over increased in all world regions, with Asia adding the greatest number of older persons, 171 million, to its population. During 2005–2010, the annual growth rate for the population aged 60 years or over (3 per cent) was twice that recorded for the total population (1 per cent). In the coming decades, this gap is expected to widen.[145]

Globally, in the last 20 years, the population of older persons aged 60 years or over has increased by 56 per cent, from 490 million in 1990 to 765 million in 2010. During this time, the increase in the population of older persons in developing countries was more than twice (72 per cent) that of developed countries (33 per cent). The number and proportion of older persons are rising in almost all countries, with projections that more than 20 per cent of the global population will be age 60 and above by 2050 (see Figure 13). Persons age 60 and above already make up more than 20 per cent of the population in

[145] United Nations, Department of Economic and Social Affairs, Population Division, 2013. World Population Prospects: The 2012 Revision. DVD Edition.

Europe, 15 per cent of the population in Oceania, and are anticipated to make up 15 per cent of the population in the Americas by 2015. Due to rapid projected growth in the population of older persons in the coming decades, the number of older persons is projected to surpass the number of children by 2047. Many developed countries are already facing extremely low old-age support ratios.[146]

Figure 13
Trends and projections in the proportion of older persons (over 60 years), worldwide and by region, 1950-2050
(medium fertility variant)

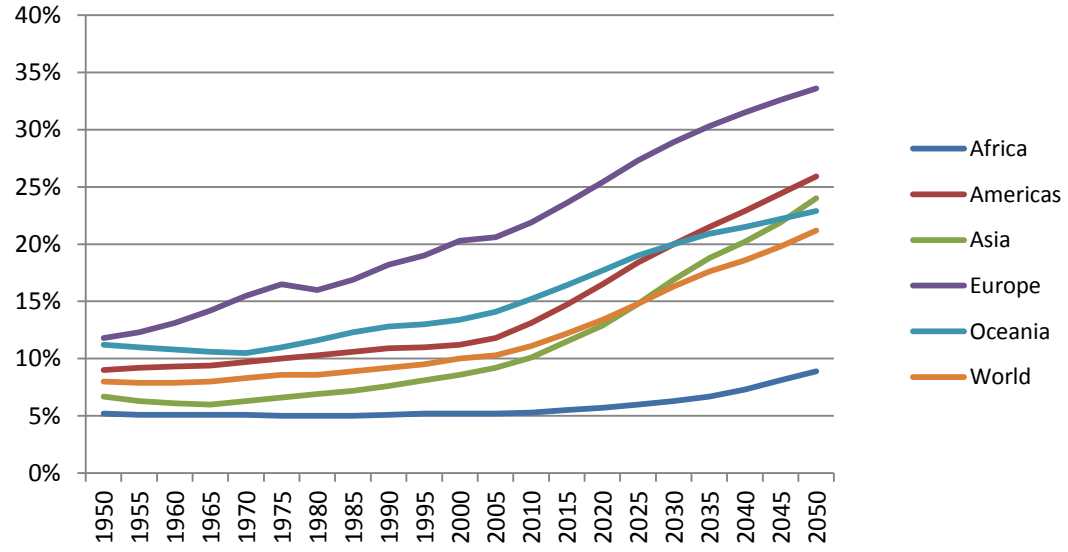
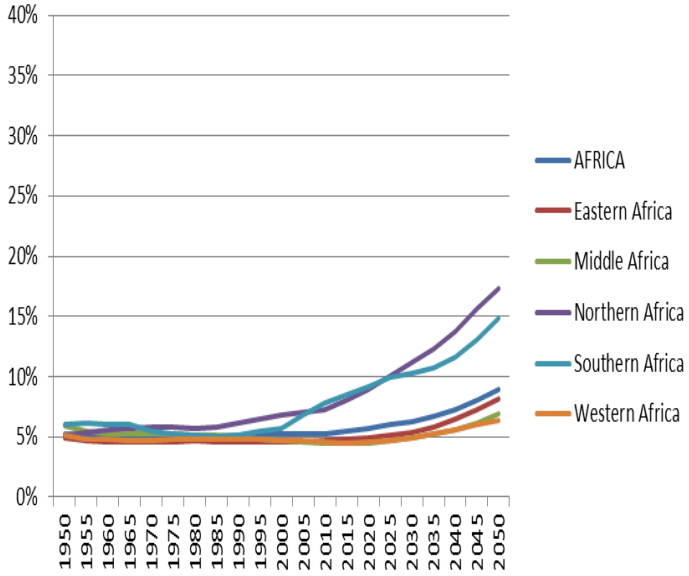


Figure 13.a
Trends and projections in the proportion of older persons (over 60 years) in Africa by sub-region, 1950-2050
(medium fertility variant)



[146] United Nations, Department of Economic and Social Affairs, Population Division, 2013. World Population Prospects: The 2012 Revision. DVD Edition.

Figure 13.b
Trends and projections in the proportion of older persons (over 60 years) in the Americas by sub-region, 1950-2050
(medium fertility variant)

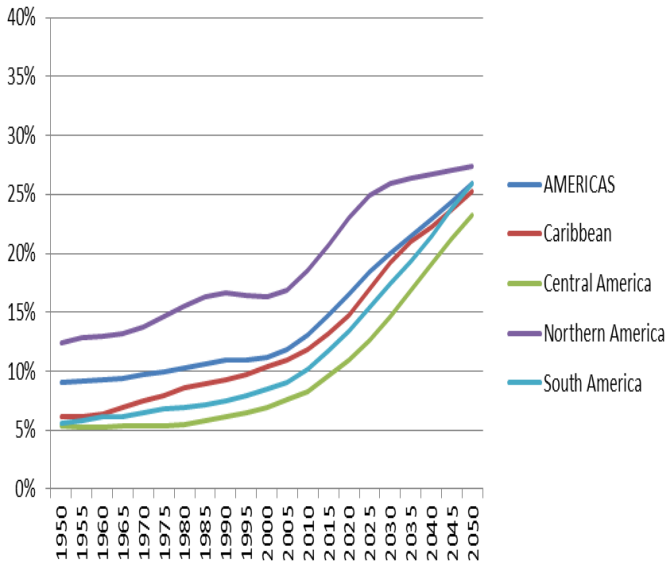


Figure 13.c
Trends and projections in the proportion of older persons (over 60 years) in Asia by sub-region, 1950-2050
(medium fertility variant)

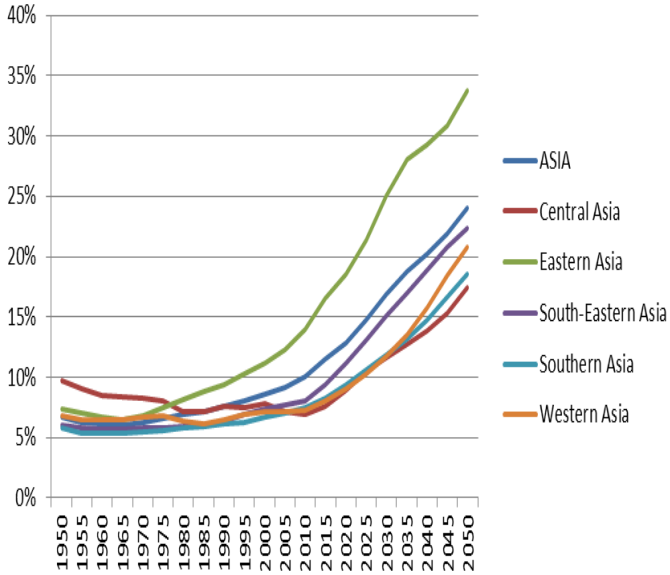


Figure 13.d
Trends and projections in the proportion of older persons (over 60 years) in Europe by sub-region, 1950-2050
(medium fertility variant)

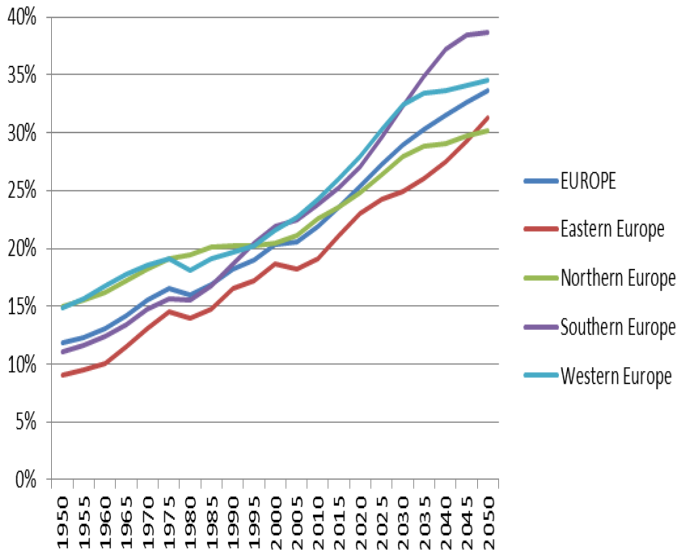
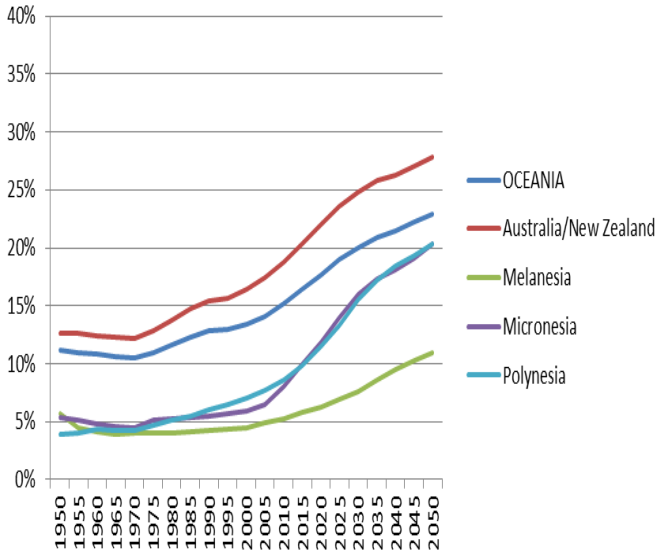


Figure 13.e
Trends and projections in the proportion of older persons (over 60 years) in Oceania by sub-region, 1950-2050
(medium fertility variant)



Source: United Nations, Department of Economic and Social Affairs, Population Division, 2013. World Population Prospects: The 2012 Revision, DVD Edition, retrieved from http://esa.un.org/unpd/wpp/index.htm,

Sub-regional trends highlight the low proportion of persons over 60 years in Africa, but greater proportions in Southern and Northern Africa, relative to other sub-regions. All sub-regions of the Americas are ageing rapidly, with North America further advanced. Within Europe, only Eastern Europe has fewer than 20% persons over 60 years in 2010, but will pass that mark soon. In Asia, only Eastern Asia has more than 10% of the population over 60 years today, but all sub-regions are ageing quickly. Oceania remains diverse, with Australia/New Zealand closer to European proportions.

Due to longer life expectancy among women than among men at older ages, elderly women outnumber elderly men in most societies. In 2012, globally, there were 84 men per 100 women in the age group 60 years or over and 61 men per 100 women in the age group 80 years or over.[147] Integrating gender into policies and support for older persons is therefore critical, including in health, other types of care, family supports and employment.

Older individuals are much more likely to live independently in developed countries than in developing countries. Globally, 40 per cent of older persons aged 60 years or over live alone or only with their spouse, and older persons living alone are more likely to be women given their longer life expectancy. But the living arrangements of older people vary greatly by level of development. About three-quarters of older persons in developed countries live independently, compared with only one-quarter in developing countries and only one-eighth in the least developed countries.[148] Population ageing demands attention to the physical infrastructure to ensure safe housing, mobility and the means of meaningful participation of older persons. **States should modify legislation, design and planning guidelines, and infrastructure to ensure that the increasing number of older, single persons have access to needed and appropriate housing, transport, recreation and the amenities of communal life.**

The sexual health of older persons is often overlooked both in academic discourse and policy responses to rapid population ageing, perhaps because the subject of sexuality in older people remains largely taboo in many cultures. Yet in a recent large study of older adults in the United States of America, where a broad definition of sexual functioning was used, women between 57 to 74 years showed no decline in sexual activity.[149] Sexual functioning was found to be more associated with self-rated physical health than age. **States should adapt policies and programmes on sexual health to better meet the changing sexual needs of older persons.**

As people live longer, there are concerns about the sustainability of benefits, such as pensions, health care and old-age support, which will need to be paid over longer periods. There are also concerns about the long-term viability of intergenerational social support systems, which are crucial for the well-being of both the older and younger generations. Such concerns are especially acute in societies where provision of care within the family becomes increasingly difficult as family size decreases, and as women, typically the main caregivers, work outside the home. Increasing longevity may also result in rising medical costs and increasing demands for health services, since older people are typically more

[147] United Nations, Department of Economic and Social Affairs, Population Division, 2013. World Population Prospects: The 2012 Revision. DVD Edition.
[148] United Nations, Department of Economic and Social Affairs, Population Division, 2012. Population ageing and development: Ten years after Madrid. Population Facts No.2012/4, December 2012; United Nations, Department of Economic and Social Affairs, Population Division, 2012. Population Ageing and Development 2012 Wallchart. Available at http://www.un.org/en/development/desa/population/theme/ageing/index.shtml
[149] Lusti-Narasimhan and Beard JR. (2013). Sexual health in older women. *Bulletin of the World Health Organization.* Retrieved from: http://www.who.int/bulletin/volumes/91/9/13-119230.pdf.

vulnerable to chronic diseases.[150] **States should ensure the social protection and income security of older persons, with particular consideration for older women, those living in isolation and those providing unpaid care, by extending pension systems and noncontributory allowances, and by strengthening intergenerational solidarity, and by ensuring the inclusion and equitable participation of older persons in the design and implementation of policies, programmes and plans that affect their lives.**

At the same time, many persons continue to contribute to their families, communities and societies well into old age. Not all older persons require support, nor do all persons of working age provide direct or indirect support to older persons. In fact, older persons in many societies are often providers of support to their adult children and grandchildren.[151] Further, while expenditures in health-care and other sectors that cater to older populations may be a challenge, they are also an investment. The expansion of these sectors generates important employment opportunities in both the public and private health care sectors.[152] **States should strengthen health and care systems by promoting universal access to an integrated, balanced continuum of care through old age, including chronic disease management, end-of-life and palliative care.**

In 2002, the international community gathered for the Second World Assembly on Ageing in Madrid to discuss the growing challenges of population ageing. By then, it was clear that ageing was no longer just a concern of developed countries. It was affecting, or beginning to affect, an increasing number of countries, both developed and developing. And its social, economic and political consequences could no longer be ignored. The phenomenon of population ageing could no longer be considered as a stand-alone issue or an afterthought. The Second World Assembly and its outcome document, the Madrid International Plan of Action on Ageing, marked the first time that governments agreed to link questions of ageing to other frameworks for social and economic development and to human rights agreed at previous United Nations conferences and summits.

2. Life-long education, economic and social participation

The Programme of Action recommended that governments enhance and promote older persons' self-reliance, quality of life, ability to work as long as possible and desired, and enable their continued participation using their skills and abilities fully for the benefit of society. Many older persons continue to work and often their earnings support the entire household. Older persons may also wish to live satisfying professional lives. Flexible employment, lifelong learning and retraining opportunities are critical to enable and encourage older persons to remain in the labour market, for their own benefit, for that of their families, and as an essential resource for successful economies that cannot afford to lose their experience and expertise.

In the decade after the ICPD, the Hamburg Declaration, promulgated by the Fifth International Conference on Adult Education (1997), and the Madrid International Plan of Action on Ageing (2002) each affirmed the importance of education for older persons.[153] The provision of life-long education

[150] United Nations, 2011, *Current Status of the Social Situation, Well-Being, Participation in Development and Rights of Older Persons Worldwide*. Department of Economic and Social Affairs, United Nations: New York. United Nations, Department of Economic and Social Affairs, Population Division, 2012. Population ageing and development: Ten years after Madrid. Population Facts No.2012/4, December 2012; United Nations, Department of Economic and Social Affairs, Population Division, 2012. Population ageing and the Non-communicable Diseases. Population Facts No.2012/1, April 2012

[151] Lee, Ronald and Andrew Mason, 2011. *Population ageing and the global economy: A global perspective*. Edward Elgar: Cheltenham, UK.; United Nations, Department of Economic and Social Affairs, Population Division, 2012. Population ageing and development: Ten years after Madrid. Population Facts No.2012/4, December 2012; United Nations, 2011, *Current Status of the Social Situation, Well-Being, Participation in Development and Rights of Older Persons Worldwide*. Department of Economic and Social Affairs, United Nations: New York.

[152] OECD, 2011. *Help Wanted? Providing and Paying for Long-Term Care*. Pp.336.; OECD, 2013. Health at a Glance 2013. OECD Indicators. OECD Publishing. Available at *http://dx.doi.org/10.1787/health_glance-2013-en*;

[153] UNESCO, Fifth International Conference on Adult Education, Final Report, 1997 (retrieved 7 October 2013), http://www.unesco.org/education/uie/confintea/pdf/finrepeng.pdf; Du Peng, "The Third Age: Opportunity for Learning and Teaching," *Population Ageing*

enables persons of all ages to strengthen and augment their literacy and related skills, to adapt to changing employment opportunities, and fully participate in changing personal and economic conditions, to the benefit of themselves, their families, communities and the society at large. Lifelong learning is not only for older persons, but also for young or middle age workers experiencing loss or changing employment, or who may have missed earlier opportunities to attain an education due to poverty, early entry into employment, early childbearing, or voluntary or forced mobility. Additionally, a global network of Universities of the Third Age focus on education to enhance quality of life for retired persons, their membership has expanded further in response to the growing demands of non-retired persons for non-formal education.[154]

Ninety-two per cent of governments appear to have some policy on adult education, and these overwhelmingly target skills development and training for the labour market, an oft-cited priority by ministers of education in both developing and developed countries.[155] Since 2000, numerous governments have adopted policies and initiatives focused on retraining older persons, with examples from Japan, Hungary, Serbia, Belize, El Salvador, Mexico, Puerto Rico, Canada, Denmark, Sweden, China and the Russian Federation.[156]

Despite national policies on life-long education and retraining, adult illiteracy remains high, with 651 million adults age 25 and over functionally illiterate in 2011, and the majority are women (64 per cent).[157] Among persons aged 65 or older, total global illiteracy rates are 26 per cent, and range from 25 per cent in Latin America to 68 per cent in Africa, with rates among women consistently above those of men (see Annex I, Figure 8). Adult illiteracy rates are higher in rural areas and zones of conflict, among persons with disabilities and ethnic minority populations.[158]

Illiteracy traps many in a cycle of poverty, with limited opportunities for employment or income generation, and greater likelihood of poor health.[159] The effects of illiteracy, incomplete and/or poor quality education (See chapter I, section C.4., Uneven progress in education) linger throughout the life course, with adverse consequences in particular for adults and older persons in countries without social security systems, and who may be compelled to work at older ages in informal, physically demanding, and poorly paid work.[160]

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and the Millenium Development Goals (New York, UNFPA), p. 157.; [153] UNDESA, Division for Social Policy and Development, Madrid International Plan of Action on Ageing, Guiding Framework and Toolkit for Practitioners and Policy Makers, 2002 (retrieved 27 September2013), https://www.un.org/ageing/documents/building_natl_capacity/guiding.pdf.

[154] China is home to 32, 697 U3As, serving 3, 335, 093 students; the UK has 903 U3As, with 319, 185 students. Du Peng, "The Third Age", p. 159; University of the Third Age UK, http://www.u3a.org.uk/u3a-movement.html

[155] See UNESCO, UIL, GRALE, Table 2.2, "Existence of laws, legal regulations or other public policy measures/initiatives with a primary focus on supporting adult education," p. 42; UNESCO Assistant Director-General for Education, Dr. Qian Tang, 2011, p. 14, in GRALE, p. 42.

[156] UNFPA, 2012, Ageing in the 21st century: A celebration and a challenge, pp190.

[157] UN Literacy Decade, http://www.unesco.org/new/en/education/themes/education-building-blocks/literacy/un-literacy-decade/; UNESCO Institute for Lifelong Learning, Global Report on Adult Learning and Education, "Rethinking Literacy," 2013, p. 18, p. 153.

[158]UNESCO Institute for Lifelong Learning, Global Report on Adult Learning and Education, "Rethinking Literacy," 2013, p. 19. See also Groce, Nora Ellen, and Bakshi, Parul, "Illiteracy among Adults with Disabilities in the Developing World: An Unexplored Area of Concern," Working Paper Series no. 09, Leonard Cheshire Centre for Disability and Inclusive Development, Division of Population Health, University College London, August 2009, retrieved from http://www.ucl.ac.uk/lc-ccr/centrepublications/workingpapers/WP09_Illiteracy_among_Adults_with_Disabilities_in_the_Developing_World_-_An_Unexplored_Area_of_Concern.pdf on 1 October 2013

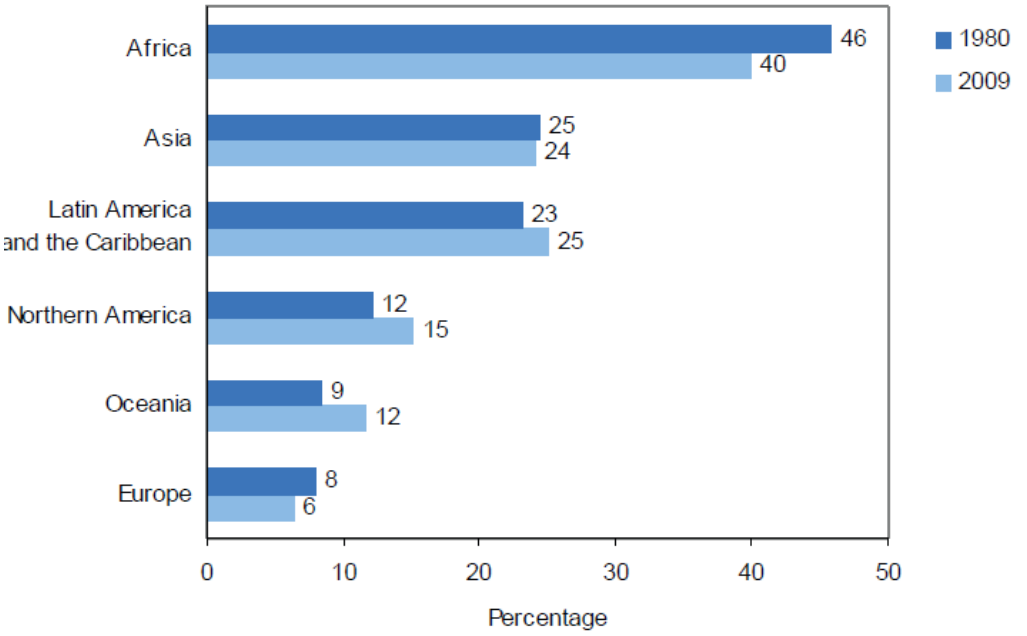
[159] World Bank, "Education Poverty," in Poverty Reduction and Equity, "Defining Welfare Measures –Non-Monetary Dimensions of Poverty," retrieved from http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/EXTPA/0,,contentMDK:20242876~isCURL:Y~menuPK:492130~pagePK:148956~piPK:216618~theSitePK:430367~isCURL:Y,00.html on 27 September 2013; World Literacy Foundation, "The Economic and Social Cost of Illiteracy," April 2012, p. 2, retrieved from http://www.worldliteracyfoundation.org/The_Economic_&_Social_Cost_of_Illiteracy.pdf on 29 September 2013

[160] International Labour Organization, Economically Active Population, Estimates and Projections, database, October 2012, http://laborsta.ilo.org/applv8/data/EAPEP/eapep_E.html; in UNFPA, HelpAge International, "Ageing in the 21st century: A Celebration and a Challenge", p. 55.

In 2002, 88 per cent of governments reported having a law or policy on adult literacy.[161] In Cambodia, where 70 per cent of women over 65 years old cannot read or write, adult literacy classes organized with volunteer teachers (retired schoolteachers and monks) markedly improved older women's ability to read and do calculations, enabling them to set up small stores and businesses.[162] **States should strengthen life-long learning and adult literacy opportunities that enable all persons regardless of age to gain new skills for a changing economy, pursue better employment and income, or simply explore the development of personal talents and ambitions.**

Globally, the highest proportion of older persons' labour force participation is in Africa, where more than 40 per cent of those over 65 years of age are economically active, followed by nearly 25 per cent in Asia, Latin America and the Caribbean (see Figure 14).

Figure 14
Labour force participation of older persons as a proportion of total population aged 65 and over by region, 1980-2009

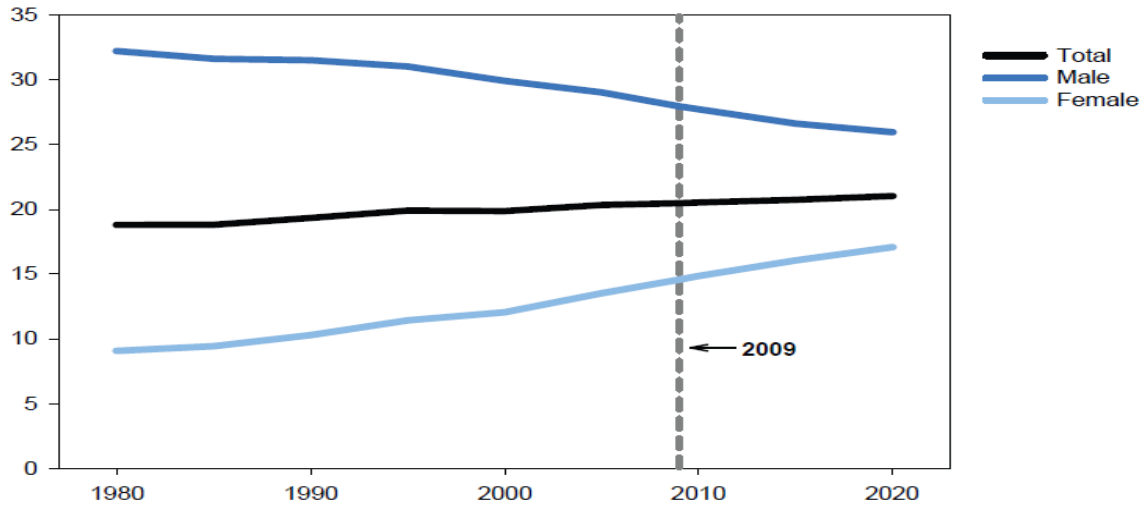


Source: UNDESA, Population Division, *World Population Ageing*, 2009, p. 42.

Given women's longer life expectancy, they make up an increasing proportion of the older workforce, and their likelihood of participating in the labour force after age 65 has been rising for several decades (Figure 15) even as men's likelihood of working after age 65 has declined. Women's increased participation in the older workforce and greater rates of illiteracy contributes to the persistent inequalities faced by working women, and their greater likelihood of participating in informal, insecure and lower paid work (see chapter I, section B.1., Changing Patterns in Productive and Reproductive Roles). **States should monitor and eradicate all forms of discrimination in employment against older persons, develop labour protection policies and programmes that ensure employment which is safe, secure, and which provides a decent wage.**

[161] See UNESCO, UIL, GRALE, Table 2.3, "Existence of laws, legal regulations or other public policy measures/initiatives with a primary focus on supporting adult literacy," p. 43.
[162] Jamie Pugh, "Changing lives through literacy", Ageways 75 (London, HelpAge International, 2010), p. 7; in Ageing in the 21st century, p. 59.

Figure 15
Global labour force participation age 65 and over by sex, 1980-2020



Source: UNDESA, Population Division, *World Population Ageing*, 2009, p. 40.

Human rights elaborations since the ICPD: Older persons

Intergovernmental human rights outcomes: General Assembly *Resolution 65/182 Follow-up to the Second World Assembly on Ageing* (2011) established the Open-Ended Working group on Ageing in order to strengthen recognition of the human rights of older persons, assess gaps, and consider, as appropriate, the feasibility of implementing further instruments and measures. Subsequent General Assembly *Resolution 67/139 Towards a Comprehensive and Integral International Legal Instrument to Promote and Protect the Rights and Dignity of Older Persons* (2013) decided that the Open-Ended Working group on Ageing will "consider proposals for an international legal instrument to promote and protect the rights and dignity of older persons."
Other intergovernmental outcomes: *The Madrid Plan of Action* and *Political Declaration* (2002) adopted at the Second World Assembly on Ageing offers a new agenda on ageing in the 21st-century focusing on: older persons and development; health and well-being into old age; and ensuring enabling and supportive environments.[163]
Other soft law: Regional systems have also showed increased momentum towards developing mechanisms to promote, protect, and fulfil the human rights of older persons. The African Commission on Human and People's Rights, The Inter-American system, and the Steering Committee for Human Rights of the Council of Europe have all developed working groups with the aim of drafting an instrument to promote the human rights of older persons.

The Global Survey shows that a higher percentage of countries with old-age structures address the issues related to the needs of older persons. These are countries with current old-age dependency ratios higher than 12 persons aged 65 or over per 100 persons of working age (15-64).

Globally, 40 countries whose populations will be ageing rapidly over the next two decades – including China, India, Indonesia, Vietnam, Brazil, Mexico and Iran – have an old-age dependency ratio between 6 and 12 in 2010. This ratio is estimated to increase to more than 12 in 2030 (medium projection). A high proportion of these countries addressed the issues of "providing social services including long-term

[163] UNDESA. "Madrid International Plan for Action on Ageing." Retrieved from: http://undesadspd.org/Ageing/Resources/MadridInternationalPlanofActiononAgeing.aspx.

care" (94 per cent), "providing affordable, appropriate and accessible health care" (91 per cent), "extending or improving old age allowances" (88 per cent), "enabling older persons to live independently as long as possible" (89 per cent) and "collecting disaggregated data" (88 per cent).

Such progress in the areas of social protection, health care and data collection have not been matched by advances in employment, non-discrimination or participation in society, with a smaller share of countries "addressing neglect, abuse and violence against older persons" (74 per cent), "enabling older persons to make full use of their skills and abilities" (69 per cent), "providing support to families caring for older persons" (67 per cent), "instituting concrete procedures and mechanisms for participation" (63 per cent), "preventing discrimination against older persons, especially widows (58 per cent), and "promoting employment opportunities for older workers" (39 per cent). **States should monitor and eradicate all forms of direct and indirect abuse, including all forms of violence, over-medication, sub-standard care, and social isolation.**

3. Government priorities: Older persons[164]

Preventive and curative health care	**54 per cent of governments**
Economic empowerment, employment and pensions/support schemes	**54 per cent**
Development of programmes, policies and strategies and the creation of laws and institutions related to older persons	**39 per cent**
Social inclusion and rights of older persons	**37 per cent**
Elder care	**36 per cent**

When countries were asked to identify the most relevant issues anticipated to receive public policy priority related to older persons, "preventative and curative health care" was a particular focus of countries in Africa, where 68 per cent listed it among their top five priorities; in Europe, Asia and the Americas, about half of countries included it, as did three in 10 countries in Oceania. European and Asian countries listed "economic empowerment, employment and pensions" most often (62 per cent and 59 per cent respectively). In these regions, as well as in the Americas, the identification of economic contributions and sustainable support systems for older persons aligns with significant progression in ageing and the need to maintain both economic growth and social welfare given the relative decline in traditionally working age populations.

Despite high poverty rates among older persons around the world and across country income groupings, "addressing poverty" among older persons only emerged as a priority among countries in Africa, where nine countries listed it. Just three other countries worldwide reported it as a priority.

In line with the significant shift of the Madrid International Plan of Action on Ageing, "social inclusion and rights" of older persons was a consistent priority of about 40 per cent of countries in Africa, the Americas and Europe. Just nine of 41 Asian countries listed it, however, and only one country in Oceania. Prioritization of "social inclusion and rights" was also more frequent on the higher end of the income spectrum: above 40 per cent of countries in the upper-middle, high non-OECD, and high OECD countries, to 30 per cent in low and lower middle-income countries.

"Capacity strengthening" on ageing, particularly in the areas of data and research, emerged more

[164] See Annex II for full table of government priorities by region including definitions of each priority.

frequently as a priority among low-income countries, where 10 of 32 countries included it among their top five priorities. Low-income countries are early in their ageing transition but share other countries' awareness of the need for support for older persons, and some are clearly looking to expand the evidentiary basis for government actions.

E. Persons with disabilities

Disability is experienced by the majority of people in the world at some point in their lives – some throughout their lives, some moving in and out of disability. It is estimated that, 15[165] to 20 per cent[166] of persons 15 years and older around the world currently live with a disability. Of these, between two and four per cent have significant or severe disabilities. According to the *Global Burden of Disease*, approximately 93 million, or 5 per cent, of children aged 0-14 are disabled.[167]

Disability is experienced unevenly across countries: countries with GPD per capita below US $3255 have a total disability prevalence of 18 per cent, compared to just 12 per cent for those above. Women are also significantly more prone to disability than men, at 22 per cent in lower income countries and 14 per cent in higher income countries. [168]

The likelihood of having a disability rises dramatically with age, with over 46 per cent of all people over 60 years of age having a moderate or severe disability compared with just 15 per cent of people aged 15-49 years. The number of persons with disabilities is growing, as a result both of general population ageing and the spread of non-communicable diseases associated with disability, such as diabetes, heart disease and mental illness.[169]

There is a suggestive, though under-studied, link between poverty and disability, both as a driver and as a consequence of disability.[170] The causality between disability and poverty is not well established due to limited availability of longitudinal data and the fact that poverty is frequently measured at the household level. Studies in both developed and developing countries have shown that disability hampers educational attainment and interferes with labour market participation.[171] **States should monitor and eradicate all forms of discrimination in employment against persons with disabilities, and develop enabling policies and programmes that ensure employment which is safe and secure, and provides a decent wage.**

Persons experiencing disabilities are more likely to experience "violations of dignity",[172] including social exclusion, violence and prejudice than persons without disabilities. And the implications of disability, including the need for social support, extend beyond the individual to households and families impacted by disability, given the added cost of resources spent on health care, loss of income, stigma, and the need for support systems for caregivers. **States should monitor and eradicate all forms of direct and indirect discrimination towards persons with disabilities, including all forms of inter-personal violence, over-medication, sub-standard care, and their social isolation, through national programmes particularly in the areas of education, employment, rehabilitation, housing, transportation, recreation, and communal life, as well as support for family caretakers.**

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[165] Data based on *World Health Survey*, cited in the WHO. 2011. *World Report on Disability*.
[166] Data based on *The Global Burden of Disease 2004 Update* (WHO, 2008), cited in the WHO. 2011. *World Report on Disability*.
[167] WHO. 2011. *World Report on Disability*, Geneva.
[168] WHO. 2011. *World Report on Disability*, Geneva.
[169] WHO. 2011. *World Report on Disability*, Geneva.
[170] Braithwaite, Jeanine and Daniel Mont. 2009. "Disability and Poverty: A Survey of World Bank Poverty Assessments and Implications." *European Journal of Disability Research* 3(219-232).
[171] WHO. 2011. *World Report on Disability.*
[172] WHO. 2011. *World Report on Disability*, Geneva.

The World Programme of Action (1983), the ICPD Programme of Action (1994), the Convention on the Rights of Persons with Disabilities (2006) and the Outcome Document that was adopted by the General Assembly at the High-Level Meeting on Disability and Development (23 September 2013) all recognized that persons with disabilities constitute a significant portion of global and national populations. These instruments set as objectives the realization of human rights, participation, equal opportunities, valuing of capabilities in social and economic development, and dignity and self-reliance of persons with disabilities. **States should take concrete measures to realize their commitments to enhancing accessibility and inclusive development and to enable full participation in social, economic and political life by all, including persons with disabilities.**

National and global data on disability also suffer from significant validity and comparability problems, leading to highly variable estimates, as well as frequent undercounting due in part to stigma associated with the term. The Washington Group on Disability Statistics, which promotes international cooperation in health statistics by focusing on disability measures suitable for censuses and national surveys, is making continual progress in the measurement of disability. Strengthening definitions and data systems for monitoring and addressing disability is a critical need for defining and monitoring progress towards well-being and participation. Enhanced international cooperation towards this end is more vital than ever before.

Based on responses to the Global Survey, the primary issue of concern relevant to persons with disabilities that is being addressed by countries is "ensuring a general education system where children are not excluded on the basis of disability". It is worth noting that 82 per cent of countries, that is, all except 28 (13 in Africa, 6 in Asia, 6 in the Americas, 2 in Europe and 1 in Oceania) were committed to implementing this issue. The level of concern around this issue was inversely proportional to the countries' population growth and directly proportional to the countries' income level.

Secondly, 78 per cent of countries were concerned to "strengthen comprehensive habilitation and rehabilitation services and programmes", with no major regional differences observed. And 77 per cent of countries reported, "creating employment opportunities for persons with disabilities". The number and percentage of countries that do not address the issue is small in Europe (8 per cent), Asia (10 per cent) and the Americas (19 per cent) and larger in Oceania (54 per cent) and Africa (38 per cent). This may suggest a higher percentage of wealthier countries have committed to addressing this issue during the past 5 years, in contrast with poorer ones.

The issues of "developing infrastructure to ensure access on an equal basis with others" (68 per cent), "ensuring the same rights and access to sexual and reproductive health services, including HIV prevention" (65 per cent) and "guaranteeing equal and effective legal protection against discrimination" (60 per cent) are addressed by around 6 in 10 countries globally, but this share always falls below the world average in the case of Oceanic and African countries. **States should guarantee persons with disabilities, in particular young people, the right to health, including their sexual and reproductive health and rights, as well as their right to the highest standard of care, ensuring that people with disabilities are partners in programming and implementation, policy development, monitoring and evaluation, taking into account the structural factors that hinder the exercise of these rights.**

"Providing support to families caring for persons with disabilities" is addressed by 61 per cent of countries, and again the level of concern is proportional to the countries' income level and inversely proportional to the countries' population growth. Although 59 countries did not commit to addressing

this issue during the past 5 years, considerable differences are observed regionally. While 88 per cent of European countries report addressing this issue, only 39 per cent of the countries in Oceania and 39 per cent of those in Africa (the majority) commit to providing this type of support.

Finally, the issue which had engendered the least commitment from countries was "promoting equality by taking all appropriate steps to ensure that reasonable accommodation in all aspects of economic, social, political and cultural life", which was not a priority issue for 47.9 per cent of countries, mostly African (23) and Asian (23) and Oceanic (10), mostly poorer and fast-growing.

Increasing "accessibility and mobility" for persons with disabilities is in the top five priorities for half or more than half of countries at the lower end and middle of the income spectrum (low-income: 50 per cent; lower middle-income: 59 per cent and upper middle-income: 66 per cent). Given the central importance of accessibility in building inclusive societies and sustainable and equitable development for all, this is an area that should receive greater attention and prioritization in the phase beyond 2014 and post 2015. If fulfilled, this priority would significantly contribute to the full economic and social participation of persons with disabilities, many of whom live in developing countries and face accessibility and mobility challenges in their everyday life.

Human rights elaborations since the ICPD: Persons with disabilities

Binding instruments: Recognized among the core international human rights instruments, the *Convention on the Rights of Persons with Disabilities* (2006; e.i.f. 2008) constitutes a tremendous advance in promoting the rights of persons with disabilities. The Convention recognizes persons with disabilities to include individuals with "long-term physical, mental, intellectual or sensory impairments," where such disabilities interact with additional barriers to prevent effective and equal participation in society. The Convention aims to, "promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity." The *Optional Protocol to the Convention on the Rights of Persons with Disabilities* provides individuals with a communications platform to address instances where human rights have not been respected. Regionally, the *Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities* (1999; e.i.f. 2001) affirms that persons with disabilities are entitled to the full enjoyment of human rights and fundamental freedoms protected through international law.

Intergovernmental human rights outcomes: The Human Rights Council has adopted a series of resolutions on persons with disabilities, most recently *Resolution 19/11 Rights of Persons with Disabilities: Participation in Political and Public Life* (2012). Regional systems have elaborated rights of persons with disabilities in regional human rights instruments and documents.[173]

1. Government priorities: Persons with disabilities[174]

Economic empowerment and employment	**65 per cent of governments**
Accessibility and mobility	**57 per cent**
Education	**55 per cent**
Social inclusion and rights	**37 per cent**
Development of programmes, policies, strategies, laws and the creation of institutions pertaining to persons with	**28 per cent**

[173] For more information on regional human rights systems and norms and standards relating to disability see UN Enable: http://www.un.org/esa/socdev/enable/comp300.htm.

[174] See Annex II for full table of government priorities by region including definitions of each priority.

disabilities

When governments were asked to identify the most relevant issues anticipated to receive public policy priority related to persons with disabilities, the top three priorities across 4 of 5 regions, and by a substantial margin, focused on the economic empowerment, access and mobility and education. Ten of 48 African countries, or 21 per cent, also listed "training for employment"[175] as a top five priority in a region above and beyond the distinct support for "economic empowerment and employment", affirming the importance of bringing disabled populations into the labour force in the region.

Equal access to "education" for disabled persons was a consistent priority for governments around the world, but particularly for low-income countries (63 per cent). Both the discrimination faced by persons with disabilities in accessing the general education system, as well as the lack of an education system tailored to their needs pose a serious barrier to their self-reliance and equal opportunity.

Finally, a number of other priorities were frequently listed. For instance, more than half of low-income (53 per cent) and high-income OECD (52 per cent) governments listed "social inclusion and rights"[176] as a key priority. Similarly, "rehabilitation and habilitation"[177] was a top five priority in more than a third of Asian governments (35 per cent), while "autonomy"[178] was prioritized by 21 per cent of European governments.

F. Indigenous peoples

There are an estimated 370 million indigenous persons worldwide.[179] Indigenous people have historically been and continue to be subject to social and political marginalization that has undercut their access to development. They have often been denied both the opportunity to sustain their own cultural heritage and the opportunities commensurate with full social, political and economic integration into the prevailing political system.[180]

For many, structural discrimination included the violence of forced displacements, loss of homeland and property, separation of families, enforced loss of language and culture, the commodification of their cultures, and a disproportionate burden of the consequences of climate change and environmental degradation. Conditions of poverty are, for some groups, exacerbated by geographic distance and the remoteness of indigenous territories, itself a consequence of historic forced displacements.[181]

[175] Includes all priorities relating to the provision of formal and informal training and skills to persons with disabilities to support a successful transition to the employment market.
[176] Captures all priorities related to maximizing social inclusion and empowerment, and achieving equality of opportunity for all groups of persons with disabilities, without distinction of any kind. This code includes all priorities that relate to addressing the violence, neglect, abuse and discrimination against persons with disabilities, as well as unspecified human rights protections.
[177] Captures all priorities related to strengthening and extending comprehensive habilitation and rehabilitation services and programmes for persons with disabilities.
[178] Captures all priorities related to enabling persons with disabilities to live autonomously, that is, reducing their needs for dependency and care.
[179] United Nations Department of Economic and Social Affairs.. (2009). State of the World's Indigenous Peoples (ST/ESA/328). UN-DESA Division for Social Policy and Development, Secretariat of the Permanent Forum on Indigenous Issues. Retrieved from: http://www.un.org/esa/socdev/unpfii/documents/SOWIP_web.pdf.

[180] United Nations Department of Economic and Social Affairs. (2009). State of the World's Indigenous Peoples (ST/ESA/328). UN-DESA Division for Social Policy and Development, Secretariat of the Permanent Forum on Indigenous Issues. Retrieved from: http://www.un.org/esa/socdev/unpfii/documents/SOWIP_web.pdf.
[181] United Nations Department of Economic and Social Affairs.(2009). State of the World's Indigenous Peoples (ST/ESA/328). UN-DESA Division for Social Policy and Development, Secretariat of the Permanent Forum on Indigenous Issues. Retrieved from: http://www.un.org/esa/socdev/unpfii/documents/SOWIP_web.pdf.

Beginning with the launching of the affirmation of the human rights of indigenous people within the Programme of Action of the ICPD in 1994 as well as the commencement of the first International Decade of Indigenous Peoples that same year, the past two decades have seen a notable growth in international responses aimed at protecting, promoting and fulfilling the rights of indigenous peoples. In 2000 the "United Nations Permanent Forum on Indigenous Issues" was established. In 2001 the Commission on Human Rights decided to appoint a Special Rapporteur on the rights of indigenous peoples, whose mandate was renewed by the Human Rights Council in 2007. Further, the "UN Declaration on the Rights of Indigenous Peoples was adopted by the UN General Assembly" in 2007, the same year in which "The Expert Mechanism on the Rights of Indigenous Peoples" was established by the Human Rights Council.

Despite the expansion of these concerted efforts to address the needs of indigenous peoples, significant disparities persist, with indigenous peoples experiencing significantly higher prevalence of TB, non-communicable diseases, poor mental health, and a shorter life expectancy compared to non-indigenous nationals of the same country. For example, more than 50 per cent of indigenous adults over age 30 suffer from type 2 diabetes worldwide. In the United States of America the risk of contracting tuberculosis is 600 times higher among Native Americans than in the general US population; in Ecuador, indigenous persons have a 30 times greater risk of throat cancer than other nationals. The life expectancy gap between an indigenous child and a non-indigenous child in Nepal or Australia is 20 years, 13 years in Guatemala, and 11 years in New Zealand.[182]

A 2005 study by the World Bank on indigenous peoples in Latin America, estimated at 28 millions persons, found that "despite significant changes in poverty overall, the proportion of indigenous peoples in the region living in poverty – at almost 80 percent – did not change much from the early 1990s to the early 2000s,"[183] with poverty rates 7.9, 5.9 and 3.3 times higher among indigenous relative to non-indigenous peoples, in Paraguay, Panama and Mexico, respectively.[184]

States should guarantee indigenous peoples' right to health, including their sexual and reproductive health and rights, as well as their right to both the highest standard of care, the respectful accommodation of their own traditional medicines and health practices, especially as regards reducing maternal and child mortality considering their socio-territorial and cultural specificities, as well as the structural factors that hinder the exercise of this right.

The Programme of Action called on governments to address the specific needs of indigenous peoples in its actions and objectives, including ensuring their access to services, full participation, and protecting, promoting and fulfilling their right to development, including their integration into national censuses.

Among respondents to the Global Survey, only a small proportion of countries reported addressing the concerns of indigenous peoples during the past 5 years, and this was consistent across all regions. No more than two-thirds of reporting countries affirmed having government policies, budgets and implementation measures to meet the needs of indigenous peoples, and responses were often only

[182] United Nations Department of Economic and Social Affairs (2009). State of the World's Indigenous Peoples (ST/ESA/328). UN-DESA Division for Social Policy and Development, Secretariat of the Permanent Forum on Indigenous Issues. Retrieved from: http://www.un.org/esa/socdev/unpfii/documents/SOWIP_web.pdf.

[183] Patrinos, H.A., Skoufias, E. 2007. Conference Edition: Economic Opportunities for Indigenous Peoples in Latin America, Washington D.C.: The World Bank. Retrieved from: http://siteresources.worldbank.org/INTLAC/Resources/Synthesis_ConferenceEditiion_FINAL.pdf.

[184]Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of José Luis Machinea and Martin Hopenhayn, "La esquiva equidad en el desarrollo latinoamericano. Una visión estructural, una aproximación multifacética", *Informes y estudios especiales* series, No. 14 (LC/L.2414–P/E), Santiago, Chile, November 2005. United Nations publication, Sales No. S.05.II.G.158. Cited in Economic Commission for Latin America and the Caribbean (ECLAC). 2007. Panorama social de America Latina 2006. Santiago: United Nations. Retrieved from: http://www.eclac.org/publicaciones/xml/4/27484/PSI2006_FullText.pdf.

provided by fewer than half of all countries in a region. This low response most likely reflects the fact that many countries do not recognize "indigenous peoples" living within their national boundaries.

The most positive response was with regard to education – for which 67 per cent of governments stated that they had policies, budgets and implementation measures to ensure access to "all levels and forms of public education without discrimination", yet such proportion fell to 59 per cent for creating access to education in a person's "own language and respecting culture". Just under half of governments (49 per cent) reported addressing the issue of "creating different work opportunities for indigenous peoples without discrimination" during the past five years. Around half of the reporting countries have addressed the issue of providing culturally appropriate "sexual and reproductive health care, including HIV prevention services" for indigenous peoples (56 per cent).

Regarding issues of governance, 58 per cent of countries report having policies, budgets and implementation measures to "institute concrete procedures and mechanisms for participation" of indigenous peoples", 52 per cent report that they have addressed the issue of "protecting and restoring natural ecosystems on which indigenous peoples depend", and just under half of all reporting countries (50 per cent) have policies, budgets and implementation measures that address "land tenure and management by indigenous peoples". The issue addressed by the smallest proportion of countries (31 per cent) is that of "seeking free, prior and informed consent in trade and foreign direct investment concessions" for indigenous peoples.

States should respect and guarantee the territorial rights of indigenous peoples, including those of peoples living in voluntary isolation and those in the initial phase of contact, with special attention to the challenges presented by extractive industries and other global investments, mobility and forced displacements, and design policies that respect the principle of free, prior and informed consent on matters that affect these peoples, pursuant to the provisions of the United Nations Declaration on the Rights of Indigenous Peoples.

Human rights elaborations since the ICPD: Indigenous peoples

Intergovernmental Human Rights Outcomes: Following the ICPD, a number of international human rights instruments have addressed the rights of indigenous peoples. The landmark *Declaration on the Rights of Indigenous Peoples* (2007) states that "indigenous peoples have the right to the full enjoyment, as a collective or as individuals, of all human rights and fundamental freedoms as recognized in the Charter of the United Nations, the Universal Declaration on Human Rights and international human rights law."

1. Government priorities: Indigenous peoples[185]

Education	**55 per cent of governments**
Economic empowerment and employment	**36 per cent**
Political empowerment and participation	**33 per cent**
Language, culture and identity	**32 per cent**
Land and territory	**30 per cent**
Social Protection	**30 per cent**

[185] See Annex II for full table of government priorities by region including definitions of each priority.

Globally, 69 governments of the 176 responding to the Global Survey responded to the question on priorities for indigenous peoples: 23 governments from the Americas, 18 from Asia, 15 from Africa, 7 from Europe and 6 from Oceania.

In the Americas, after "education", which is prioritized by 14 of 23 governments, the next most frequently mentioned priorities were "political empowerment and participation" and "land and territory", which were identified by 12 and 10 of 23 governments respectively. These were followed by "social protection" (9 of 23 governments), "health care (other than sexual and reproductive health)"[186] (9 of 23 governments), and "development of policies, programmes, strategies, laws/creation of institutions"[187] (8 of 23 governments). Hence, the key foci for the region are capabilities and security, including education, health care, land and ways to secure them, particularly through political participation.

In Asia, "education" for indigenous persons was also the top priority listed (11 of 18 governments) followed by "economic empowerment of employment" (9 of 18 governments), suggesting the importance of accessing income-generating activities for indigenous persons. Prioritized by a smaller number of governments, the issues of "political empowerment and participation", "language, culture and identity" and "health care (other than sexual and reproductive health)" all garnered the same level of support (5 of 18 governments).

In Africa, contrary to global and regional trends, "economic empowerment and employment" was the most frequently mentioned priority (8 of 15 governments) and the only priority mentioned by more than half of governments. "Education" (7 of 15 governments) and "language, culture and territory" (6 of 15) were the second and third most important priorities respectively, in the region.

States should adopt, in conjunction with indigenous peoples, the measures needed to ensure that all indigenous persons enjoy protection from, and full guarantees against, all forms of violence and discrimination, and take measures to ensure that their human rights are respected, protected, and fulfilled.

States should respect and implement the provisions of the United Nations Declaration on the Rights of Indigenous Peoples, as well as Convention No. 169 of the International Labour Organization on indigenous and tribal peoples —and call on those countries that have not already done so to sign it and ratify it— adapting legal frameworks and formulating the policies necessary for their implementation, with the full participation of these peoples, including indigenous peoples that live in cities.

G. Non-discrimination applies to all persons

The ICPD Programme of Action affirmed human rights principles related to equality and non-discrimination established in the Universal Declaration of Human Rights (1948), the International Covenant on Civil and Political Rights (1966), and the International Covenant on Economic, Social, and Cultural Rights (1966), and elaborated in other international human rights instruments such as the International Convention on the Elimination of All Forms of Racial Discrimination (1965), and United Nations Declaration on the Rights of Persons Belonging to National or Ethnic Religious and Linguistic

[186] Captures all priorities related to improving the provision of health care for indigenous peoples, with the exception of sexual and reproductive health and HIV care (see code 15). This code includes measures such as the provision of culturally-appropriate, affordable, accessible and quality health care to meet the needs of indigenous peoples.
[187] Captures all priorities that address the above, where the priority did not specify a particular sector.

Minorities (1992). Yet many people throughout the world continue to suffer from discrimination, a fact affirmed at the ICPD Beyond 2014 regional meetings.

The review shows that diverse sexual orientation and gender identity exist and that persons with diverse sexual orientation and gender identity in parts of the world suffer from risk of harassment and physical violence.[188] The outcomes of the regional reviews reinforced the importance of the principles of freedom and equality in dignity and rights as well as non-discrimination. Structural violence in the form of homonegativity marginalizes and dehumanizes persons of diverse sexual orientation and gender identity, hindering their capacity to fully contribute to society, and denying them the civil rights that are typically afforded to other persons.[189] The commitment to individual well-being cannot co-exist with tolerance of hate crimes or any other form of discrimination against any person.

The Inter-American and African human rights systems have both reported upsurges in violence against sexual minorities, and the Council of Europe found that hate-motivated violence against lesbian, gay, bisexual, and transgender (LGBT) persons takes place in all Council member states.[190] The 2011 Report of the UN High Commissioner on Human Rights, *Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity*, notes that "young LGBT people and those of all ages who are seen to be transgressing social norms are at risk of family and community violence."[191] Discrimination is compounded by the fact that 76 countries world-wide continue to criminalize consensual, same-sex behaviour,[192] and new research underscores a relationship between laws restricting the civil rights of persons of diverse sexual orientation and gender identity, and their mental health and well-being.[193] **States and the international community should express grave concern at acts of violence, discrimination and hate crimes committed against individuals on the grounds of their sexual orientation and gender identity. National leaders should advocate for the**

[188] United Nations General Assembly, Annual report of the United Nations High Commissioner for Human Rights. (2011). *Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity*, 17 November 2011. Retrieved from: http://www.ohchr.org/Documents/Issues/Discrimination/A.HRC.19.41_English.pdf.

[189] Bostwick WB, Boyd CJ, Hughes TL, & McCabe SE. (2010). Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. *American Journal of Public Health*, 100(3), 468-475.; Cochran, S. D., Mays, V. M., Alegria, M., Ortega, A. N., & Takeuchi, D. (2007). Mental health and substance use disorders in Latino and Asian-American lesbian, gay and bisexual adults. *Journal of Consulting and Clinical Psychology*, 75(5), 785–794.; Cochran, S. D., Mays, V. M., & Sullivan, J. G. (2003). Prevalence of mental disorders, psychological distress and mental health services use among lesbian, gay and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology*, 71(1), 53–61.; De Graaf R, Sandfort TG, & Have M. (2006). Suicidality and sexual orientation: Differences between men and women in a general population-based sample from the Netherlands. *Archives of Sexual Behavior*, 35(3), 253-262.; DuRant, R.H., Krowchuk, D.P., & Sinal, S.H. (1998). Victimization, use of violence, and drug use at school among male adolescents who engage in same-sex sexual behavior. *Journal of Pediatrics*, 132, 13-18.; Faulkner, A. H., & Cranston, K. (1998). Correlates of same-sex sexual behavior in a random sample of Massachusetts high school students. *American Journal of Public Health*, 88(2), 262–266.; Garofalo, R., Wolf, R. C., Kessel, S., Palfrey, J., & DuRant, R. H. (1998). The association between health risk behaviors and sexual orientation among a school-based sample of adolescents. *Pediatrics*, 101(5), 895–902.; Garofalo, R., Wolf, R. C., Wissow, L. S., Woods, E. R., & Goodman, E. (1999). Sexual orientation and risk of suicide attempts among a representative sample of youth. *Archives of Pediatric& Adolescent Medicine*, 153, 487–493.; Fergusson DM, Horwood LJ, & Beautrais AL. (1999). Is sexual orientation related to mental health problems and suicidality in young people? *Archives of General Psychiatry*, 56, 876-880.; Haas AP, Eliason M, Mays VM, et al. (2011). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal of Homosexuality*, 58:10-51.; King M, Semlyen J, Tai SS, et al. (2008). A systemic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay, and bisexual people. *BMC Psychiatry*, 8:70.; Mathy, R. M. (2002a). Suicidality and sexual orientation in five continents: Asia, Australia, Europe, North America, and South America. *International Journal of Sexuality and Gender Studies*, 7(2/3), 215–225.; Remafedi G. (2002). Suicidality in a venue-based sample of young men who have sex with men. *Journal of Adolescent Health*, 31(4), 305-310.;
Russell, S. T., & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health*, 91(8), 1276–1281.; Paul JP, Cantania J, Pollack L, et al. (2002). Suicide attempts among gay and bisexual men: Lifetime prevalence and antecedents. *American Journal of Public Health*, 92, (8), 1338-1345.

[190] United Nations General Assembly, Annual report of the United Nations High Commissioner for Human Rights. (2011). *Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity*, 17 November 2011. Retrieved from: http://www.ohchr.org/Documents/Issues/Discrimination/A.HRC.19.41_English.pdf

[191] United Nations General Assembly, Annual report of the United Nations High Commissioner for Human Rights. (2011). *Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity*, 17 November 2011. Retrieved from: http://www.ohchr.org/Documents/Issues/Discrimination/A.HRC.19.41_English.pdf

[192] Itaborahy L.P, Zhu J.State-sponsored Homophobia: A world survey of laws: Criminalisation, protection and recognition of same-sex love, May 2013, 8th edition. International Lesbian, Gay, Bisexual, and Trans and Intersex Association. Retrieved from: http://old.ilga.org/Statehomophobia/ILGA_State_Sponsored_Homophobia_2013.pdf

[193] Hatzenbuehler, M.L., McLaughlin, K.A., Keyes, K.M., Hasin, D.S. (2010). The impact of institutional discrimination on psychiatric disorders in lesbian, gay, and bisexual populations: a prospective study. *American Journal of Public Health*, 100(3): 452-459.

rights of all persons, without distinction of any kind.

Many individuals and groups continue to be frequently exposed to discriminatory behaviour, including stigma, unfair treatment, or social exclusion, due to dimensions of their identity or circumstances. Discrimination may be compounded by laws criminalizing their behaviour; or laws that remain silent regarding their need for social protection. The persistence of discriminatory laws, or the unfair and discriminatory application of law, may reflect underlying stigma held by powerful sectors of society, generalized public indifference, and/or weak political leverage of those suffering discrimination.[194]

The Global Survey and the regional reviews and outcomes highlight the continuing gaps in fulfilling the human rights principles of non-discrimination affirmed at the ICPD in all cases where the rights of individuals or groups remain vulnerable, with direct effects on their health, including their risk of HIV and AIDS, and their exposure to violence, including sexual violence. The regional review outcomes contain various commitments regarding addressing these gaps. Addressing these gaps require States to protect the human rights of all individuals, including the right to gainful employment, residence, access to services and equality before the law.

States should guarantee equality before the law and non-discrimination for all people, by adopting laws and policies to protect the human rights of all individuals, without distinction of any kind, in the exercise of their social, cultural, economic, civil and political rights. States should also promulgate, where absent, and enforce laws to prevent and punish any kind of violence or hate crimes, and take active steps to protect all persons from discrimination, stigma, and violence, without distinction of any kind.

International human rights law reflects the global commitments to ending discrimination against racial and ethnic minorities. (See human rights box on non-discrimination). Yet racial and ethnic minorities worldwide continue to face discrimination and marginalization that negatively impacts their health and freedoms, and their access to education, employment, land, and natural resources.[195]

Mapping global racial and ethnic diversity requires tackling the complex challenge of defining and classifying what constitutes a distinct "ethnic or racial" group, categories that do not always hold consistent definitions. Ethnicity and race may be defined through self-identity, or state-defined census categories, and they may also reflect cultural, political, linguistic, phenotypic, or religious affiliations, many which have marginal or no correspondence to genetic distinctions, and exist largely as social categories.

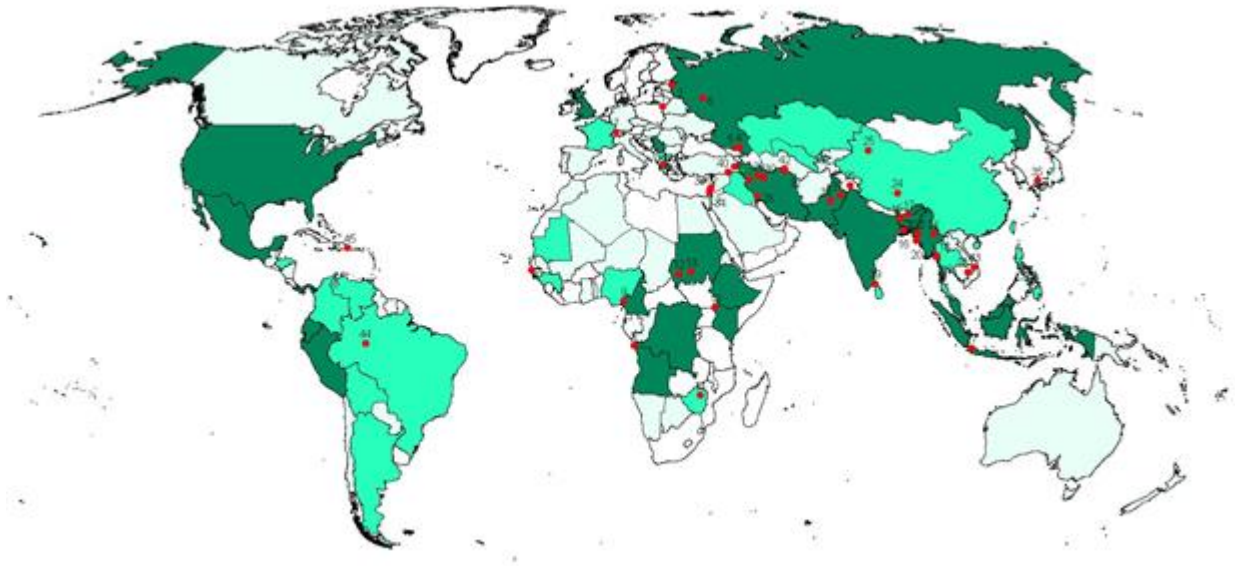
Estimates of global ethnic diversity, for example, have documented 822 ethnic groups[196] in 160 countries. With 351 ethnic groups, sub-Saharan Africa, which comprises approximately a quarter of the world's countries, accounts for a striking 43 per cent of the world's culturally defined ethnic groups.[197]

The Minorities at Risk project, which monitors the status of over 280 ethnopolitical minority groups worldwide, has identified 183 minority groups experiencing political discrimination, out of which 45 are most at risk through repressive policies that exclude group members from political participation (see

[194] ICPD Beyond 2014 International Conference on Human Rights. (forthcoming). Conference Report. Noordwijk, the Netherlands, 7-10 July, 2013.
[195] Minority Rights Group International. (2012). State of the World's Minorities and Indigenous Peoples 2012: Events of 2011, Focus on Land Rights and Natural Resources. Ed. Beth Walker. Retrieved from: http://www.unesco.org/library/PDF/MRG.pdf.
[196] Ethnic groups were defined by several criteria, including (a) group membership reckoned primarily by descent by both members and non-members; (b) common group identity; and (c) member share some distinguishing cultural features, such as common language, religion, and customs. Source: Fearon J.D. (2003). Ethnic and cultural diversity by country. *Journal of Economic Growth*, 8:195-222.
[197] Fearon J.D. (2003). Ethnic and cultural diversity by country. *Journal of Economic Growth*, 8:195-222.

Figure 16 below).[198]

Figure 16
Political discrimination against ethnopolitical minority groups, 2006



Source: Center for International Development and Conflict Management, 2009, Minorities at Risk, University of Maryland, retrieved from http://www.cidcm.umd.edu/mar/on 26 September 2013.

Note: *a*. The Minorities at Risk project tracks over 280 politically-active ethnic minority groups worldwide.

b. A "minority at risk" is defined as an ethnopolitical group that: 1) collectively suffers, or benefits from, systematic discriminatory treatment vis-à-vis other groups in a society; and/or 20) collectively mobilizes in defense or promotion of its self-defined interests. Membership in a group is determined primarily by descent by both members and non-members: 1) Membership in the group is recognized and viewed as important by members and/or non-members. The importance may be psychological, normative and/or strategic, 2) Members share some distinguishing cultural features, such as common language religion and customs, 3) One or more of these cultural features are practiced by a majority of the members of the group, 4) The group has at least 100,000 members or constitutes one percent of a country's population. The project does not make claims regarding the comprehensiveness of the dataset. Source: Minorities at Risk. Minorities at Risk (MAR) Codebook Versions 2/2009. A project of the Center for International Development and Conflict Management. Retrieved from: http://www.cidcm.umd.edu/mar/data/mar_codebook_Feb09.pdf.

c. Ethnopolitical groups tracked by Minorities at Risk and identified as politically discriminated are: Hazaras in Afghanistan; Greeks in Albania; Berbers in Algeria; Bakongo, Cabinda and Ovimbundu in Angola; Indigenous Peoples and Jews in Argentina; Aborigines in Australia; Shi'is in Bahrain; Biharis, Chittagong Hill Tribes and Hindus in Bangladesh; Poles in Belarus; Lhotshampas in Bhutan; Indigenous Highland Peoples and Lowland Indigenous Peoples in Bolivia; San Bushmen in Botswana; Afro-Brazilians and Amazonian Indians in Brazil; Roma in Bulgaria; Kachins, Karens, Mons, Rohingya (Arakanese), Shans and Zomis (Chins) in Burma; Hutus in Burundi; Vietnamese in Cambodia; Bamileke, Kirdi and Westerners in Cameroon;

[198] Minorities at Risk Project. (2009). "Minorities at Risk Dataset." College Park, MD: Center for International Development and Conflict Management. Retrieved from: http://www.cidcm.umd.edu/mar/ on 20 September 2013..

Indigenous Peoples in Canada; Southerners in Chad; Indigenous Peoples in Chile; Tibetans and Turkmen in China; Blacks and Indigenous Peoples in Colombia; Antillean Blacks in Costa Rica; Serbs in Croatia; Roma in Czech Republic; Hutus, Lunda, Yeke, Ngbandi and Tutsis in Dem. Rep. of the Congo; Afars in Djibouti; Haitian Blacks in Dominican Republic; Blacks, Indigenous Highland Peoples and Lowland Indigenous Peoples in Ecuador; Copts in Egypt; Indigenous Peoples in El Salvador; Afars in Eritrea; Russians in Estonia; Afars, Oromo and Somalis in Ethiopia; East Indians in Fiji; Muslim (Noncitizens) and Roma in France; Turks in Germany; Mossi-Dagomba in Ghana; Muslims and Roma in Greece; Indigenous Peoples in Guatemala; Fulani and Malinke in Guinea; Africans in Guyana; Black Karibs and Indigenous Peoples in Honduras; Roma in Hungary; Assamese, Bodos, Kashmiris, Muslims, Nagas, Scheduled Tribes and Tripuras in India; Acehnese, Chinese and Papuans in Indonesia; Arabs, Baha'is, Bakhtiari, Baluchis, Christians, Kurds and Turkmen in Iran; Kurds and Sunnis in Iraq; Arabs and Palestinians in Israel; Roma in Italy; Koreans in Japan; Palestinians in Jordan; Germans and Russians in Kazakhstan; Kikuyu, Kisii, Luo, Maasai and Somalis in Kenya; Uzbeks in Kyrgyzstan; Hmong in Laos; Russians in Latvia; Palestinians and Shi'is in Lebanon; Albanians and Roma in Macedonia; Chinese, Dayaks, East Indians and Kadazans in Malaysia; Tuareg in Mali; Black Moors and Kewri in Mauritania; Mayans, Other Indigenous Peoples and Zapotecs in Mexico; Saharawis in Morocco; San Bushmen in Namibia; Maori in New Zealand; Indigenous Peoples in Nicaragua; Tuareg in Niger; Ijaw and Ogani in Nigeria; Ahmadis, Baluchis, Hindus and Sindhis in Pakistan; Blacks, Chinese and Indigenous Peoples in Panama; Bouganvilleans in Papua New Guinea; Indigenous Peoples in Paraguay; Blacks (Afro-Peruvians), Indigenous Highland Peoples and Lowland Indigenous Peoples in Peru; Igorots and Moros in Philippines; Lari in Rep. of the Congo; Roma in Romania; Chechens, Ingush and Roma in Russia; Hutus in Rwanda; Shi'is in Saudi Arabia; Diolas in Casamance in Senegal; Malays in Singapore; Roma in Slovakia; Roma in Spain; Indian Tamils and Sri Lankan Tamils in Sri Lanka; Darfur Black Muslims, Nuba and Southerners in Sudan; Foreign Workers in Switzerland; Kurds in Syria; Aboriginal Taiwanese in Taiwan; Uzbeks in Tajikistan; Malay-Muslims and Northern Hill Tribes in Thailand; Ewe in Togo; Kurds in Turkey; Russians in Turkmenistan; Crimean Tatars in Ukraine; Afro-Caribbeans, Asians and Catholics in Northern Ireland in United Kingdom; African-Americans, Hispanics and Native Americans in United States of America; Russians and Tajiks in Uzbekistan; Blacks and Indigenous Peoples in Venezuela; Montagnards in Vietnam; Croats, Roma and Sandzak Muslims in Yugoslavia; Europeans and Ndebele in Zimbabwe. Source: Minorities at Risk Project. (2009). "Minorities at Risk Dataset." College Park, MD: Center for International Development and Conflict Management. Retrieved from http://www.cidcm.umd.edu/mar/ on 20 September 2013.

d. Lower degrees of political discrimination include: (1) Substantial under-representation in political office and/or participation due to historical neglect or restrictions. Explicit public policies are designed to protect or improve the group's political status; (2) Substantial under-representation due to historical neglect or restrictions. No social practice of deliberate exclusion. No formal exclusion. No evidence of protective or remedial public policies; and (3) Substantial under-representation due to prevailing social practice by dominant groups. Formal public policies toward the group are neutral or, if positive, inadequate to offset discriminatory social practices.

e. The 45 ethnopolitical groups that experience high political discrimination enumerated with a red dot above: 1 = Poles in Belarus; 2 = Russians in Estonia; 3 = Roma in Greece; 4 = Chechens in Russia; 5 = Ingush in Russia; 6 = Roma in Russia; 7 = Foreign Workers in Switzerland; 8 = Cabinda in Angola; 9 = Westerners in Cameroon; 10 = Somalis in Kenya; 11 = Diolas in Casamance in Senegal; 12 = Darfur Black Muslims in Sudan; 13 = Nuba in Sudan; 14 = Europeans in Zimbabwe; 15 = Biharis in Bangladesh; 16 = Hindus in Bangladesh; 17 = Lhotshampas in Bhutan; 18 = Karens in Burma; 19 = Mons in Burma; 20 = Rohingya (Arakanese) in Burma; 21 = Shans in Burma; 22 = Zomis (Chins) in Burma; 23 = Vietnamese in Cambodia; 24 = Tibetans in China; 25 = Turkmen in China; 26 = Kashmiris in India; 27 = Chinese in Indonesia; 28 = Arabs in Iran; 29 = Baha'is in Iran; 30 = Christians in Iran; 31 = Kurds in Iran; 32 = Turkmen in Iran; 33 = Arabs in Israel; 34 = Palestinians in Israel; 35 = Koreans in Japan; 36 = Palestinians in Lebanon; 37 = Ahmadis in Pakistan; 38 = Hindus in Pakistan; 39 = Sri Lankan Tamils in Sri Lanka; 40 = Kurds in Syria; 41 = Kurds in Turkey; 42 = Russians in Turkmenistan; 43 = Montagnards in Vietnam; 44 = Amazonian Indians in Brazil; 45 = Haitian Blacks in Dominican Republic

Often historic and sustained, discrimination can lead to intergenerational cycles of poverty, and disadvantage. For example, Afro-descendent populations in the Caribbean and Latin American face persistent conditions of poverty and social exclusion, as well as ongoing exploitation through large-scale development projects that compromise their access to land and natural resources. In a wide range of countries, public health data illustrate persistent disparities in morbidity and mortality among minority racial and ethnic groups, reflecting the collective impact of numerous overlapping discriminations in arenas such as access to health care, education, paid employment, nutrition and housing; socioeconomic and wealth disparities; and limited opportunities for advancement over the life-course.[199]

States should guarantee the full and equal participation of racial and ethnic minorities in social,

[199] Minority Rights Group International. (2012). State of the World's Minorities and Indigenous Peoples 2012: Events of 2011, Focus on Land Rights and Natural Resources. Ed. Beth Walker. Retrieved from: http://www.unesco.org/library/PDF/MRG.pdf.; Williams, DR., & Collins, C. (1995). U.S. socioeconomic and racial differences in health: Patterns and explanations. *Annual Review of Sociology*, 21: 349-386.; World Health Organization. (2001). *Health and freedom from discrimination*. WHO's Contribution to the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance, *Health & Human Rights Publication Series*, Issue No. 2. Retrieved from: http://www.who.int/hhr/activities/q_and_a/en/Health_and_Freedom_from_Discrimination_English_699KB.pdf.

economic and political life; guarantee free and safe integration in housing; lead open dialogue on agreed public reconciliation and/or redress for past wrongs; and actively promote ties of mutual regard which are the backbone of a diverse civic life, such that men and women from different backgrounds may find with one another the fulfilment of their humanity.

Human rights elaborations since the ICPD: Non-discrimination

Binding instruments: "Noting that the Universal Declaration of Human Rights proclaims that all human beings are born free and equal in dignity and rights and that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status," the *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights* (2008; e.i.f. 2013), establishes a complaint and inquiry mechanism for persons who believe their economic, social and cultural rights have been violated, advancing human rights principles related to non-discrimination and providing individuals with a mechanism to register rights violations.

Intergovernmental human rights outcomes: Non-discrimination is a special focus of the Office of the High Commissioner for Human Rights. Rights related to non-discrimination are elaborated through numerous instruments, and monitored through Special Rapporteur reports, Committees, Forums, Independent Experts and Working Groups that strive to combat discrimination and ensure the application of human rights to particular cases and/or issues.[200] Select relevant resolutions include: Human Rights Council *Resolution 17/19: Human Rights, Sexual Orientation and Gender Identity* (2011), the first UN resolution on sexual orientation, which expressed grave concern at violence and discrimination based on sexual orientation and gender identity; Commission on Human Rights *Resolution 2005/85 The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)* (2005).

Other intergovernmental outcomes: The *Durban Declaration and Programme of Action* (2001) of the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance recognized and affirmed that "a global fight against racism, racial discrimination, xenophobia and related intolerance and all their abhorrent and evolving forms and manifestations is a matter of priority for the international community" and "that everyone is entitled to a social and international order in which all human rights can be fully realized for all, without any discrimination."

Migratory flows are more visible and more diverse than ever before, with profound socio-economic impacts both at destination and origin, yet migrants are frequently stigmatized and their risk of social discrimination remains high. The ratification of migrants' rights conventions has been limited and unequal. International protocols against the trafficking and smuggling of people, focused mainly on criminalizing trafficking, suppressing organized crime and facilitating orderly migration, have garnered broad support. By comparison, the series of ILO conventions seeking to promote minimum standards for migrant workers have received less endorsement. The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990), entered into force in 2003, has been ratified by only 47 countries to date, and the rates of signing are particularly low in countries with higher migration or emigration rates.[201] **States should ensure that migrants are able to realize fundamental human rights of liberty, security of person, freedom of belief and protection against**

[200] For additional information on UN activities related to human rights and non-discrimination see OHCHR "A Special Focus on Discrimination" at http://www.ohchr.org/EN/Issues/Discrimination/Pages/discrimination.aspx.

[201] International Organization for Migration. (2011). World Migration Report 2011: Communicating Effectively about Migration. Geneva, Switzerland. Retrieved from: http://publications.iom.int/bookstore/free/WMR2011_English.pdf.; United Nations Development Programme. (2009). Human Development Report 2009: Overcoming Barriers: Human Mobility and Development. New York, USA. Retrieved from: http://hdr.undp.org/en/media/HDR_2009_EN_Complete.pdf.

forced labour and trafficking, and full rights in the workplace, including equal pay for equal work and decent working conditions, as well as equal access to basic services, particularly equal access to education, health, including sexual and reproductive health services, and support for integration for migrant children.[202]

While negative effects of migration are generally assessed as small, negative public attitudes towards migrants may nevertheless reflect fear of work displacement or reduction in wages, increase in the risk of crime, and added burden to the local public services.[203] As observed within analysis of the World Values Survey, attitudes towards immigrants and foreign workers vary greatly between and within regions (Figure 17) pointing to a variety of important contextual factors including not only migration flows, but also political debates, media discourse, and the overall economic and cultural environment. In Latin America and the Caribbean the proportion of the population sharing intolerant attitudes towards immigrants and foreign workers is fewer than 10 per cent, the lowest of any region. Low proportions are also observed in most of the Western European countries; however, the range is wide, from two per cent in Sweden to 37 per cent in France. In Eastern Europe the proportion of the population sharing intolerant attitudes varies from 14 per cent in Poland to 32 per cent in the Russian Federation; while in Asia, it varies from 20 per cent in China to 66 per cent in Jordan.[204]

Changes in attitudes towards immigrants and foreign workers over the past five to 10 years have been mixed in all regions. Of 24 countries with available trend data, more tolerant attitudes over time were observed in 8 countries, less tolerant attitudes in 9 countries, with the remaining 7 countries showing no statistically significant changes within the past decade.[205] **More active efforts, including through training of relevant law enforcement officials, are needed to combat discrimination, reduce misinterpretation of migration in public and political discourse, address social tensions and prevent violence against migrants.**

HIV-related stigma acts as a barrier to prevention, testing, disclosure, treatment, and care.[206] The People living with HIV Stigma Index has shown that in a number of countries people living with HIV reported being denied access to health services and employment because of their HIV status.[207] Stigma is manifest in many forms, including physical, social, and institutional stigma, contributing to isolation from one's family and community; experiences of violence; reduced participation in economic and social life; poor physical and mental health outcomes.[208] Persecution of persons living with HIV, including through laws that criminalize HIV non-disclosure, exposure, and/or transmission,[209] creates a

[202]United Nations Development Programme. (2009). Human Development Report 2009: Overcoming Barriers: Human Mobility and Development. New York, USA. Retrieved from: http://hdr.undp.org/en/media/HDR_2009_EN_Complete.pdf.

[203] United Nations Development Programme. (2009). Human Development Report 2009: Overcoming Barriers: Human Mobility and Development. New York, USA. Retrieved from: http://hdr.undp.org/en/media/HDR_2009_EN_Complete.pdf.

[204] World Values Surveys (data downloaded and analysed 20 August 2013). Retrieved from: http://www.worldvaluessurvey.org/.

[205] World Values Surveys (data downloaded and analysed 20 August 2013). Retrieved from: http://www.worldvaluessurvey.org/.

[206] Karim, Q.A., et al. (2008). The influence of AIDS stigma and discrimination and social cohesion on HIV testing and willingness to disclose HIV in rural KwaZulu-Natal, South Africa. *Global Public Health*, 3(4): 351–365.; 2. Brou, H., et al. (2007). When do HIV-infected women disclose their HIV status to their male partner and why? A study in a PMTCT programme, Abidjan. *PLoS Med*, 4(12): e342; 3. Bwirire, L.D., et al. (2008). Reasons for loss to follow-up among mothers registered in a prevention-of-mother-to-child transmission program in Rural Malawi. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 102(12): 1195-1200.

[207] Analysis of Surveys conducted using People Living with HIV Stigma Index, www.stigmaindex.org presented in UNAIDS. (2013). Global Report: UNAIDS Report on the Global AIDS Epidemic 2013. Retrieved from: Surveys conducted using People Living with HIV Stigma Index, www.stigmaindex.org.

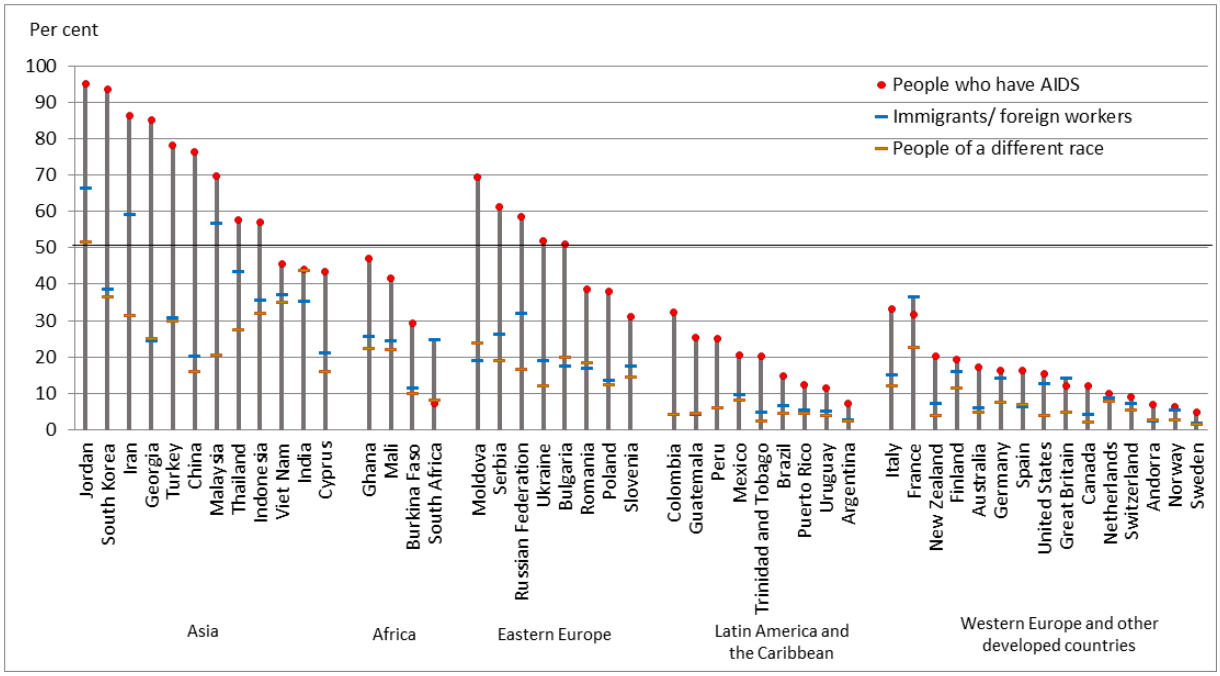
[208] Ogden J and Nyblade L. (2005) Common at Its Core: HIV-Stimga Across Contexts. International Center for Research on Women. Retrieved from: http://www.icrw.org/files/publications/Common-at-its-Core-HIV-Related-Stigma-Across-Contexts.pdf; UNAIDS Report on the Global AIDS Epidemic 2013. Retrieved from: Surveys conducted using People Living with HIV Stigma Index, www.stigmaindex.org.

[209] Joint United Nations Programme on HIV/AIDS. (2012). *Criminalisation of HIV Non-disclosure, Exposure and Transmission: Background and Current Landscape*, revised version (Geneva: UNAIDS). http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/BackgroundCurrentLandscapeCriminalisationHIV_Final.pdfPaper prepared as background for the Expert Meeting on the Science and Law of Criminalisation of HIV Non-Disclosure, Exposure and Transmission, (Geneva: UNAIDS). Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/BackgroundCurrentLandscapeCriminalisationHIV_Final.pdf.

climate of fear that undermines human rights, and efforts to encourage people to seek HIV prevention, testing, treatment and social support.[210] **States should respect, protect, and promote the human rights of all people living with HIV, and enact protective laws facilitating access to health and social services to ensure that all persons living with, and at risk of, HIV can live free from stigma and discrimination.**

Across 48 countries with the latest available data from the World Values Survey, the proportion of the population that expressed intolerant attitudes towards persons with HIV and AIDS was higher than for immigrant or foreign workers, or for persons of a different race (Figure 17). More tolerant attitudes were evident in high-income countries, but also from Latin America and the Caribbean, and select countries from Africa and Asia. In more than a quarter of the countries, mostly located in Asia and Eastern Europe, more than 50 per cent of respondents expressed intolerant attitudes. Several such countries also scored high on intolerance towards other population groups, suggesting that intolerant attitudes tend to cluster towards multiple types of "difference."[211]

Figure 17
Public tolerance towards select population groups varies across countries from Asia, Africa and Eastern Europe, 2004-2009



Source: World Values Surveys (data downloaded and analysed from 20 August 2013).

Note: Intolerance is measured in the World Values Survey as the proportion of respondents who mention certain population groups, when asked: "On this list are various groups of people. Could you please mention any that you would not like to have as neighbors?"). The list includes the following: people with a criminal record; people of a different race, heavy drinkers, emotionally unstable people, immigrant/foreign workers, people who have AIDS, drug addicts, and homosexuals. This list is common to most countries covered by the World Value Survey, but selected countries added to the list population groups specific to their country contexts.

Over the past two decades sex workers[212] have been the focus of many public health initiatives concerned with the spread of HIV and AIDS, but rarely have their own rights to health been

[210] Joint United Nations Programme on HIV/AIDS and United Nations Development Programme. (2008). Policy Brief: Criminalization of HIV Transmission. Retrieved from: http://data.unaids.org/pub/basedocument/2008/20080731_jc1513_policy_criminalization_en.pdf

[211] World Values Surveys (data downloaded and analysed from 20 August 2013). Retrieved from: http://www.worldvaluessurvey.org/.

[212] Sex workers include "female, male and transgender adults and young people [age 18-24] who receive money or goods in exchange of sexual services." See UNAIDS.Source: Joint United Nations Programme on HIV/AIDS (UNAIDS). (2002). Technical Update Sex Work and HIV/AIDS. Retrieved from: http://data.unaids.org/publications/IRC-pub02/jc705-sexwork-tu_en.pdf.

acknowledged, nor their rights to social protection from either poverty or violence.[213] With 116 countries criminalizing some aspect of sex work,[214] sex workers face deeply-rooted stigma, as well as institutionalized discrimination through legal and policy environments that reinforce and exacerbate their vulnerabilities. Sex workers are often living in conditions of extreme structural poverty, and subject to high rates of often brutal violence, including sexual violence, without redress or protection.[215] Violence is linked to other health vulnerabilities, with female sex workers 13.5 times more likely to acquire HIV than women aged 15-49 globally.[216] Criminalization of sex work limits their political voice or collective representation[217], thereby reducing their chances to improve their living and working conditions, gain financial security, adequately protect their health, and expand opportunities for themselves and their families.[218] **States should decriminalize adult, voluntary sex work to recognize the right of sex workers to work without coercion, violence or risk of arrest; provide social protection and meaningful employment alternatives and opportunities for economic empowerment, so that individuals who wish to leave sex work have the ability to do so; and include sex workers in the design and implementation of policies and programmes for which they are the intended beneficiaries.**

H. The social cost of discrimination

The past 20 years have witnessed enormous leaps in scientific understanding of how discrimination and stigma impact both physical and mental health, as well as human performance; such research affirms the extent and manner by which a climate of discrimination curtails the well-being and productivity of persons and nations.[219]

A growing body of research from around the world affirms that physical health, mental health and productivity are not only compromised by physical harassment, bullying, or violence; similar effects are prompted by pervasive negative stereotypes, experience of stigma, and fear of discrimination.[220] The costs to society of having substantial proportions of its citizens undergoing a sustained struggle for dignity and fundamental rights should concern political leaders, given the evident losses incurred to health, well-being and productivity, and the potential for increasing social instability where human

[213] Kerrigan D, Wirtz A, Baral S et al. Kerrigan, D., Wirtz, A., Baral, S., Decker, M., Murray, L., Poteat, T., Pretorius, C., Sherman, S., Sweat, M., Semini, I., N'Jie, N. Stanciole, A., Butler, J., Osornprasop, S., Oelrichs, R., and Beyrer, C. (2013). The global HIV epidemics among sex workers. The World Bank. Retrieved from: http://www.worldbank.org/content/dam/Worldbank/document/GlobalHIVEpidemicsAmongSexWorkers.pdf.

[214] United Nations Development Programme. (2012). Global Commission on HIV and the Law: Risks, Rights & Health. Retrieved from: http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf.

[215] World Health Organization Department of Gender, Women and Health, Global Coalition on Women and AIDS. (2005). Violence Against women and HIV/AIDS: Critical Intersections – Violence against sex workers and HIV prevention. Retrieved from: http://www.who.int/gender/documents/sexworkers.pdf.; Joint United Nations Programme on HIV/AIDS (UNAIDS). (2012). UNAIDS Guidance Note on HIV and Sex Work. Retrieved from http://www.aidsdatahub.org/en/tools-guides/guidelines/item/24231-unaids-guidance-note-on-hiv-and-sex-work-unaids-2012.

[216] Kerrigan, D., Wirtz, A., Baral, S., Decker, M., Murray, L., Poteat, T., Pretorius, C., Sherman, S., Sweat, M., Semini, I., N'Jie, N. Stanciole, A., Butler, J., Osornprasop, S., Oelrichs, R., and Beyrer, C. (2013). The global HIV epidemics among sex workers. The World Bank. Retrieved from: http://www.worldbank.org/content/dam/Worldbank/document/GlobalHIVEpidemicsAmongSexWorkers.pdf.

[217] Open Societys Foundations. (2012). *10 reasons to decriminalize sex work: A reference brief.* Retrieved from: http://www.opensocietyfoundations.org/sites/default/files/decriminalize-sex-work-20120713.pdf.

[218] Joint United Nations Programme on HIV/AIDS (UNAIDS). (2012). UNAIDS Guidance Note on HIV and Sex Work. Retrieved from http://www.aidsdatahub.org/en/tools-guides/guidelines/item/24231-unaids-guidance-note-on-hiv-and-sex-work-unaids-2012.

[219] Krieger, N. (1999). Embodying Inequality: A review of concepts, measures, and methods for studying health consequences of discrimination. *International Journal of Health Services*, 29(2): 295-352; Pascoe, E.A., Smart Richman, L. (2009). Perceived discrimination and health: A meta-analytic review. *Psychological* Bulletin, 135(4): 531-554.; Williams, D.R., Neighbors, H.W., Jackson, J.S. (2003). Racial/ethnic discrimination and health: findings from community studies. *American Journal of Public Health*, 93(2): 200-208.; Williams, D.R., Mohammed, S.A. (2009). Discrimination and racial disparities in health: Evidence and needed research. *Journal of Behavioral Medicine*, 32(1): 20-47.

[220] Williams DR, neighbors HW, Jackson JS. 2003. Racial/Ethnic discrimination and health: Findings from community studies. *American Journal of Public Health*, 93:200-8; Spencer SJ, Steele CM, Quinn DM (1999) Stereotype threat and women's math performance. *Journal of Experimental Social Psychology*. 35 4-28; Smith JL, White PH. 2002. An examination of implicitly activated, explicitly activated, and nullified stereotypes on mathematical performance: It's not just a women's issue. Sex Roles, 47 (3/4): 179-91.

suffering is not addressed. New thinking on the "cost of inaction," estimates the significant, and often hidden, consequences of failing to take appropriate action to address injustices and inequalities, and underscores the high toll that such inaction extracts from communities, as illustrated below.[221]

In the area of women's health, birth outcomes are increasingly recognized as responsive to conditions of stress due to discrimination against the mother.[222] A recent illustrative investigation of California mothers compared birth outcomes before and after the terrorist attacks of September 11, 2001. Mothers with Arabic-sounding names had a significantly increased risk of preterm delivery and low birth weight over a six-month period just after 9/11, compared to the same calendar time a year earlier; those with the most ethnically distinctive names had the greatest risk of poor birth outcomes after 9/11. No similar change in birth outcomes before and after 9/11 was observed among mothers without Arabic-sounding names, providing strong evidence that the stress and discrimination of anti-Arab sentiment in the post-9/11 period compromised birth outcomes among Arabic-named mothers.[223]

The evidence of discrimination's effect on performance and productivity is equally compelling. When junior high school boys in India were asked to perform a maze puzzle, there was no difference in performance between boys considered of high and low caste when caste identity was not revealed. But when family name and caste were announced and affirmed before a second round of testing, there was suddenly a large and significant performance differential by caste, with low caste boys under-performing. The public announcement of caste in front of other boys had a debilitating effect on the performance of lower caste boys.[224]

A daily struggle for dignity and against discrimination is a lived experience for millions of people around the world. Government support in that struggle is manifest in reported policies, budgets and programmes to protect specific populations from abuse, neglect or violence, and also in laws that respect, protect and guarantee the human rights of these populations. The evidence from the Global Survey suggests a world in which most countries recognize and protect their citizens, but not all countries, and not all population groups.

The overwhelming majority of countries (87 per cent) report that they have addressed the issue of "preventing children's abuse and neglect and provide assistance to children victims of abuse, neglect or abandonment, including orphans" during the past five years. Protecting children as they attend school does not garner a similar level of support, with 59 per cent of countries reporting that they have addressed the issue of "improving the safety of pupils, especially girls, in and on their way to school". A higher proportion of countries address this issue in Asia (66 per cent) and Africa (63 per cent), followed by Oceania (55 per cent), the Americas (54 per cent) and Europe (48 per cent). Similarly,

[221] "The Cost of Inaction," or the negative consequences to families, communities and society of failing to take appropriate action to address injustices and inequalities, has been applied to climate change, environmental issues, and children's well-being. The concept was applied to child wellbeing through the Cost of Inaction Initiative launched at the Francois-Xavier Bagnoud Center for Health & Human Rights at Harvard University in 2008 (see Anand S, Desmond C, Fuje H, Marques N. (2012). The cost of Inaction: Case studies from Rwanda and Angola. Francois-Xavier Bagnoud Center for Health and Human Rights, Harvard University, Harvard School of Public Health) The United Nations Population Fund has explored the "cost of inaction" as applied to sexual and reproductive health and rights, and gender inequality in an Expert Group Meeting, *The Cost of Inaction in Reproductive Rights: Linking Sustainable Development, Human Rights and Sexual and Reproductive Health*, New York, 7-8 October 2013.

[222] Colen CG**,** Geronimus AT, Bound J, James SA. Maternal Upward Socioeconomic Mobility and Black-White Disparities in Infant Birthweight**.** *American Journal of Public Health* 2006; 96:2032-2039.; Collins, J.W. Jr, David, R.J., Handler, A., Wall, S., Andes, S. (2004). Very Low Birthweight in African American Infants: The Role of Maternal Exposure to Interpersonal Racial Discrimination. American Journal of Public Health, 94(12): 2132-2138.; Mustillo, S., Krieger, N., Gunderson, E.P., Sidney, S., McCreath, H., Kiefe. C.I. (2004). Self-Reported Experiences of Racial Discrimination and Black–White Differences in Preterm and Low-Birthweight Deliveries: The CARDIA Study. *American Journal of Public Health*, 94(12:2125-2131.

[223]Lauderdale, D.S. (2006). Birth outcomes for Arabic-named women in California before and after September 11. *Demography*, 43(1): 185-201.

[224] Hoff K., Pandey P. (2003) Hoff, K. and Pandey, P. (2003). Belief systems and durable inequalities: An experimental investigation of Indian Caste. *World Bank Policy Research Working Paper* 3351. Retrieved from
: http://siteresources.worldbank.org/DEC/Resources/BeliefSystemsandDurableInequalities.pdf.; Hoff, K., Pandey P. (2012). Making up people: The effect of identity on preferences and performance in a modernizing society. *World Bank Policy Research Working Paper* 6223. Retrieved from: http://www-wds.worldbank.org/external/default/WDSContentServer/IW3P/IB/2012/10/10/000158349_20121010144013/Rendered/PDF/wps6223.pdf.

"addressing gender-based violence and bullying in schools" has been addressed, budgeted and implemented by almost two-thirds of countries (63 per cent), but a higher share of countries in the Americas (83 per cent) have done so, in contrast with Africa (62 per cent), Europe (61 per cent), Asia (53 per cent) and Oceania (50 per cent).

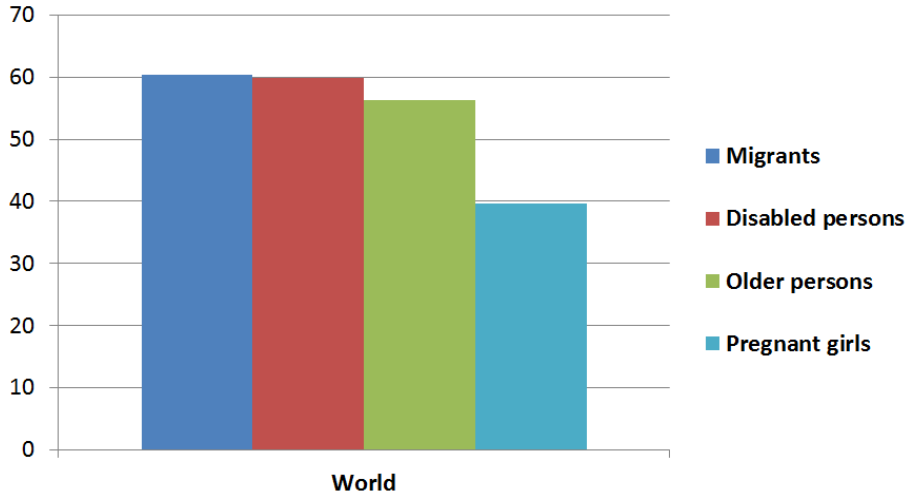
With regards to explicitly addressing discrimination for persons other than children, the proportion of countries with policies, budgets and implementation measures in place is not encouraging (around 60 per cent or less), depending on the groups addressed. For example, 57 per cent of countries have addressed the issue of "preventing discrimination against older persons, especially widows", and 60 per cent have addressed the issue of "guaranteeing to persons with disabilities equal and effective legal protection against discrimination on all grounds."

The same proportion of countries have addressed, budgeted and implemented the issue of "protecting migrants against human rights abuses, racism, ethnocentrism and xenophobia" (60 per cent). Regionally, a higher proportion of countries address this issue in Asia (71 per cent) and the Americas (70 per cent), compared with Europe (59 per cent), Africa (56 per cent) and Oceania (20 per cent). With regards to the legal and practical restrictions on the movement of people within countries, which include, among others, the need for a work permit, a proof of identity, a proof of employment or a legal address at the place of destination, the need for women to be authorized by their husbands or legal guardians/tutors, and restrictions based on HIV status, only 4 countries reported legal restrictions (2 in Asia and 2 in Africa), 4 others reported practical restrictions (2 in Asia and 2 in Africa), and 9 reported both legal and practical restrictions (3 in Africa, 3 in Asia, 2 in the Americas, and 1 in Oceania).

Unfortunately, only 40 per cent of countries have addressed the issue of "facilitating school completion for pregnant girls" during the past five years, a form of discrimination that is especially costly to society given the age of the young women involved, and the importance of their education not only to their own long-term prospects, but also to the well-being of their children. This proportion decreases to 29 per cent among countries in Europe and 21 per cent in Asia, while it increases to 67 per cent in the Americas. This may be linked to the fact that Latin America and the Caribbean have the second highest rate of adolescent pregnancies in the world.

Figure 18

Percentage of governments addressing discrimination against migrants, disabled persons, older persons, pregnant girls



Source: The ICPD Beyond 2014 Global Survey.

The reported commitments by governments in the Global Survey do not necessarily reflect the extent to which relevant laws are upheld or enforced.

Comprehensive measures are needed to ensure non-discrimination, equality, and the realization of human potential for all population groups. States should address the multiple and overlapping forms of inequality, disempowerment and discrimination, through commitment to equality and non-discrimination for all persons, without distinction of any kind, in the exercise of their social, cultural, economic, civil and political rights, including the right to gainful employment, residence and access to services, as well as the need to promulgate and enforce laws that take active steps to protect people from discrimination, stigma and violence.

States should adapt legal frameworks and formulate policies necessary with full participation of those who are discriminated against including women, adolescents, older persons, persons with disabilities, indigenous persons, ethnic and racial minorities, migrants, persons living with HIV, persons of diverse sexual orientation and gender identity, sex workers; and with the participation of civil society throughout the process of design, implementation evaluation of those policies.

I. Dignity and human rights: Key areas for future action

1. Despite significant gains in poverty reduction and economic growth since the ICPD, economic inequalities have been increasing, and threaten further progress towards sustainable development; addressing these issues requires increased efforts to eradicate poverty and promote equitable livelihood opportunities.

Significant poverty reduction has occurred in the last two decades, yet 1.2 billion people are still living in extreme poverty, lacking fulfilment of basic needs, meaningful work, access to social protection, or public services in health or education. The current state of wealth inequality, where almost 70 per cent of adults possess only 3 per cent of the world's wealth, is unsustainable, as it threatens future economic growth, the cohesion and security of societies, and the capacity of people to adapt and innovate in response to changing environmental conditions. The principal message of the ICPD in 1994 – *that the fulfillment of individual rights and capabilities is the foundation of sustainable development* - is even more relevant today, with ample evidence that investments in substantive equality for all persons results in long-term development and population well-being.

2. The empowerment of women and girls and gender equality remain unfulfilled, requiring further actions to ensure women's leadership in public spheres, equality before the law and in practice, elimination of all forms of violence, and empowerment of women in exercising their sexual and reproductive health and rights.

Discrimination against women is evident in all societies, and women continue to have fewer opportunities than men to define the directions of their lives, exercise their human rights, expand their capabilities and elaborate their chosen contribution to society. Despite advances in legislation, harmful practices, such as child, early and forced marriage and FGM/C, remain prevalent in many countries. Despite gains in universal primary education for both sexes, adolescent girls are disproportionately excluded from lower and higher secondary education. In the labour market, women continue to be paid less than men for equal work, to be substantially over-represented in vulnerable and informal employment where jobs are less secure and provide fewer benefits. Women and girls bear a disproportionate share of unpaid household labour. Women also remain substantially under-represented in positions of power and decision-making in politics, business, and public life.

Violence against women and girls continues to be one of the most prevalent forms of human rights violations worldwide, creating a life of extreme insecurity with lifelong costs. UN agencies and researchers have made critical inroads into measuring violence in the past decade, exposing the startling extent to which sexual and domestic violence begins early, and affects 1 in 3 women. Such efforts deserve all possible support within and across countries, to strengthen routine monitoring, extend research into important unaddressed issues such as the number of people living in conditions of sustained fear; violence within schools, prisons and the military; the causes of violence; the effectiveness of interventions, and of laws and systems for protection and recovery of victims and/or survivors.

3. Substantial investment is needed in the capabilities of children, adolescents and youth, while ensuring that every child and young person, regardless of circumstances, has access to quality pre-primary, primary and secondary education and comprehensive sexuality education holistically defined and consistent with their evolving capacities, and has a rapid, safe and productive transition from school to working life and adulthood.

Adolescents and youth are central to the development agenda of the coming two decades in the developing countries, because the proportion of the population entering the productive and reproductive years is historically high at over a quarter of the total population. These cohorts can – if provided with quality education and the opportunities to define their futures, to secure their sexual and reproductive health and rights, and to delay family formation – jumpstart economic growth and spur the innovations needed for a sustainable future. Safeguarding the rights of young people and investing their human capital development deserve urgent attention, including access to quality education and training linked to expanding sectors of the economy, sexual and reproductive health information, education and services, and participation in the design and evaluation of programmes for which they are the intended beneficiaries.

4. Active efforts are needed to eliminate discrimination and marginalization, and promote a culture of respect for all.

Many individuals and groups continue to be exposed to discrimination due to dimensions of their identity or circumstances. The social cost of discrimination is high, with growing evidence that stigma and discrimination negatively affect every aspect of the lives of those who are impacted, including mental and physical health, childbearing, and productivity. Public opinion research is a powerful instrument for advocacy, identifying where stigma and discrimination may be most entrenched, and therefore where individuals may be most vulnerable. In regard to public discrimination towards women and intolerance towards racial and ethnic minorities, immigrants and foreign workers, and towards people living with HIV, the Report highlights between-country variations in stigma, and where trends are improving. The UN Task Team on the Post-2015 UN Development Agenda has underscored the importance of public opinion data on attitudes, and regular monitoring, within national statistics, of public values regarding sexism, ageism, racism, and other forms of discrimination is recommended. The protection of the human rights of all individuals is crucial, requiring an enabling environment where people can exercise autonomy and choice, with all individuals, particularly women, adolescents and those belonging to other marginalized groups, empowered to claim their human rights.

II. Health

The changes in global population health over the last two decades are striking in two ways – in the dramatic aggregate shifts in the composition of the global health burden towards non-communicable diseases and injuries, including due to global ageing, and the persistence of communicable, maternal, nutritional and neonatal disorders (i.e. diseases of poverty) in sub-Saharan Africa and South Asia. Efforts to improve the quality and accessibility of sexual and reproductive health care since 1994 have led to significant improvements in many sexual and reproductive health indicators, with evidence of stronger government commitments to policy, budgeting and programmes for many of the most pressing sexual and reproductive health goals. Yet aggregate improvements mask significant inequalities both between and within countries, with far too many countries exhibiting progress among households in the upper wealth quintiles, while progress is flat or marginal among poor households. The persistence of poor sexual and reproductive health outcomes among the poor, particularly in Africa and South Asia, underscores the near impossibility of further progress in the realization of health for all persons without sustained attention to strengthening the reach, comprehensiveness, and quality of health systems. The number and distribution of skilled health workers, a vibrant knowledge sector, and systems of public accountability are among the prerequisites of a *rights-based* health system, and pivotal to future sustainable gains in sexual and reproductive health. This thematic section celebrates progress in many sexual and reproductive health outcomes since the ICPD, but underscores the continuing fragility of health systems for the poor, and the unfulfilled right to sexual and reproductive health.

"Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents." (ICPD Programme of Action, Para 7.3)

"To increase the accessibility, availability, acceptability and affordability of health-care services and facilities to all people in accordance with national commitments to provide access to basic health care for all; To increase the healthy life-span and improve the quality of life of all people, and to reduce disparities in life expectancy between and within countries." (ICPD Programme of Action, Para 8.3)

"Implementation of key elements of the Programme of Action must be tied closely to a broader strengthening of health systems." (Key Actions for the Further Implementation of the Programme of Action of the ICPD, Para 85)

A. A human rights-based approach to health

Numerous United Nations and bi-lateral development agencies have defined a human rights-based approach to health as one that aims to realize the right to the highest attainable standard of health based on "a conceptual framework … that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights."[225]

[225] The concept of a human rights-based approach adopted by the UNFPA. UNFPA. A human-rights based approach to programming. Practical implementation manual and training materials. 2010.

WHO has proposed that a human rights-based approach to health is based on seven key principles: availability, accessibility, acceptability, and quality of facilities and services, participation, equality and non-discrimination, and accountability.[226] Further the Human Rights Council recognizes that, "a human rights-based approach to eliminate preventable maternal mortality and morbidity is an approach underpinned by the principles of, inter alia, accountability, participation, transparency, empowerment, sustainability, non-discrimination and international cooperation."[227] As these principles were affirmed within the Programme of Action, the Review afforded the opportunity to address the question of whether health achievements since 1994, particularly the provision of services and underlying social determinants affecting the sexual and reproductive health of women and girls, reflect the expansion and strengthening of human rights-based approach to health.

B. Child survival

There have been significant improvements in the survival of children since 1990. The global under-five mortality rate has dropped from 90 deaths per 1,000 live births in 1990 to 48 in 2012. All regions made substantial progress, many by 50 percentage points or more. Sub-Saharan Africa has the highest child mortality rate (98 per 1,000 live births in 2012) and increasingly concentrates the largest share of all under-five deaths (nearly half of global under-five deaths). South Asia also continues to have both a high rate of under-five mortality (58 deaths per 1,000 live births) and a large number of total deaths (nearly a third the global under-five deaths).[228]

Countries from all regions and at all income levels have made progress in saving children's lives. While low-income countries tend to have the highest rates of under-five mortality, a large reduction in child mortality has been observed recently for several low-income countries including Bangladesh, Cambodia, Eritrea, Ethiopia, Guinea, Liberia, Madagascar, Malawi, Mozambique, Nepal, Niger, Rwanda, Uganda and the United Republic of Tanzania.[229]

The proportion of neonatal deaths among total under-five deaths has been increasing because declines in mortality rates among neonates have been slower than those for older children in all regions (see Figure 19).[230] Neonatal survival is highly dependent on the overall health and the continuity of clinical care of mothers, in the preconception period, during pregnancy, at delivery and during the postpartum period. To improve neonatal survival women need access to good nutrition before, during, and after pregnancy; prevention and treatment of malaria during pregnancy; syphilis screening and treatment; management of birth complications; adequate treatment of infections in the neonate; and routine support throughout the neonatal period.[231] In 2012, 34 per cent of neonatal deaths were caused by complications from preterm birth, and a quarter by sepsis and meningitis (12 per cent), pneumonia (10 per cent) or diarrhea (2 per

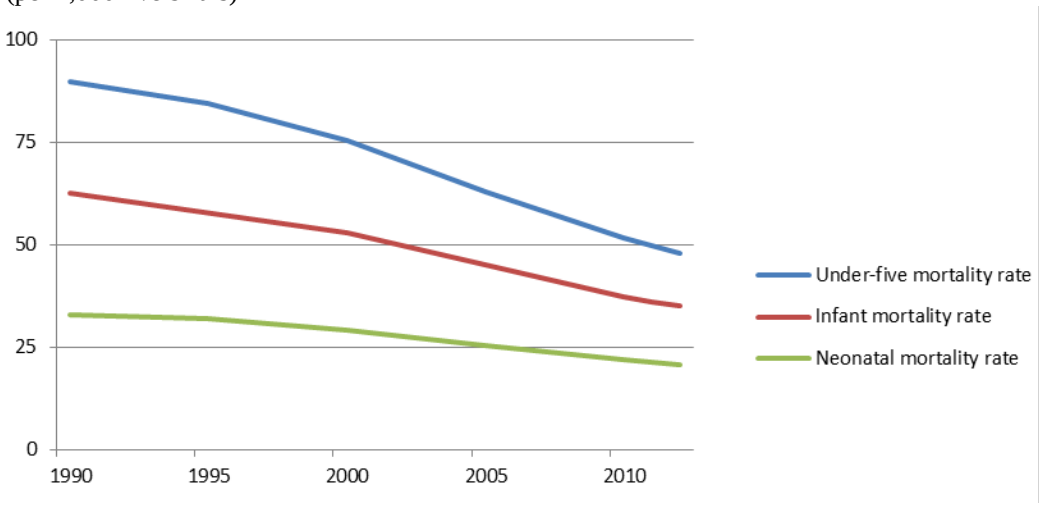
[226] World Health Organization (2013), Women's and Children's Health: Evidence of Impact of Human Rights, Geneva: WHO Press., p 13.
[227] Human Rights Council, *Resolution 18/2 Preventable Maternal Mortality and Morbidity and Human Rights* (2011).
[228] UNICEF, WHO, The World Bank and United Nations, 2013. Levels and Trends in Child Mortality. Report 2013. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation. UNICEF: 2013. Retrieved from: http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf.
[229] UNICEF, 2013. Committing to Child Survival: A Promise Renewed. Progress Report 2013. UNICEF: 2013. Retrieved from: http://www.unicef.org/publications/files/APR_Progress_Report_2013_9_Sept_2013.pdf.
[230] UNICEF, WHO, The World Bank and United Nations, 2013. Levels and Trends in Child Mortality. Report 2013. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation. UNICEF: 2013. Retrieved from: http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf.
[231] UNICEF, WHO, The World Bank and United Nations, 2013. Levels and Trends in Child Mortality. Report 2013. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation. UNICEF: 2013. Retrieved from: http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf.; UNICEF, 2013. Committing to Child Survival: A Promise Renewed. Progress Report 2013. UNICEF: 2013. Retrieved from: http://www.unicef.org/publications/files/APR_Progress_Report_2013_9_Sept_2013.pdf.; The Partnership for Maternal, Newborn and Child Health: Improving health, Saving Lives. Opportunities for Africa's Newborns: Practical data, policy and programmatic support for newborn care in Africa. Cape Town, South Africa: PMNCH, Save the Children, UNFPA, UNICEF, USAID, WHO, 2008.

cent).[232]

In 2012 neonatal deaths represented 44 per cent of under-five deaths at the global level.[233] Sub-Saharan Africa maintains the highest neonatal mortality rate (32 deaths per 1,000 live births), and accounts for 38 per cent of global neonatal deaths.[234] This region also has the highest maternal mortality rate (500 maternal deaths per 10,000 live births) underscoring the close link between maternal and neonatal survival.[235] Neonatal deaths in the region represent a lower share of all child deaths, 34 per cent, because of the still high mortality rates for older children in sub-Saharan Africa.[236]

A significant proportion of under-five deaths are due to preventable causes and treatable diseases.[237] Although declining, infectious diseases and conditions still account for almost two thirds of the global total of deaths under-five. Pneumonia and diarrhea, followed by malaria, remain the major causes of child death, and account for 17 per cent, 9 per cent and 7 per cent respectively of all under-five deaths.[238]

Figure 19
Global under-five, infant and neonatal mortality rates, 1990-2010
(per 1,000 live births)



Source: Child Info: Monitoring the situation of children and women, Child mortality: statistical tables. Downloaded: 25 October 2013 http://www.childinfo.org/mortality_tables.php

Children are at greater risk of dying before age five if they are born in rural areas, within poor

[232] UNICEF, WHO, The World Bank and United Nations, 2013. Levels and Trends in Child Mortality. Report 2013. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation. UNICEF: 2013. Retrieved from: http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf.
[233] UNICEF, WHO, The World Bank and United Nations, 2013. Levels and Trends in Child Mortality. Report 2013. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation. UNICEF: 2013. Retrieved from: http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf.
[234] UNICEF, WHO, The World Bank and United Nations, 2013. Levels and Trends in Child Mortality. Report 2013. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation. UNICEF: 2013. Retrieved from: http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf.
[235] UNFPA, UNICEF, WHO, World Bank. (2012). Trends in Maternal Mortality: 1990-2010. World Health Organization, Geneva, 2012. Retrieved from: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf.
[236] UNICEF, WHO, The World Bank and United Nations, 2013. Levels and Trends in Child Mortality. Report 2013. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation. UNICEF: 2013. Retrieved from: http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf.
[237] UNICEF, WHO, The World Bank and United Nations, 2013. Levels and Trends in Child Mortality. Report 2013. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation. UNICEF: 2013. Retrieved from: http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf.
[238] UNICEF. (2013). "Under-five mortality," Childinfo: Monitoring the Situation of Children and Women. (September 2013). Retrieved from: http://www.childinfo.org/mortality_underfive.php

households, or to a mother without basic education.[239] In 2012 it was estimated that under-nutrition was a contributing factor for approximately 45 per cent of under-five deaths at the global level.[240]

Yet some of these disparities are decreasing. For example, evidence from select sub-Saharan African, Asian and Latin American countries suggests that neonatal, post-neonatal and child mortality have declined between the 1990s and early 2000s in both rural and urban areas, including in urban slums, with the larger decline observed inrural areas.[241] Also, under-five mortality rates declined in both poorer and wealthier households and disparities in under-five mortality between the richest and the poorest households have declined in most regions of the world (See Annex I, Figure 9). The exception is Sub-Saharan Africa, where disparities in under-five mortality rates by wealth quintile have increased slightly.[242]

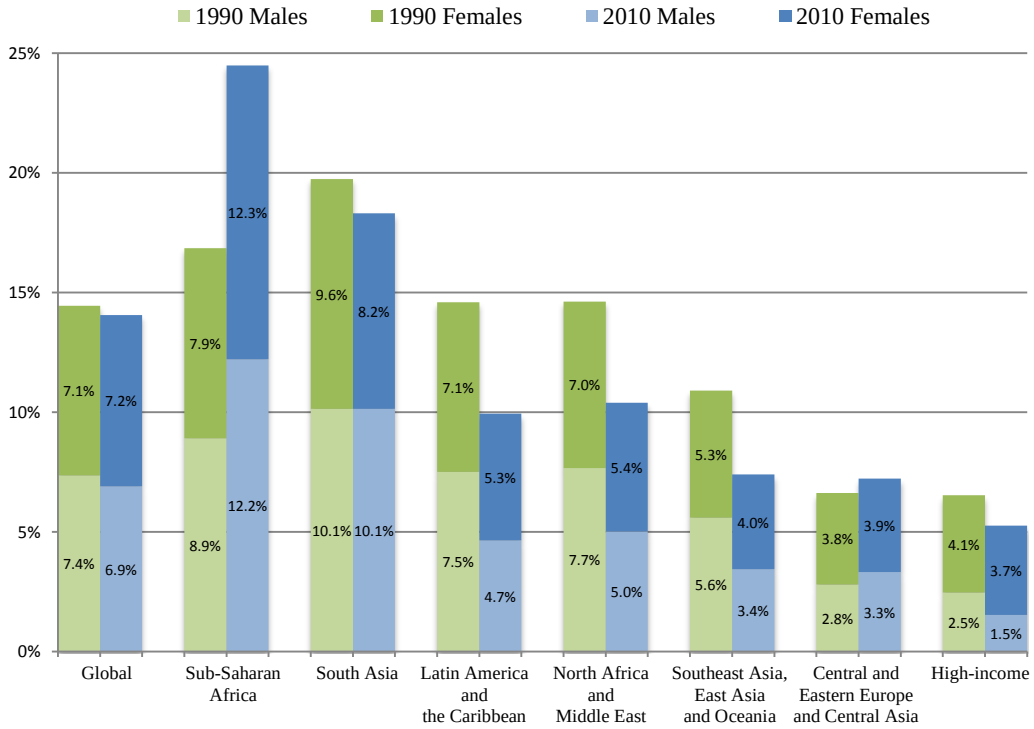
C. Sexual and reproductive health and rights

In 1990, sexual and reproductive health represented 14.4 per cent of the global burden of disease, which is 14 per cent of all disability adjusted life years (DALYs) lost, a proportion virtually unchanged in 2010.[243] The burden has declined in most regions – but increased substantially in Africa (Figure 20), largely reflecting the added burden of HIV and AIDS since 1990. The burden remains highest in Africa and South Asia, and the degree to which these two regions lag behind the others in the burden of sexual and reproductive health conditions is larger in 2010 than it was in 1990.

There has been a significant change in the composition of the sexual and reproductive health burden over the intervening 20 years, with a decline in the DALYs lost to perinatal conditions, syphilis, and maternal mortality since 1990, compensated by increases in DALYs lost to HIV and AIDS in 2010.

[239] UNICEF, 2013. Committing to Child Survival: A Promise Renewed. Progress Report 2013. UNICEF: 2013. Retrieved from: http://www.unicef.org/publications/files/APR_Progress_Report_2013_9_Sept_2013.pdf.
[240] UNICEF, WHO, The World Bank and United Nations, 2013. Levels and Trends in Child Mortality. Report 2013. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation. UNICEF: 2013. Retrieved from: http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf.
[241] Fink G, Gunther I, Hill K. (2013). Urban mortality transitions: The role of slums. Program on the Global Demography of Aging, Harvard School of Public Health, WPGDA Working Paper No 99. Retrieved from: http://www.hsph.harvard.edu/pgda/WorkingPapers/2013/PGDA_WP_99.pdf.
[242] UNICEF, 2013. Committing to Child Survival: A Promise Renewed. Progress Report 2013. UNICEF: 2013. Retrieved from: http://www.unicef.org/publications/files/APR_Progress_Report_2013_9_Sept_2013.pdf.
[243] The DALY remains the one metric that offers us a chance to estimate – with sizeable confidence intervals – the relative burden of sexual and reproductive health as a proportion of the overall global burden of disease, by sex and region.

Figure 20
Total DALYs attributed to sexual and reproductive health conditions among males and females (all ages), worldwide and by region, 1990-2010



Source: WHO, Global Burden of Disease database, 2013

The gains in maternal health and other dimensions of sexual and reproductive health and rights during the past 20 years reflect advances in many distinct goals of the Programme of Action – for example, in technical advances during childbirth, access to contraception to avert unwanted pregnancies, and proximate factors such as gains in women's education and social, legal and political empowerment. While many sexual and reproductive health rights remain unfulfilled, the gains nonetheless underscore the dramatic re-direction of development programmes that occurred at the ICPD.

1. A troubled history

In 1994, a substantial proportion of sexual and reproductive health-related investment in the preceding two decades had focused on population control and contraceptive innovations, and those investments had yielded an unprecedented expansion of new contraceptive products, variations of which are now part of the modern contraceptive market: injectables Depo-Provera, Cyclofem and Mesigyna; low-dose combined oral contraceptives and the progesterone mini-pill; improved Copper and steroid-releasing intrauterine devices (IUDs); an entirely new delivery system through implants; and a female condom. Combined injections for men were under early development in 1994, and a contraceptive vaccine was facing scientific hurdles and resistance by women's groups in almost equal measure.

Yet the political atmosphere in 1994 was one of substantial mistrust by women's groups towards the agencies, private companies and governments developing and evaluating these new contraceptive methods, as well as those delivering contraceptives and related services to women. The provider-controlled nature of many new products heightened the potential for coercion and involuntary fertility control, and women's groups were increasingly adept at sharing information on a global scale about

cases of such human rights violations, some of which were occurring systematically and at national scale. In the decade running up to the ICPD, the escalation of incidents in which women's rights were transgressed through family planning programmes suggested a sector-wide subordination of women's health and human rights to population control imperatives.[244]

Disputes over Norplant, depot medroxyprogesterone (DMPA, branded as Depo-Provera) and quinacrine are illustrative. In 1987, one country's Ministry of Health embarked upon a Norplant campaign, the world's largest contraceptive implant programme. In the first year, new users numbered 145,826, with insertions rising to 398,059 in 1989-90. By 1997, approximately four million women in the country had had the 6-rods of Norplant inserted, with 62 per cent of insertions done by mobile clinics. However, the ambitious programme focused more on insertions than on follow up, failing to account for the necessary staffing and training for removals. All too frequently, women had to make numerous removal requests before they were attended, and many women, suffering from side effects about which they had not been counseled, were charged fees for early removals, in contrast to free, or highly subsidized, insertions.[245]

The long-delayed United States Food and Drug Administration (FDA) approval of the 3-month injectable contraceptive Depo-Provera (DMPA) reflected another case of wide-scale institutional disregard for the health, safety and reproductive rights of poor women, in this case within the clinical trial of DMPA at the Grady Medical Center in Atlanta, Georgia from 1968-79. While DMPA was gaining approval in a growing number of countries world-wide, the U.S. FDA trials were based on clinical data from 14,000 predominantly rural, African American, low-income women.[246] When reviewed by the FDA, the trial data showed egregious misconduct by the presiding clinicians, including enrolments without informed consent, enrolments of women with medical contraindications (e.g. cancer, type 2 diabetes, obesity, hypertension); and inconsistent data collection with more than half the women lost to follow-up. The FDA rejected approval three times (1967, 1978, and 1983). In 1991 WHO completed a study satisfying outstanding safety concerns, and in 1992 the FDA approved DMPA.[247]

In the case of quinacrine, the controversies were transnational. Quinacrine hydrochloride pellets inserted into the vagina dissolve into liquid, burning and scarring the fallopian tubes, and leading to permanent sterilisation. Although major family planning organizations and government agencies, including WHO, opposed quinacrine's use for sterilisation, the procedure was performed on more than 104,410 women by 2001, through a network mobilized by two American doctors. The drug lacked approved testing for long-term side effects or possible effects on fetuses. The United States of America ordered an end to production and export in 1998, and the product is banned in India and Chile.[248]

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[244] Hartmann B. (1995). Reproductive rights and wrongs: The global politics of population change. Boston: South End Press. Chapter 6, pp. 93-112.; Garcia-Moreno, C, Carlo, A. (1994). Challenges from the women's health movement: Women's rights versus population control. In: Sen G, Germaine A, Chen LC (Eds). Population Policies Reconsidered. Cambridge: Harvard University Press, pp 47-62.

[245] Ninuk Widyantora, "The Story of Norplant Implant in Indonesia," *Reproductive Health Matters* (3)(May 1994), pp. 20-28; J. Tuladhar , P. J. Donaldson, J. Noble, "The Introduction and Use of Norplant Implants in Indonesia," *Studies in Family Planning*, (29)(3) (September 1998), pp. 291-9; Jeanne Bereiter, "Controversial Contraception." Review of *Norplant: Under Her Skin*, Barbara Mintzes, Anita Hardon, Jannemieke Hanhart Eburon, Eds., *Canadian Family Physician* (41) (November 1995), pp. 1967-69; A. A. Fisher, J. Prihartono, J. Tuladhar, R. H. Hoesni, "An Assessment of Norplant Removal in Indonesia," *Studies in Family Planning* (28)(4)(December 1997), pp. 308-16.

[246] Anita L. Nelson, DMPA: "Battered and Bruised but Still Needed and Used in the USA," *Expert Review of Obstetrics & Gynecology* (5) (6) (2010), pp. 673-686; Karen Hawkins, Jeff Elliott, "Seeking Approval," *Albion Monitor*, 5 May 1996, pp. x, http://www.monitor.net/monitor/controlled/bc-depohearing.html , retrieved 16 August 2013; Polly F. Harrison and Allan Rosenfield, Editors, *Contraceptive Research and Development: Looking to the Future* (The National Academies Press), p. 297; "Depo Provera Fact Sheet," Committee on Women, Population and the Environment, 6 January 2007, retrieved 14 August 2013; Thomas W. Volscho, "Racism and Disparities in Women's Use of the Depo-Provera Injection in the Contemporary USA," Critical Sociology (37)(2011), (pp. 673-88).

[247] Hawkins, Elliott, "Seeking Approval," *Albion Monitor*, May 5, 1996, retrieved from http://www.monitor.net/monitor/controlled/bc-depohearing.html

[248] Judith A.M. Scully, *Maternal Mortality, Population Control, and the War in Women's Wombs: A Bioethical Analysis of Quinacrine Sterilizations*, 19 Wisconsin International Law Journal (103) (149) (2001), retrieved from http://www.law-lib.utoronto.ca/diana/fulltext/scul.htm, on 12 August 2013; C. Pies, M. Potts, B. Young, "Quinacrine pellets: An examination of nonsurgical sterilization," *International Family Planning Perspectives* (20) (4) (Dec. 1994); Rajani Bhatia and Anne Hendrixson, "Quinacrine Controversy," *Women's Health Activist Newsletter-National Women's Health Network*, May June 1999.

The political mobilization of women's rights groups in response to such cases fueled the human rights basis and achievements of the ICPD, and changed the criteria by which technological and service innovations were evaluated, and in whether or not they received investment. Numerous population and development agencies including the World Health Organization's Special Programme of Research, Development and Research Training in Human Reproduction (HRP) (now Department of Reproductive Health Research (RHR)), and the United Nations Population Fund (UNFPA) established gender or women's advisory panels to ensure that future priorities and investments were women-centred, and met more stringent criteria on side-effects, user-control, and reversibility. WHO pursued "Common Ground" dialogues in regions to bring women's reproductive health advocates, activists, scientists, government ministers and family planning leaders to a common table to establish collaborative agreement about family planning programme priorities. The agency also established an "*Introductory Task Force"* to support a more participatory process for selecting the contraceptive method mix within countries.[249]

These new mechanisms for the participation of women's health advocates and other civil society organizations (CSOs) in family planning governance at both national and global levels ultimately re-shaped research and development portfolios in notable ways, contributed to greater investment in women-centred technologies and guidelines, and further contributed to a loss of investment for technologies that were regarded as potentially risky to women's health and user control such as the contraceptive vaccine. A sampling of women-centred innovations in sexual and reproductive health technologies and guidelines since 1994 is noted in Annex I, Box 1.

2. Reproductive rights

This troubled history of human rights violations leading up to the ICPD, shaped the foundational emphasis on reproductive rights in the Programme of Action.

Since the ICPD, countries have made progress in the promulgation and enforcement of national laws responding to the ICPD priority areas related to sexual and reproductive health and rights. Although gaps remain in the access to reproductive health and in the accountability of governments, including in recourse to justice, such legal instruments serve as the basis to respect, protect and guarantee reproductive rights.

In the area of sexual and reproductive health and reproductive rights, less than two-thirds of countries (63 per cent) have promulgated and enforced a law protecting the right to the highest attainable standard of physical and mental health, including sexual and reproductive health, a percentage that increases to 80 per cent in the case of Europe and remains around the world average for the remaining regions (Asia: 66 per cent; Oceania: 62 per cent; Americas: 58 per cent; Africa: 55 per cent).

The vast majority of governments allow abortion on request, or to save the life of the woman and for at least one other condition such as fetal anomaly, or to safeguard the woman's health. As recognized in the 1999 Key Actions for Further Implementation, in all cases where abortion is not against the law it must be safe.[250] The World Health Organization has however noted that: "*the more restrictive*

[249] UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, World Health Organization Regional Office for the Eastern Mediterranean (1998). *Creating common ground in the Eastern Mediterranean Region: Women's needs and gender perspectives in reproductive health in the Eastern Mediterranean Region*.; Report of an intercountry meeting between women's health advocates, researchers, service providers and policy-makers, Casablanca, 10-13 November 1997. Geneva: World Health Organization. WHO/FRH/WOM/98.2; WHO Special Programme of Research, Development and Research Training in Human Reproduction *(1994). Creating common ground in Asia: Women's perspectives on the selection and introduction of fertility regulation technologies*. Report of a meeting between women's health advocates, researchers, providers and policy-makers, Manila, 5-8 October 1992 / organized by UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. Geneva: World Health Organization. WHO/HRP/WOM/94.1

[250] UNFPA. (1999). Key Actions for Further Implementation of the Programme of Action of the International Conference on Population and Development,

legislation on abortion [is], the more likely abortion [is] to be unsafe and to result in death."[251] The fundamental human rights to life and to security of the person, as well as freedom from cruel and inhumane treatment, and from discrimination, among others, means that unnecessary restrictions on abortion should be removed and governments should provide access to safe abortion services, both to safeguard the lives of women and girls and as a matter of human rights respect, protection and fulfilment, including the right to health.[252]

Globally, 73 per cent of countries have promulgated and enforced laws that ensure non-discrimination in the access to comprehensive sexual and reproductive health services, including HIV services, and a similar percentage (70 per cent) have promulgated and enforced a national law protecting the rights of people living with HIV. In this latter case, a higher proportion of countries in the Americas have done so (76 per cent), followed by Africa (72 per cent), Europe (69 per cent), Asia (67 per cent) and Oceania (57 per cent).

Only 60 per cent of countries have promulgated and enforced a national law protecting against coercion, including forced sterilization and forced marriage, and this proportion is lowest in the Americas (45 per cent).

If a composite indicator is computed for the above-mentioned five sexual and reproductive health and reproductive rights dimensions, only 32 per cent of countries have promulgated and enforced laws in all cases, although this percentage increases to 54 per cent in the case of Europe.

Efforts to improve the quality and accessibility of sexual and reproductive health services since 1994 have led to significant improvements in many sexual and reproductive health indicators, with evidence of strong government actions in terms of policies, budgets and implementation measures for some of the greatest vulnerabilities, yet comparatively limited progress in other areas. The following chapter highlights both areas of progress and continuing challenges in fulfilling sexual and reproductive health and rights.

Human rights elaborations since the ICPD: Reproductive rights

Intergovernmental human rights outcomes: The Human Rights Council has recognized the critical role of sexual and reproductive health contained in the right to health. *Resolution 6/29 Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* (2007) encourages the Special Rapporteur "to continue to pay attention to sexual and reproductive health as an integral element of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

Other soft law: *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (2000) of the Committee on Economic, Social and Cultural Rights clarifies the normative content of the right to the highest attainable standard of health, "The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation." Further, *General Recommendation No. 24*: *Women and Health* (1999) of the Committee on the Elimination of Discrimination against Women elaborates measures that should be taken to ensure the equality for all women in the implementation of

Para 63 (iii)

[251] UN Committee on Economic Social and Cultural Rights, Day of General Discussion on the Right to Sexual and Reproductive Health, 26 November 2010, comments by WHO, para. 55.

[252] CRR, *Whose Right to Life*, 2012; Committee Against Torture, CAT/C/NIC/CO/1; Report of UN Special Rapporteur on Right to Health, A/66/254.

the right to health, "affirming that access to health care, including reproductive health, is a basic right under the Convention on the Elimination of All Forms of Discrimination against Women."

D. Sexual and reproductive health and rights and lifelong health for young people

The largest generation of adolescents ever in history is now entering sexual and reproductive life. Their access to sexual and reproductive health information, education, care, and family planning services and commodities are essential to achieving the goals set out in the Programme of Action 20 years ago. The Programme of Action requires that countries ensure that health care providers do not restrict the access of adolescents to services and information, and that "…these services must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and religious beliefs."[253] **States should review all such policies and remove legal, regulatory and social barriers to reproductive health information and care for adolescents.**

Pregnancy has major consequences on a girl's health. About 70,000 adolescents in developing countries die annually of causes related to pregnancy and childbirth. Nine of ten births to girls below age 18 occur within early marriage. Researchers have found that girls who become pregnant before age 15 in low- and middle-income countries have double the risk of maternal death and obstetric fistula than older women (including older adolescents), in particular in sub-Saharan Africa and South Asia. There are also significant health risks to the infants and children of adolescent mothers: stillbirths and newborn deaths are 50 per cent higher among infants of adolescent mothers than among infants of mothers between the ages of 20 and 29. About 1 million children born to adolescent mothers do not make it to their first birthday.[254]

The extent to which young people have access to quality services is not well documented, yet their poor health outcomes—for example, 8.7 million annual abortions among adolescent girls and young women aged 15–24 years in 2008,[255] and high rates of STIs, including HIV infection—point to significant gaps in coverage. A 2012 review of available international data on sexual and reproductive health of young people (up to age 24), underscores these numerous gaps[256]. The Review also emphasizes the paucity of comparable data on adolescent health, even in the priority areas (such as HIV infection and maternal mortality) with the greatest policy focus[257].

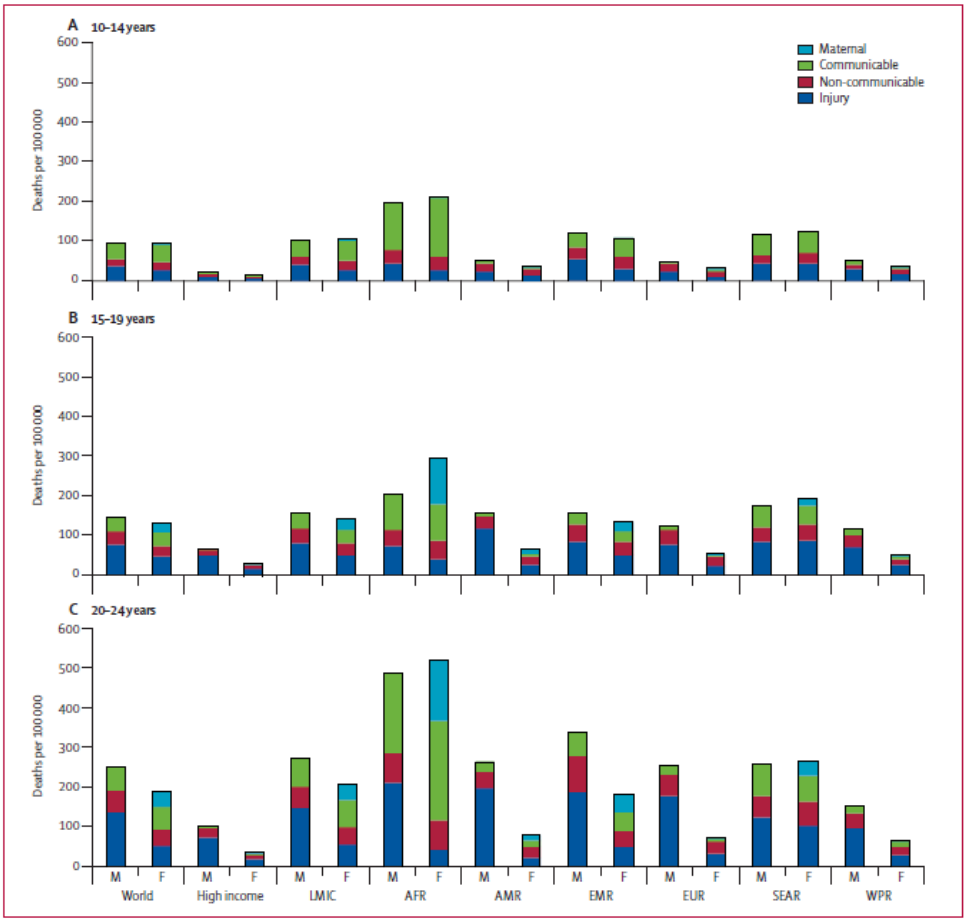
Based on the available evidence, the poorest adolescent health profiles are in sub-Saharan Africa, including the highest rates of mortality from both maternal and infectious causes – and higher for females than males (Figure 21). There is a greater than 70-fold variation in maternal mortality rates between countries in the region, with the highest maternal mortality rates among 15-19 year olds in Chad, and the lowest in South Africa[258]. Deaths due to injury become increasingly significant with age (that is, comparing the age groups 10-14, 15-19, and 20-24 years), and by age 15-19 they account for more than 50 per cent of deaths among males in the Americas, and close to 50 per cent in all other

[253] International Conference on Population and Development Programme of Action, Para 7.45.
[254] UNFPA, 2013. State of the World's Population, Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy.
[255] Shah IH. Ahman E. (2012). Unsafe abortion differentials in 2008 by age and developing country region: High burden among young women. *Reproductive Health Matters*, 20(39)): 169-173.
[256] George C Patton, Carolyn Coffey, Claudia Cappa, Dorothy Currie, Leanne Riley, Fiona Gore, Louisa Degenhardt, Dominic Richardson, Nan Astone, Adesola O Sangowawa, Ali Mokdad, Jane Ferguson, "Health of the world's adolescents: a synthesis of internationally comparable data", *Lancet*, 379, published online April 28, 2012, pp. 1665–75.
[257] George C Patton, Carolyn Coffey, Claudia Cappa, Dorothy Currie, Leanne Riley, Fiona Gore, Louisa Degenhardt, Dominic Richardson, Nan Astone, Adesola O Sangowawa, Ali Mokdad, Jane Ferguson, "Health of the world's adolescents: a synthesis of internationally comparable data", *Lancet*, 379, published online April 28, 2012, pp. 1665.
[258] George C Patton, Carolyn Coffey, Claudia Cappa, Dorothy Currie, Leanne Riley, Fiona Gore, Louisa Degenhardt, Dominic Richardson, Nan Astone, Adesola O Sangowawa, Ali Mokdad, Jane Ferguson, "Health of the world's adolescents: a synthesis of internationally comparable data", *Lancet*, 379, published online April 28, 2012, pp. 1667.

regions (e.g. Europe, the Eastern Mediterranean, Southeast Asia, and the Western Pacific regions) except for Africa.

Figure 21

Mortality rates (per 100,000) among young people due to maternal, communicable, non-communicable and injury causes



Source: Patton, GC, Coffey, C, Sawyer, S, Viner, RM, Haller, DM, Bose, K, Vos, T, Ferguson, J, Mathers, CD, Global patterns of mortality in young people: a systematic analysis of population health data," Lancet, (374), 2009, p. 885.

Note: Mortality rates shown by sex, country classification, and age group: 10-14 years (A), 15-19 (B), 20-24 years (C). Maternal=group IA. Communicable=group IB. Non communicable=group II. Injury=group III. M=Male deaths. F=Female deaths. High income=high-income countries. LMICs=low- and middle-income countries. AFR=African region. AMR= Americas region. EMR=eastern Mediterranean region. EUR=European region. SEAR=southeast Asia region. WPR=western Pacific region.

For females, adolescence and young adulthood are accompanied by acute needs for sexual and reproductive health services. Early childbirth (before age 18), is closely correlated with early marriage. The highest global rate of early marriage (before age 18), is in Niger at 75 per cent, with high rates in the rest of sub-Saharan Africa. Bangladesh has the highest regional rate in Southern Asia, with over two thirds of women married before age 18[259]. Sixteen million adolescent girls aged 15-19 years and two million girls under 15 years give birth every year.[260]

[259] George C Patton, Carolyn Coffey, Claudia Cappa, Dorothy Currie, Leanne Riley, Fiona Gore, Louisa Degenhardt, Dominic Richardson, Nan Astone, Adesola O Sangowawa, Ali Mokdad, Jane Ferguson, "Adolescent Health 4—Health of the world's adolescents: a synthesis of internationally comparable data", *Lancet*, 379, published online April 28, 2012, p. 1670.

[260] World Health Organization Fact Sheet Number 364, "Adolescent Pregnancy." May 2012. Retrieved from: http://www.who.int/mediacentre/factsheets/fs364/en/index.html

Girls under age 15 are five times more likely to die from maternal causesthan women over age 20, and pregnancy and childbirth are the leading cause of death for women of childbearing age in Africa and South Asia.[261]

From 2001 to 2012 HIV prevalence declined globally among young people for both females and males[262]. Across sub-Saharan Africa, the region with the highest prevalence of HIV, prevalence declined by 42 per cent. Dramatic decreases have been noted across all low- and middle-income countries. Variations are significant, however, with increases in HIV prevalence noted for male youths in Eastern Europe and Central Asia; and increases noted for both male and, in lesser proportion, female youths, in the Middle East and North Africa.[263]

Furthermore, in HIV endemic regions such as Africa – where almost three-quarters of all people living with HIV reside – female youth have higher prevalence rates of HIV than male,[264] particularly at the youngest ages, and males do not have comparable prevalence levels in many African countries until age 30 or more. These patterns are reversed in regions where HIV is predominantly transmitted through men having sex with men (MSM) or intravenous drug use, where young males are at higher risk than young females.[265]

Despite progress, in 2009 young people aged 15-24 years accounted for approximately 41 per cent of new HIV infections worldwide, [266] highlighting the urgency for renewed efforts towards ensuring availability of targeted sexual and reproductive health information, education and services that keep young people informed of their risks, and provide them access to condoms, STI screening and treatment, and HIV testing and care. Regarding data coverage, 29 countries, representing only 29 per cent of the adolescent population globally, collect data on HIV prevalence among youth aged 15-24, with data predominantly collected from sub-Saharan Africa and parts of central and Southern Asia, and a selection of wealthy countries with comparatively lower HIV rates[267]. HIV data on young adolescents aged 10-14 years old is very limited, hindering advancements toward the prevention of new infections within this group.[268]

The 2013 UNAIDS Report on the Global AIDS Epidemic also reported that there is limited data on rates of comprehensive knowledge of HIV transmission, with data available for only 35 per cent of the global adolescent population.[269] Knowledge levels are low in many countries with generalized HIV epidemics, generally falling below 50 per cent of the national adolescent population, and no country exhibited comprehensive HIV knowledge among more than 65 per cent of their adolescent population.

[261] UNFPA, 2012, *Giving Birth Should Not Be a Matter of Life and Death.*

[262] UNAIDS, Global Report: UNAIDS Report on the Global AIDS Epidemic, 2013, p. 16-7. Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf

[263] UNAIDS, Global Report: UNAIDS Report on the Global AIDS Epidemic, 2013, Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf

[264] UNAIDS, Global Report: UNAIDS Report on the Global AIDS Epidemic, 2013, Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf

[265] UNAIDS, Global Report: UNAIDS Report on the Global AIDS Epidemic, 2013, Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf

[266] Unpublished estimates from UNAIDS report on global AIDS epidemic 2010, cited in UNAIDS. (2011). Securing the future today: Synthesis of strategic information on HIV and young people. Retrieved from: http://unfpa.org/webdav/site/global/shared/documents/publications/2011/SecuringtheFuture.pdf.

[267] George C Patton, Carolyn Coffey, Claudia Cappa, Dorothy Currie, Leanne Riley, Fiona Gore, Louisa Degenhardt, Dominic Richardson, Nan Astone, Adesola O Sangowawa, Ali Mokdad, Jane Ferguson, "Adolescent Health 4—Health of the world's adolescents: a synthesis of internationally comparable data", *Lancet*, 379, published online April 28, 2012, p. 1667.

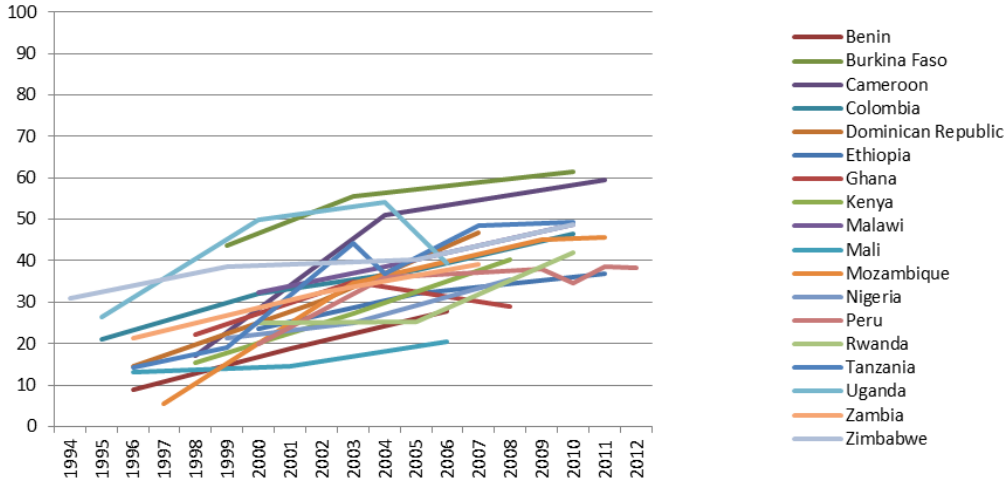
[268] UNAIDS, Global Report 2013, p. 18.

[269] UNAIDS, Global Report: UNAIDS Report on the Global AIDS Epidemic, 2013, Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf; George C Patton, Carolyn Coffey, Claudia Cappa, Dorothy Currie, Leanne Riley, Fiona Gore, Louisa Degenhardt, Dominic Richardson, Nan Astone, Adesola O Sangowawa, Ali Mokdad, Jane Ferguson, "Adolescent Health 4—Health of the world's adolescents: a synthesis of internationally comparable data", *Lancet*, 379, published online April 28, 2012, p. 1671.

Significantly, females in sub-Saharan African countries had lower knowledge levels than males, alarming considering the high risk of HIV among young women.

Demographic and Health Survey (DHS) data from countries with at least three surveys since 1994 show that condom use at last sex among young men and women aged 15-24 has been on the rise in most countries since 1994, however condom use by females overall has been consistently lower than condom use by males (see Figure 22 and Figure 23). Self-reported condom use can vary by sex due to sex differentials in multiple partnerships and in tendencies to report desirable behaviours, that is, social desirability bias. These trends in condom use are most likely contributing to the declining HIV incidence among young people 15-24 years that has been observed over the last decade.

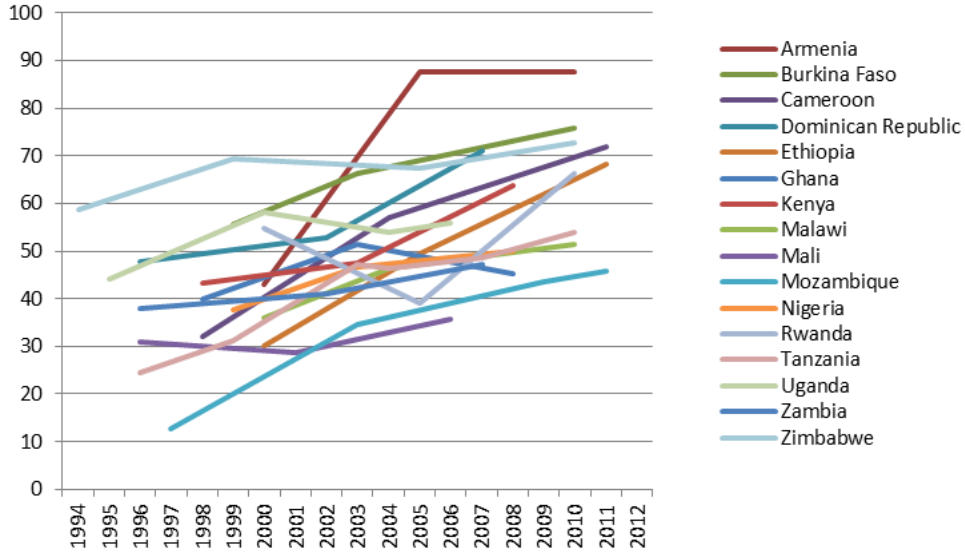
Figure 22
Trends in the percentage of never married women aged 15-24 using a condom at last sex
(Countries with at least 3 Demographic and Health Surveys or AIDS Indicators Survey since 1994)



Source: Demographic and Health Surveys and AIDS Indicators Survey on 28 October 2013, retrieved from www.measuredhs.com.

Note: all countries with available data for at least 2 timepoints

Figure 23
Trends in the percentage of never married young men aged 15-24 using a condom at last sex
(Countries with at least 3 Demographic and Health Surveys or AIDS Indicators Surveys since 1994)



Source: Demographic and Health Surveys and AIDS Indicators Survey on 28 October 2013, retrieved from www.measuredhs.com. Note: all countries with available data for at least 2 timepoints

Human rights elaborations since the ICPD: Adolescents and youth health

Binding instruments: Both the *Ibero-American Convention on the Rights of Youth* (2005; e.i.f. 2008) and the *African Youth Charter* (2006; e.i.f. 2009) contain articles elaborating the right to health for youth. The African Youth Charter encourages youth participation in health, obliging States to "[s]ecure the full involvement of youth in identifying their reproductive and health needs." The Charter requires States to "provide access to youth friendly reproductive health services including contraceptives, antenatal and post natal services," to "[i]nstitute comprehensive programmes . . . to prevent unsafe abortion" and to "[t]ake steps to provide equal access to health care services and nutrition for girls and young women." The Charter also devotes specific attention to HIV and AIDS obliging states to institute programmes to address the HIV and AIDS pandemic, including to "expand the availability and encourage the uptake of voluntary counselling and confidential testing for HIV/AIDS," and to "provide timely access to treatment for young people infected with HIV/AIDS." The Ibero-American Convention on the Rights of Youth affirms that "youth have the right to comprehensive and quality health," including "specialized health care… and promotion of sexual and reproductive health."

Other soft law: Through *General Comments* and *Recommendations*, human rights treaty bodies have recognized the evolving capacities of adolescents to make decisions about their sexual and reproductive health, and urged States to develop programmes to provide such services to adolescents.[270] *General Comment No.* 15: *The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health* (2013) of the Committee on the Rights of the Child clarifies the normative content of the right of children and adolescents to the enjoyment of the highest attainable standard of health, including health care services, as well as the binding obligations of States party to the Convention to respect, protect, promote, and fulfil the rights of the child to health. States are urged to ensure access to sexuality education and information,[271] not limiting access based on third party consent (that is, parental or health

[270] CRC Committee, *General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, supra note 19, paras. 1, 31. (33rd Sess., 2003).
[271] CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999).

authority),[272] and to eliminate laws that act as barriers to accessing sexual and reproductive health services.[273] Treaty bodies have also emphasized that all young people should have access to confidential and child-sensitive services[274], and adolescents who become pregnant should be able to remain in, and return to, school.[275]

1. Targeted youth programmes

Failures to recognize, prioritize and invest in adolescents and their sexual and reproductive health have fatal consequences: high rates of HIV that can lead to early death; unplanned and unwanted early pregnancies, with exacerbated risks for maternal mortality and morbidity, such as obstetric fistula; and higher rates of infant and child mortality.[276] Furthermore, adolescents have limited life and work skills to care for their children, and are often forced by schools or their circumstances to abandon their schooling. Therefore, early parenthood can enhance the risk of poverty.[277] The need for greater investments in youth-friendly sexual and reproductive education and health services tailored to adolescents is critical. Youth may be afraid of, or deterred by, intimidating environments, including inflexible opening hours; cost of services; resistant or unresponsive health care providers; long distances to clinics; or discomfort in requesting assistance or resources; they may also be unaware of what services are offered.[278]

Globally, the number of adolescent sexual and reproductive health programmes documented in the literature is substantial, with varied designs, and comparatively few at national scale or with reliable periodic evaluation.[279] While programmes may benefit from local tailoring, far greater attention should be given to systematic interventions and evaluation of impact.[280]

In 2006, WHO conducted a retrospective study of 16 interventions aimed at increasing young people's use of health services and their effectiveness.[281] It evaluated these interventions against the explicit targets set by the United Nations General Assembly Special Session (UNGASS) on HIV and AIDS that 90 per cent of young people aged 15-24 years should have access to the necessary services to decrease

[272] CEDAW Committee, *General Recommendation No. 24*, supra note 21, para. 14.
[273] CRC Committee, *Concluding Observations: Benin*, para. 25, U.N. Doc. CRC/C/15/Add.106 (1999); ESCR Committee, *Concluding Observations: Peru*, para. 21, U.N. Doc. E/C.12/PER/CO/2-4 (2012)
[274] CRC Committee, *Concluding Observations: Oman*, U.N. Doc. CRC/C/OMN/CO/2 (2006); *Paraguay*, para. 42, U.N. Doc. CRC/C/15/Add.166 (2001).
[275] CRC Committee, *Concluding Observations: Senegal*, para. 54-55, U.N. Doc. CRC/C/SEN/CO/2 (2006); *Paraguay*, para. 42, U.N. Doc. CRC/C/15/Add.166 (2001).
[276] UNFPA, "Adolescent Pregnancy. A review of the evidence," Technical Division, Population and Development Branch, forthcoming (October 2013), cited in UNFPA, *State of the World Population, Motherhood in Childhood, Facing the Challenge of Adolescent Pregnancy*, p. 2; Save the Children, *State of the World's Mothers, Children Having Children*, 2004; WHO. "Adolescent pregnancy," Issues in Adolescent Health and Development, WHO discussion papers on adolescence, 2004; cited in UNFPA, *Giving Girls Today and Tomorrow: Breaking the Cycle of Adolescent Pregnancy*, pp. 1, 2, 5; UNFPA, *Framework for Action on Adolescents and Youth. Opening Doors with Young People: 4 Keys*, 2007, p. 21.
[277] UNFPA, *State of the World Population, Motherhood in Childhood*, 2013, pp. iv-vi, Chapter 2, "The Impact on Girls' Health, Education, and Productivity," pp. 17-31.
[278] Chandra-Mouli V et al, "The World Health Organization's work on adolescent sexual and reproductive health," Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz 56 (2), February 2013, pp. 256-61; UNICEF, SOWC; UNFPA, Strategy on Adolescents and Youth, November 2012; WHO, "Making health services adolescent friendly: developing national quality standards for adolescent friendly health services," 2012, http://apps.who.int/iris/bitstream/10665/75217/1/9789241503594_eng.pdf,
; Guttmacher Institute, IPPF, "Facts on the Sexual and Reproductive Health of Adolescent Women in the Developing World," April 2010, http://www.guttmacher.org/pubs/FB-Adolescents-SRH.pdf; UNFPA, Framework for Action on Adolescents and Youth, 2008; Tylee, A, Maller, DM, Graham, T, Churchill, R, Sanci, LA "Youth-friendly primary care services: how are we doing and what more needs to be done?", Lancet (369), 2007, pp. 1565-73, published online 27 March 2007, p. 1571.
[279] Haberland N, Rogow D. Comprehensive Sexulaity Education: Background Paper for Expert Group Meeting on Adolescent Sexual and Reproductive Health. 2013
[280] Dick, B, Ferguson, J, Chandra-Mouli, V, Brabi, L, Chatterjee, S, Ross, D.A, "Review of the evidence for interventions to increase young people's use of health services in developing countries", in Ross, D, Dick, B, Ferguson, J, *Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries*, UNAIDS intragency task team on HIV and Young People, WHO Technical Report Series TRS/938, 2006, pp. 151-204; see endnotes 13-15.
[281] Dick, B, Ferguson, J, Chandra-Mouli, V, Brabi, L, Chatterjee, S, Ross, D.A, "Review of the evidence for interventions to increase young people's use of health services in developing countries", in Ross, D, Dick, B, Ferguson, J, *Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries*, UNAIDS intragency task team on HIV and Young People, WHO Technical Report Series TRS/938, 2006, pp. 151-204; see endnotes 13-15.

their vulnerability to HIV by 2005, and 95 per cent by 2010.[282]

The review concluded that there was sufficient evidence of components of these interventions' effectiveness to recommend the wide implementation of interventions that included training for service providers, improvements for clinics to be more youth-friendly and to include community-based activities to generate demand, with careful monitoring of quality, impact and coverage of sexual and reproductive health services.[283]

While the use of health services increased as a result of these interventions, the WHO review also acknowledged that the evidence to assess impact was generally weak or mixed, that reporting lacked detailed descriptions in some cases, and that there were difficulties interpreting data, limiting conclusions or recommendations. Thus, the review called for more rigorous research and evaluation, particularly to determine the effectiveness of involvement of other sectors in interventions.[284]

A 2007 global assessment of youth-friendly primary care services, that examined the benefits and effectiveness of accessing youth-friendly health services and facilities on health outcomes, drew further conclusions about the need for stronger research and evaluation. The well-documented barriers faced by young people in accessing services have not been addressed in a comprehensive way, and the evidence for the effectiveness of youth-friendly initiatives, was inadequately measured against young peoples' health outcomes. Although utilization has often increased, there has been little clear evidence on whether making services youth-friendly, and the investments required to do so, improved health outcomes. The study calls for systematic and well-designed interventions with regular assessments, for interventions to incorporate targets and principles into their design and to assess their strategies against these targets, including those listed in the WHO framework for development of youth friendly services.[285]

States should fund and develop, in partnership with young people and health care providers, policies, laws, and programmes that recognize, promote, and protect young peoples' sexual and reproductive health and rights and lifelong health. All programmes serving adolescents and youth, in and out of school, should provide referral to reliable, quality, sexual and reproductive health counselling and services.

States should remove legal, regulatory and policy barriers to sexual and reproductive health services for adolescents and youth, and ensure information and access to contraceptive technologies, prevention, diagnosis and treatment for STIs and HIV, including the HPV vaccine, and referrals to other health concerns such as mental health problems.

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[282] Dick, B, Ferguson, J, Chandra-Mouli, V, Brabi, L, Chatterjee, S, Ross, D.A, "Review of the evidence for interventions to increase young people's use of health services in developing countries", in Ross, D, Dick, B, Ferguson, J, *Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries*, UNAIDS intragency task team on HIV and Young People, WHO Technical Report Series TRS/938, 2006, p. 153, endnote 3.

[283] WHO, *Analytic case studies: initiatives to increase the use of health services by adolescents*, "Evolution of the National Adolescent-Friendly Clinic Initiative in South Africa", 2009, p. 6-7.; Dick, B, Ferguson, J, Chandra-Mouli, V, Brabi, L, Chatterjee, S, Ross, D.A, "Review of the evidence for interventions to increase young people's use of health services in developing countries", in Ross, D, Dick, B, Ferguson, J, *Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries*, UNAIDS intragency task team on HIV and Young People, WHO Technical Report Series TRS/938, 2006Pp. 151-152, 198-9. NB: in 2009, at the request of policymakers and programme managers in countries, WHO subsequently published the detailed findings of the evaluation in its series titled *Initiatives to Increase the Use of Health Services by Adolescents*, to assist governments and NGOs to implement and scale up quality adolescent-friendly health services, and to assist health workers that provide initiatives with necessary technical and financial support. WHO, *Analytic case studies: initiatives to increase the use of health services by adolescents, Evolution of the National Adolescent-Friendly Clinic Initiative in South Africa*, 2009, p. 6-7; WHO, *Analytic case studies: initiatives to increase the use of health services by adolescents*; 2009, http://www.who.int/maternal_child_adolescent/documents/9789241598354/en/

[284] Dick, B, Ferguson, J, Chandra-Mouli, V, Brabi, L, Chatterjee, S, Ross, D.A, "Review of the evidence for interventions to increase young people's use of health services in developing countries", in Ross, D, Dick, B, Ferguson, J, *Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries*, UNAIDS intragency task team on HIV and Young People, WHO Technical Report Series TRS/938, 2006, pp. 151, 191-2, 198-9.

[285] Andre Tylee et al., Adolescent Health 6, "Youth-friendly primary-care services: how are we doing and what more needs to be done?" Lancet, 2007; 369: 1565–73, published online Published Online March 27, 2007

2. Comprehensive sexuality education

The ICPD's Programme of Action called on governments to provide sexuality education to adolescents and to ensure that such programmes address specific topics, among them gender relations and equality, violence against adolescents, responsible sexual behaviour, contraception, family life, and sexually transmitted infections (STIs), HIV and AIDS prevention.[286]

(a) Recent Findings from Comprehensive Sexuality Education (CSE) Evaluations

Since 1994, numerous reviews of sexuality education evaluation studies have been conducted. These evaluations are of community-based and school-based programmes in both developing and developed countries. The evidence from these more inclusive reviews points to several findings and lessons:

a) Comprehensive sexual risk reduction interventions do not lead to earlier sexual initiation or greater sexual frequency [287]
b) Most sexuality education programmes demonstrated increased knowledge and about two-thirds of them demonstrated some positive results on behaviour[288]
c) Among CSE programmes that track health outcomes to measure impact, there is little measurable effect on rates of HIV, STIs and unintended pregnancy[110]
d) Efforts to link programme results with specific programme characteristics have been inconsistent or lacked consensus[289]
e) However, several reviews identified elements related to teaching methods:
    i. Effective programmes tend to incorporate skills building, especially condom use skills[290]
    ii. Interactive activities help students personalize information[291]

Reviewers recommend the use of biological health outcomes as a more reliable, objective measure of programme efficacy than self-reported sexual behaviour.[292] One recent review that considered only

[286] International Conference on Population and Development Programme of Action, paragraphs 4.29, 7.37, 7.41, and 7.47. For example, the International Conference on Population and Development repeatedly calls for sexuality education, including in para. 7.37, which states, "Support should be given to integral sexual education and services for young people, with the support and guidance of their parents and in line with the Convention on the Rights of the Child, that stress responsibility of males for their own sexual health and fertility and that help them exercise those responsibilities." (International Conference on Population and Development Programme of Action, para. 7.37). Commission on Population and Development Resolution (E/CN.9/2009/10) OP7 "Urges Governments, in order to ensure the contribution of the Programme of Action of the International Conference on Population and Development to the internationally agreed development goals, including the Millennium Development Goals, to, inter alia, protect and promote the full respect of human rights and fundamental freedoms regardless of age and marital status, including by … providing young people with comprehensive education on human sexuality, on sexual and reproductive health, on gender equality and on how to deal positively and responsibly with their sexuality."

[287]. Napierala Mavedzenge SM, Goyle AM, Ross DA. (2011). HIV prevention in young people in sub-Saharan Africa: A systematic review. *The Journal of Adolescent Health*, 49(6): 568-586.; Kirby, D. 2007. *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. Washington, DC: National Campaign to Prevent Teen Pregnancy; Michielsen K, Chersich MR, Luchters S, De Koker P, Van Rossem R, Temmerman M. (2010). Effectiveness of HIV prevention for youth in sub-Saharan Africa: A systematic review and meta-analysis of randomized and nonrandomized trials. *AIDS*, 24(8): 1193-1202; Kirby, D. 2007. *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. Washington, DC: National Campaign to Prevent Teen Pregnancy; Chin HB, Sipe TA, Elder R. (2012). The effectiveness of group-based comprehensive risk-reduction and abstinence education interventions to prevent or reduce the risk of adolescent pregnancy, Human Immunodificiency Virus, and sexually transmitted infections: Two systematic reviews for th guide to community preventive services. *Am J Prev Med*, 42(3): 272-294.

[288] Kirby, D. 2007. *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. Washington, DC: National Campaign to Prevent Teen Pregnancy.

[289] Kirby, D. 2007. *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. Washington, DC: National Campaign to Prevent Teen Pregnancy; Napierala Mavedzenge SM, Goyle AM, Ross DA. (2011). HIV prevention in young people in sub-Saharan Africa: A systematic review. *The Journal of Adolescent Health*, 49(6): 568-586.; Jukes, M., S. Simmons, and D. Bundy. 2008. Education and Vulnerability: The Role of Schools in Protecting Young Women and Girls from HIV in Southern Africa. AIDS 22(4): S41–S56.

[290] Paul-Ebhohimhen, V. A., Poobalan, A. and van Teijlingen, E. R. (2008) A systematic review of school-based sexual health interventions to prevent STI/HIV in sub-Saharan Africa. BMC Public Health, 2008, 8:4;

[291] Paul-Ebhohimhen, V. A., Poobalan, A. and van Teijlingen, E. R. (2008) A systematic review of school-based sexual health interventions to prevent STI/HIV in sub-Saharan Africa. BMC Public Health, 2008, 8:4.

[292] Napierala Mavedzenge SM, Goyle AM, Ross DA. (2011). HIV prevention in young people in sub-Saharan Africa: A systematic review. *The Journal of Adolescent Health*, 49(6): 568-586.; Kirby, D. 2007. *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. Washington, DC: National Campaign to Prevent Teen Pregnancy; Michielsen K, Chersich MR, Luchters S, De Koker P, Van Rossem R, Temmerman M. (2010). Effectiveness of HIV prevention for youth in sub-Saharan Africa: A systematic review and meta-analysis of randomized and nonrandomized trials. *AIDS*, 24(8): 1193-1202; Harrison A, Newell ML, Imrie J, Hoddinott G. (2010). HIV prevention for South African youth: Which

studies that utilized health outcomes as a measure of impact found the CSE curricula emphasizing gender and power were markedly more likely to reduce rates of STIs and/or unintended pregnancy than "gender-blind" curricula.[293] This finding resonates with other evidence on the value of addressing gender norms and relationship dynamics within CSE. For example, studies have found that women and men with more equitable gender attitudes are significantly more likely to use contraception and/or condoms[294] and significantly more likely to receive prenatal care and to deliver in a maternity facility.[295] In five high-fertility countries in East Africa, men who support gender inequality had higher fertility aspirations, independent of education, income, or religion.[296]

Relationship skills are necessary for many young people, as not all children have had the mentoring to treat others with dignity, respect and non-discrimination; schools can provide values-based learning that will enhance human relationships. **States should guarantee for boys, girls, adolescents and young people the opportunities, mentoring and skills to build healthy social relationships, harmonious co-existence and a life free from violence through multi-sectoral strategies and education that engages peer groups and families, and promotes tolerance and appreciation for diversity, gender equality, self-respect, conflict resolution and peace.**

National leaders at the highest level, community leaders, faith based institutions and other thought leaders are called upon to creatively and publicly develop, in collaboration with young people, media and communications that address the negative social consequences of gender stereotypes, promote the values and practice of gender equality, and honour non-violent masculinities.

A 2012 review of curricula in 10 East and Southern African countries suggests that critical thinking about gender and rights is not yet sufficiently implemented within comprehensive sexuality and HIV education.[297]

Support by governments for youth sexual and reproductive health services in the ICPD Beyond 2014 Global Survey (2012) varied starkly. Only 54 per cent of countries in the Africa region address the issue of ensuring access of adolescents and youth to sexual and reproductive health information and services that warrant and respect privacy, confidentiality and informed consent, compared with 96 per cent, 90 per cent and 80 per cent of countries in the Americas, Europe and Asia.

As the evidence builds for a paradigm shift toward programmes that emphasize critical thinking about gender and power, the question arises about the extent to which this is being implemented. The Global Survey found 70 per cent of governments reported that the issue of "revising the contents of curricula to make them more gender-sensitive" was being addressed, but the implication or thoroughness of that effort was not queried. The ICPD Beyond 2014 regional reviews and outcomes stressed the importance of designing and implementing effective comprehensive sexuality education that addresses the key elements linking the five thematic pillars of the ICPD Review.

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interventions work? A systematic review of current evidence. *BMC Public Health*, 10:102. doi:10.1186/1471-2458-10-102

[293] Haberland N, Rogow D. Comprehensive Sexulaity Education: Background paper for Expert group Meeting on Adolescent sexual and Reproductive Health. 2013

[294] Karim, Ali Mehryar, Robert Magnani, Gwendolyn Morgan, Katherine Bond. 2003. "Reproductive Health Risk and Protective Factors Among Unmarried Youth in Ghana," *Intl Family Planning Perspectives* 29(1):14-24; Stephenson, Rob, Doris Bartel, Marcie Rubardt. 2012. "Constructs of power and equity and their association with contraceptive use among men and women in rural Ethiopia and Kenya," *Global Public Health* 7(6):618-634.

[295] Cui, Ying, Qiaoli Zhang, Li Yang, Jianli Ye, Mentao Lv. 2013. "Effect of married women's beliefs about gender equity on their use of delivery care in rural China," *Intl Journal of Gynecology and Obstetrics* 111:148-151.

[296] Snow, Rachel, Rebecca Winter, Sioban Harlow. 2013. "Gender Attitudes and Fertility Aspirations among Young Men in Five High Fertility East African Countries." *Studies in Family Planning* 44(1)1-24.

[297] UNESCO and UNFPA. (2012). Sexuality education: A ten-country review of school curricula in East and Southern Africa. Retrieved from: http://unesdoc.unesco.org/images/0022/002211/221121e.pdf

States should recognize that comprehensive sexuality education, consistent with the evolving capacities of young people both in and out of school is essential to enable them to protect themselves from unwanted pregnancy, HIV and sexually transmitted infections, to promote values of tolerance, mutual respect and non-violence in relationships, and to plan their lives. States should design and implement comprehensive sexuality education programmes that provide accurate information, taking into account scientific data and evidence, about human sexuality, including growth and development, anatomy and physiology; reproduction, pregnancy and childbirth; contraception; HIV and STIs; family life and inter-personal relationships; culture and sexuality; human rights protection, fulfilment and empowerment; non-discrimination, equality and gender roles; sexual behaviour; sexual abuse, gender based violence and harmful practices; as well as youth-friendly programmes to explore values, attitudes and norms concerning sexual and social relationships; promote the acquisition of skills and encourage young people to assume responsibility for their own behaviour and to respect the rights of others; are gender-sensitive and life-skills based; and provide young people with the knowledge, skills and efficacy to make informed decisions about their sexuality.

Human rights elaborations since the ICPD: Comprehensive sexuality education

Binding Instruments: The *Ibero-American Convention on the Rights of Youth* (2005; e.i.f. 2008) recognizes that "the right to education also includes the right to sexual education" and that "sexual education shall be taught at all educational levels."

Other Soft Law: Human rights treaty bodies have recognized that the right to health includes "underlying determinants of health, such as…access to health-related education and information, including on sexual and reproductive health," as well as the right to seek, receive, and disseminate health information.[298] Treaty monitoring bodies have also highlighted that states should ensure that all adolescents have access to information on sexual and reproductive health both in school and in other settings for adolescents who are not in school.[299]

3. Fertility, contraception and family planning

Globally, fertility fell by 23 per cent between 1990 and 2010.[300] Falling fertility is largely the result of desire for smaller families, coupled with better access to contraception. Aspirations for smaller families are affected by many factors, including improvements in child survival and expanded opportunities for women, especially education. In Africa as a whole, and sub-Saharan Africa in particular, fertility has fallen more slowly than in other regions, and remains higher than in any other region in the world.[301]

Globally, contraceptive prevalence for women ages 15 to 49 who are married or in union and currently using any method of contraception, rose from 58.4 per cent in 1994 to 63.6 per cent in 2012, a rise of approximately 10 per cent.[302] While contraceptive use increased faster over that period among developing countries (excluding China), (from 40 to 54 per cent), use in developing regions remained

[298] ESCR Committee, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, (22nd Sess., 2000), paras. 11, 12(b)(iv), U.N. Doc. HRI/GEN/1/Rev.9.

[299] CRC Committee, *General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child* (33rd Sess., 2003), para. 26 and supra note 36, para. 28 U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008); CRC Committee, *Concluding Observations: Australia*, para. 67, U.N. Doc. CRC/C/AUS/CO/4 (2012); ESCR Committee, *Concluding Observations: Russian Federation*, para. 30, U.N., Doc. E/C.12/RUS/CO/5 (2011); CEDAW Committee, *General Recommendation No. 24*, supra note 28, para. 23; CEDAW Committee, *Concluding Observations: Turkmenistan*, paras. 30-31, U.N. Doc. CEDAW/C/TKM/CO/2 (2006); CRC Committee, *Concluding Observations: Uruguay*, para. 52, U.N. Doc. CRC/C/URY/CO/2 (2007); ESCR Committee, *Concluding Observations: The Kingdom of the Netherlands*, para. 27, U.N. Doc. E/C.12/NDL/CO/4-5 (2010).

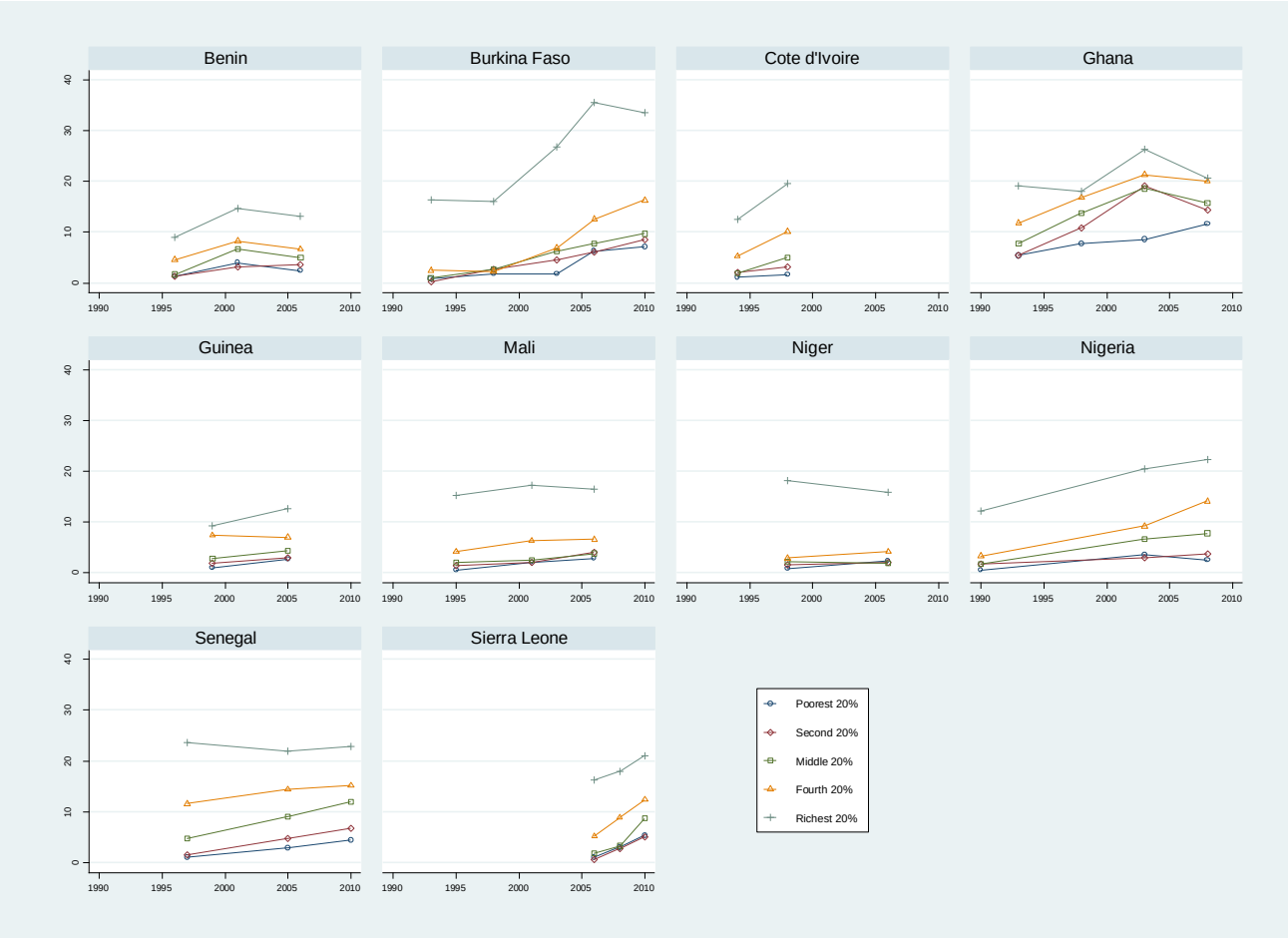
[300] The decrease in the global total fertility rate is calculated using the point estimates for the years 1990 and 2010 from the United Nations, Department of Economic and Social Affairs, Population Division (2013) *World Population Prospects: The 2012 Revision*

[301] Cleland JG, Ndugwa RP, Zulu EM. (2010). Family planning in sub-Saharan Africa; Progress or stagnation? *Bulletin of the World Health Organization*, 89:137-143. doi: 10.2471/BLT.10.077925

[302] United Nations, Department of Economic and Social Affairs, Population Division (2012). World Contraceptive Use 2012 (POP/DB/CP/Rev2012).

much lower than in developed countries, where nearly 72 per cent of married or in union women use contraception. Contraceptive prevalence increased more rapidly in the 1990s than in the most recent decade, and in a number of extremely poor countries, prevalence has remained below 10 per cent.[303]

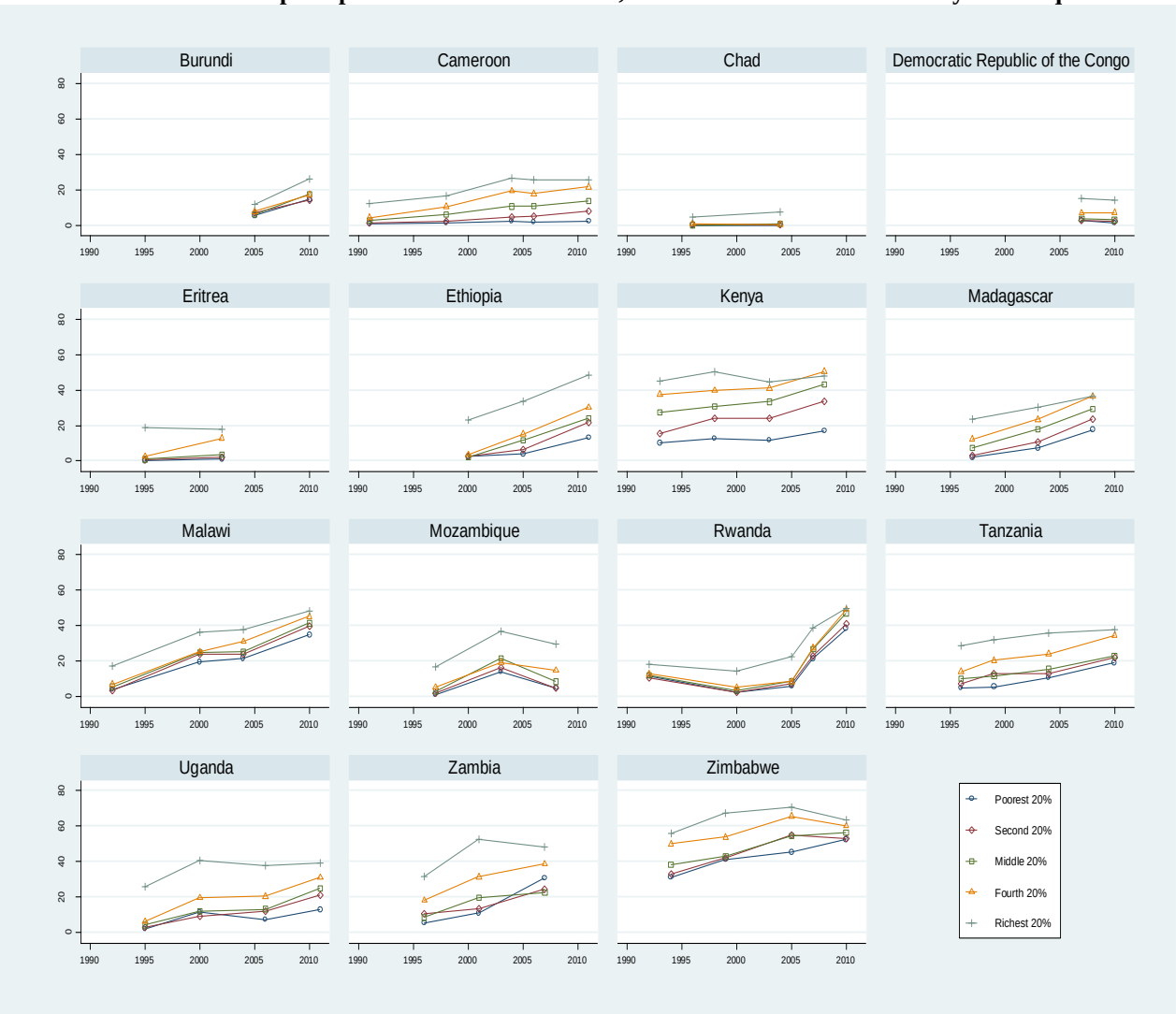
Figure 24
Trends in modern contraceptive prevalence rate in Northern and Western Africa by wealth quintile



Source: Demographic and Health Surveys, retrieved from www.measuredhs.com on 15 June 2013; Multiple Indicator Cluster Surveys, retrieved from http://www.unicef.org/statistics/index_24302.html on 15 June 2013, all countries with available data for at least 2 time points

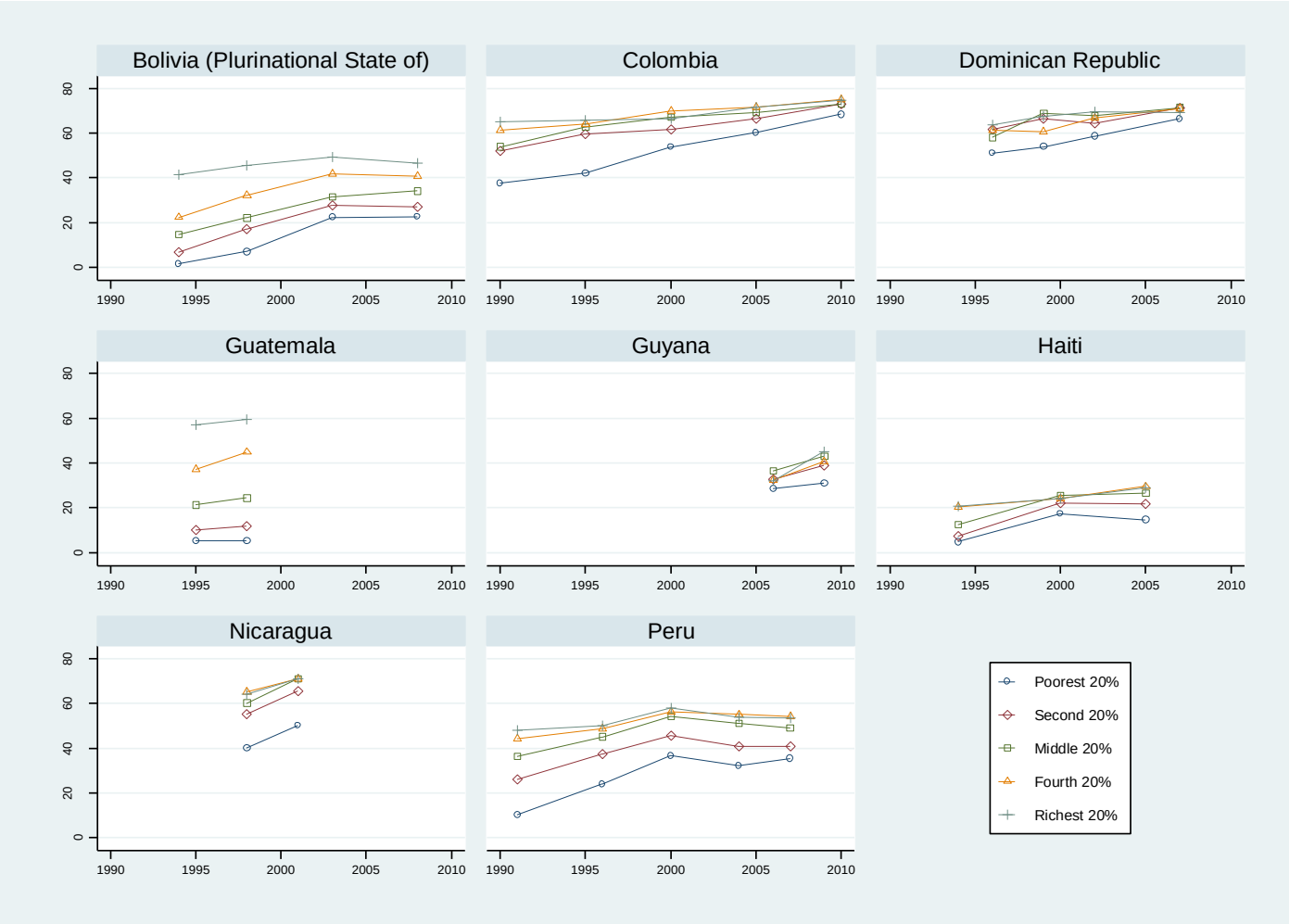
[303] Ortayli, N and Mararcher, S, Equity analysis: identifying who benefits from family planning programs. Studies in Family Planning 41(2):101-108, 2010.; Alkema, L, Kantorova, V, Menozzi,C and Biddlecom, A, National, regional and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis. Lancet SO140-6736(12)62204-1, published online March 12, 2013.

Figure 25
Trends in modern contraceptive prevalence rate in Eastern, Middle and Southern Africa by wealth quintile



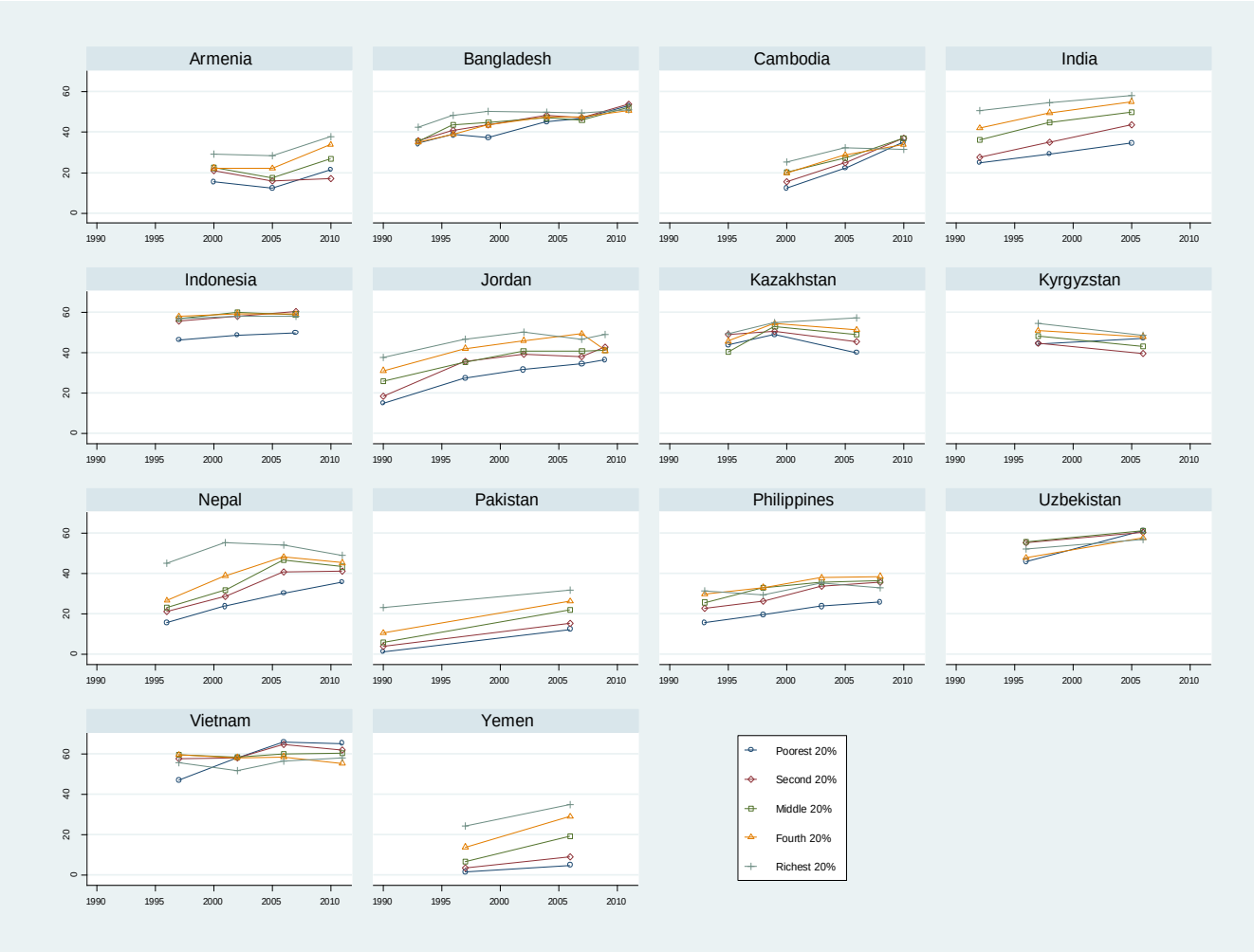
Source: Demographic and Health Surveys, retrieved from www.measuredhs.com on 15 June 2013; Multiple Indicator Cluster Surveys, retrieved from http://www.unicef.org/statistics/index_24302.html on 15 June 2013, all countries with available data for at least 2 timepoints

Figure 26
Trends in modern contraceptive prevalence rate in the Americas by wealth quintile



Source: Demographic and Health Surveys, retrieved from www.measuredhs.com on 15 June 2013; Multiple Indicator Cluster Surveys, retrieved from http://www.unicef.org/statistics/index_24302.html on 15 June 2013, all countries with available data for at least 2 timepoints

Figure 27
Trends in modern contraceptive prevalence rate in Asia by wealth quintile



Source: Demographic and Health Surveys, retrieved from www.measuredhs.com on 15 June 2013; Multiple Indicator Cluster Surveys, retrieved from http://www.unicef.org/statistics/index_24302.html on 15 June 2013, all countries with available data for at least 2 timepoints

Global unmet need for modern methods declined modestly from 20.7 per cent in 1994 to 18.5 per cent in 2012.[304] Ninety per cent of women with unmet need today live in developing countries, with the greatest need among women and men in Africa. In 28 sub-Saharan African countries, including all countries in West Africa, with the exception of one country, fewer than 25 per cent of women of reproductive age use contraception, with unmet need as high as 36 per cent.[305]

Findings from the Global Survey indicate that approximately 8 of 10 countries have addressed "increasing women's access to information and counseling on sexual and reproductive health" (84 per cent) and "increasing men's access to sexual and reproductive health information, counseling, and services" (78 per cent) during the past 5 years. Similarly, 8 out of 10 countries report having addressed the issue of "increasing access to comprehensive sexual and reproductive health services for women" (82 per cent) as well as for "adolescents" (78 per cent). However, this percentage decreases in the case

[304] UN Dept of Economic and Social Affairs, World Contraceptive Use 2012, Model-estimates for unmet need for modern contraception.
[305] Cleland, J and Shah, I. The contraceptive revolution: focused efforts are still needed, Lancet, Published online March 12, 2013.; Alkema, L, Kantorova, V, Menozzi, C, Biddlecom, A, National, regional and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis. Lancet 2013. http://dx.doi.org/10.1016/S0140-6736(12)62204-1

of providing sexual and reproductive health services to "persons with disabilities" (55 per cent) and "indigenous peoples and cultural minorities" (62 per cent).

Human rights elaborations since the ICPD: Contraceptive information and services

Other soft law: Article 12 of the *Convention on the Elimination of All Forms of Discrimination Against Women* (1979; e.i.f. 1981) provides that States "shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning." Further, article 16(1)(e) protects the rights to decide the number and spacing of one's children and to have access to the information, education and means to exercise this right. Building on these standards, recognizing the correlation between unmet need for contraceptives and higher rates of pregnancy among adolescents, abortion, and maternal mortality, and that barriers to access to contraception disproportionately affect certain populations, treaty monitoring bodies since 1994 have urged states to ensure access to medications on the WHO Essential Medicines List, including hormonal contraception and emergency contraception. In elaborating State obligations under article 12 of the *International Covenant on Economic, Social, and Cultural Rights*, the Committee on Economic, Social and Cultural Rights in *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (2000) urges that, "States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people's participation in health-related matters." Further, *General Comment No.* 15: *The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health* (2013) of the Committee on the Rights of the Child states, "Short-term contraceptive methods such as condoms, hormonal methods and emergency contraception should be made easily and readily available to sexually active adolescents. Long-term and permanent contraceptive methods should also be provided."

(a) Contraceptive method mix

Over the past twenty years, the diversification of modern contraceptive method mix has been considerable, and the direction of product innovations (see Annex I, Box 1) has been towards innovations that ease administration (and removal), lower doses, and reduce side effects.[306] Yet the current array of contraceptive products is not without risks of failure and side-effects, some serious – and many women have clinical contraindications to specific methods. Because clients differ in their method preferences and clinical needs, including over their own life-course, a range of distinct contraceptive method types is a hallmark of safety and quality in human rights-based family planning services, and added method choices typically increases overall use prevalence.

In 1994, global contraceptive method mix was dominated by female sterilization and the IUD, capturing 31 and 24 per cent of overall contraceptive use respectively, followed by use of pills at 14 per cent of the global use (See Annex I, Table 2).[307] Twenty years later, these three methods continue to dominate, but

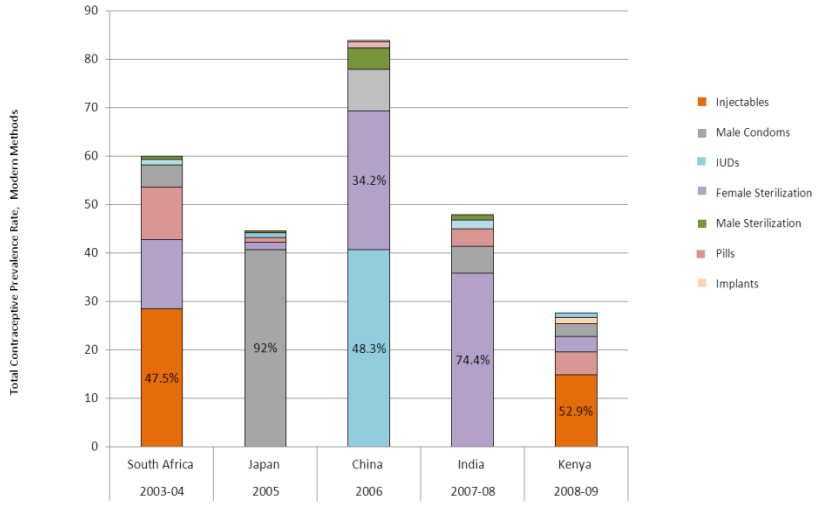
[306] Brache, V., Faundes. A., "Contraceptive vaginal rings: a review," *Contraception* 2010, Vol.82, Issue 5, pp. 418-427; Reproductive Health Supplies Coalition, "Caucus on new underused reproductive health technologies; Contraceptive Implants" , July 2013, retrieved from http://www.fhi360.org/sites/default/files/media/documents/rhsc-brief-contraceptive-implants_A4.pdf; WHO, Reproductive Health Library, "Subdermal implantable contraceptives versus other forms of reversible contraceptives or other implants as effective methods of preventing pregnancy,"retrieved from http://apps.who.int/rhl/fertility/contraception/CD001326_bahamondesl_com/en/; Nelson, A., "New low dose extended cycle pill with levonorgestrel and ethinyl estradiol: an evolutionary step in birth control," International Journal of Womens Health, 2010; 2, pp. 99-106.

[307] Biddlecom, A, Kantorova, V, "Global trends in contraceptive method mix and implications for meeting the demand for family planning," Preliminary Draft, 19 August 2013, Presentation to the XXVII IUSSP International Population Conference (Busan, Republic of Korea), August 2013, retrieved at http://www.iussp.org/sites/default/files/event_call_for_papers/Biddlecom%26Kantorova_Global-trends-method-mix_19August2013.pdf , model-based estimates based on Alkema L, Kantorova V, Menozzi C, Biddlecom A, "National, regional and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis," *Lancet* 381, pp. 1642-52, published online 12 March

they are accompanied by some greater diversification of female methods, including increased use of injectables and implants, and a rise in the use of male condoms. Select countries that were dominated by single methods in the 1990s continue to be so (see Figure 28 below), suggesting limited product choice and/or limited capacity among service providers in these countries.[308]

Figure 28

Percentage distribution of women, ages 15-49, according to contraceptive method use, highlighting single method dominance in select countries



Source: South Africa, Demographic and Health Surveys, Final Report, 2003-04; Kenya, Demographic and Health Surveys, Final Report, 2008-09; Japan, 13th National Fertility Survey, 2005; China, National Family Planning and Reproductive Health Survey, 2006; India, District Level Household and Facility Survey (DLHS-3), 2007-08; quoted in UN DESA, Population Division World contraceptive Use, 2011(Data downloaded and analyzed on 5 September 2013).

Programmes dominated by single methods may reflect the legacy of past state family planning policies, sustained through public choice, and/or routine commodity flows, provider bias, or technical training.[309] Regardless of the reason for programmes dominated by use of a single method, such programmes are unable to respond to the variable needs of women for delaying, spacing and ending reproduction; the varying needs that women have for different contraceptive technologies for health reasons; or user preferences for distinct technical attributes of methods at different phases of their life, such as for user-controlled, and reversible methods, among others.

A criterion of quality family planning programmes is the availability of a selection of methods with distinct clinical features that can be safely and affordably offered to clients. Persistent dominance of a single method within countries highlights the trade-offs that country programmes make between mass provision of a familiar method, versus health system investments to diversify commodities and ensure the necessary provider expertise for safe delivery and informed counseling for a range of methods.

2013, using method-mix computations based on United Nations, Department of Economic and Social Affairs, Population Division, 2012, World Contraceptive Use 2012 (POP/DB/CPRev2012), available at http://www.un.org/esa/population/publications/WCU2012/MainFrame.html, and United Nations, Department of Economic and Social Affairs, Population Division, 2013, 2013 Update for the MDG Database: Contraceptive Prevalence (POP/DB/CP/A/MDG2013), available at http://www.un.org/en/development/desa/popluation/theme/mdg/index.shtm

[308] South Africa, DHS, Final Report, 2003-04; Kenya, DHS Measure, Final Report, 2008-09; Japan, 13th National Fertility Survey, 2005; China, National Family Planning and Reproductive Health Survey, 2006; India, District Level Household and Facility Survey (DLHS-3), 2007-08; quoted in UN DESA, Population Division, World Contraceptive Use, 2011 (Downloaded and analyzed on 5 September 2013).

[309] Seiber, Eric, Betrand, Jane T, Sullivan, Tara M, "Changes in Contraceptive Method Mix in Developing Countries," *International Family Planning Perspectives*, 2007(33)(3); Brown JJ, Bohua L and Padmadas SS, "A multilevel analysis of the effects of a reproductive health programme that encouraged informed choice of contraceptive method rather than use of officially preferred methods, China 2003-2005," *Population Studies* 2010, 64(2), in Anonymous, "Changing China's Contraceptive Policy," *International Perspectives on Sexual and Reproductive Health* (36) (4) (Dec 2010); Daniel R. Mishell, Jr., "Intrauterine contraception: An under-utilized method of family planning," European Journal of Contraception & Reproductive Health Care 12.1 (Mar 2007)

(b) Emergency contraception

Emergency contraception (EC) has been included as part of the WHO Essential List of Medicines[310] since 1995; is included in norms, protocols and guidelines issued by International Federation of Gynaecology and Obstetrics (FIGO); is registered in most developing and developed countries, and registered as a non-prescription product in over 50 countries.[311] Nonetheless, inadequate knowledge and information regarding EC pose barriers to its use in most countries. A recent (2012) commission[312] found that where emergency contraception is not registered, it is generally due to policies conflating EC with abortion, and general opposition to contraception. It noted that restrictions on access are often due to unnecessary prescription requirements or lack of provision in the public sector, and EC remains little known by health care providers.

(c) Male sterilization

While the number of men using condoms has increased where HIV is of concern, male participation in modern family planning has advanced very little since 1994, and there have been very few countries that report increases in male sterilization over the past 20 years.

Of 92 countries with more than 2 data points on the proportion of overall contraceptive prevalence attributable to male sterilization,[313] with at least one data point during or since 2005, 38 countries (41 per cent) report no use of male sterilization, and in only 4 countries does male sterilization contribute to more than 10 per cent of contraceptive prevalence: the United Kingdom (21 per cent), the Republic of Korea (17 per cent), the United States of America (14 per cent) and Bhutan (13 per cent). Twenty-seven countries (29 per cent) have seen declines in the relative use of male sterilization since 1994, Sri Lanka (-4 per cent), India (-2 per cent), Thailand (-2 per cent), and Myanmar (-1.4 per cent), USA (-0.5 per cent), suggesting either absolute declines in use of male sterilization or increased reliance on other (largely female) contraceptive methods.[314]

In 2002, 180 million women relied on female sterilization, compared with 43 million men who relied on male sterilization.[315] This disparity is especially striking given that female sterilization is more expensive, incurs more health risks and is irreversible, in contrast to the relatively safe and reversible procedure for males. Research into male hormonal contraception (MHC) continues to advance, slowly,[316]

States must, as a matter of urgency, provide widespread and high-quality information and counseling regarding the benefits and risks of a full range of affordable, accessible, quality contraceptive methods, with special attention to dual method use with male or female condoms given the continuing risk of STIs and HIV, and ensure access to both contraceptive knowledge and commodities irrespective of marital status.

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[310] 18th WHO Model List of Essential Medicines (April 2013) http://apps.who.int/iris/bitstream/10665/93142/1/EML_18_eng.pdf.

[311] Emergency Contraception in National Essential Medicines Lists. International Consortiuom for Emergency Contraception (July 2013) http://www.cecinfo.org/custom-content/uploads/2013/07/EC-in-EMLs-07-16-13.pdf.

[312] 2012 Working Paper - Prepared for the United Nations Commission on Life-Saving Commodities for Women and Children, March 2012 - http://www.everywomaneverychild.org/images/UN_commission_FP_COMPLETEresizedfinal5.7.12.pdf (last accessed 16 October 2013)

[313] United Nations, Department of Economic and Social Affairs, Population Division (2012). World Contraceptive Use 2012 (POP/DB/CP/Rev2012); The first point is closest to 1994 and another closest to 2012 with the cut-off point at 2005. Number of countries originally: 194; Countries excluded due to following reasons: Countries without data: 26 Countries with only one data point: 33; Countries with last data point before 2005: 43.

[314] Darroch, J.E. (2008) Male fertility control- where are the men? Contraception 78:S7-S17.

[315] EngenderHealth. (2002). Contraceptive Sterilization Global Issues and Trends. Chapter 2 http://www.engenderhealth.org/files/pubs/family-planning/factbook_chapter_2.pdf

[316] Amory, JK, and WJ Bremner (2000) "Newer agents for hormonal contraception in the male." Trends in Endocrinology and Metabolism 11(2): 61-66.

4. Abortion

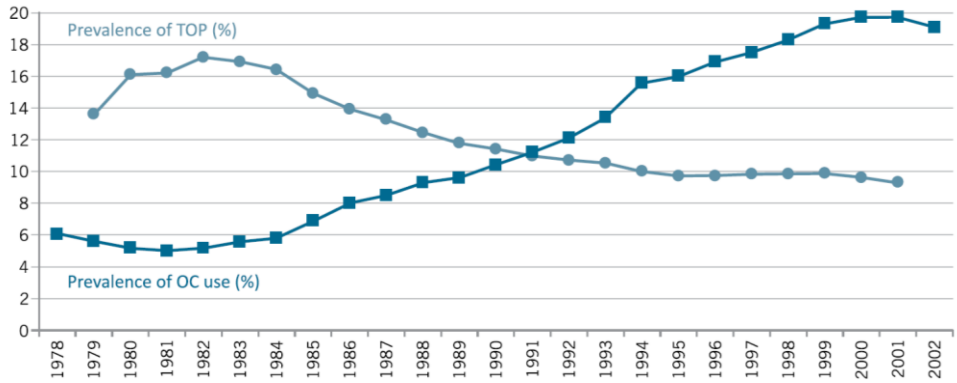
The use of abortion reflects many circumstances that can be difficult for women to prevent, such as contraceptive failure, lack of knowledge about the fertile period or how to use contraception, shortfalls in access or affordability of contraceptives, changing fertility aspirations, disparities in the desire for a pregnancy between a woman and her partner, fear of asking a partner to use contraception, unplanned or forced sex.[317] Rates of abortion vary dramatically between countries (Table 1)[318] and recent estimations suggest declines in both the rate of abortion, and abortion-related deaths, with the following trends:

a) The risk of death due to complications of unsafe abortion is decreasing at both global and regional levels,[319] This improvement is widely attributed to improved technologies, increased use of the WHO guidelines for safe abortion and post-abortion care, and greater access to safe abortion.
b) At 460 and 160 deaths per 100,000 unsafe abortions[320] the death rates from abortion in Africa and Asia respectively are still shockingly high.
c) The overall rate of abortions declined globally from 35 abortions per 1000 women (age 15-44 years) in 1995, to 28 per 1000 in 2003, but has remained stable at 29 per 1000 in 2008.[321]
d) The absolute numbers of estimated abortions declined from 45.6 million in 1995 to 41. 6 million in 2003 and increased to 43.8 million in 2008.[322] This increase in absolute numbers is attributable to stagnation in the rate of abortions from 2003 to 2008 coupled with population growth over time.
e) The highest sub-regional abortion rates are in Eastern Europe (43), the Caribbean (39), East Africa (38) and Southeast Asia (36); the lowest sub-regional rate is in Western Europe (12).[323]
f) An estimated 86 per cent of all abortions took place in the developing world in 2008, the last year of available estimates.[324]

Governments committed themselves in the Programme of Action, as well as in the Key Actions for the Further Implementation of the Programme of the Action of the ICPD, to place the highest priority on preventing unwanted pregnancies, and thereby making "every attempt to eliminate the need for abortion". Key requirements for fulfilling that commitment are ensuring good public knowledge regarding the risk of pregnancy, strong gender equality norms, and affordable access to a range of safe contraceptive methods with different attributes that would enable most women and men to secure a method that conforms to their needs and any contra-indications. Increased use of contraceptives may sometimes correspond to a direct decline in the rates of abortion, as observed in Italy over a 20-year period (Figure 29).[325] While the interaction between the rate of abortion and the use of modern contraception is affected by other conditions, such as fertility aspirations, when fertility rates are held constant over time, increased use of effective modern contraception corresponds to a reduction in the rate of abortions.[326]

[317] Gilda Sedgh et al " Induced abortion: Incidence and trends worldwide from 1995-2008; www.thelancet.com Vol. 379 February 18 2012
[318] Data compiled from Gilda Sedgh et al " Legal Abortion Worldwide: Incidence and Recent Trends" Journal: International Family Planning Perspectives 2007, 33(3):106-116
[319] World Health Organization (WHO), Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008, sixth ed., Geneva: WHO, 2011
[320] World Health Organization (WHO), Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008, sixth ed., Geneva: WHO, 2011.
[321] Gilda Sedgh et al " Induced abortion: Incidence and trends worldwide from 1995-2008; www.thelancet.com Vol. 379 February 18 2012.
[322] Gilda Sedgh et al " Induced abortion: Incidence and trends worldwide from 1995-2008"; www.thelancet.com Vol. 379 February 18 2012
[323] Gilda Sedgh et al " Induced abortion: Incidence and trends worldwide from 1995-2008"; www.thelancet.com Vol. 379 February 18 2012
[324] Gilda Sedgh et al " Induced abortion: Incidence and trends worldwide from 1995-2008"; www.thelancet.com Vol. 379 February 18 2012
[325] WHO, Women and Children's Health: Evidence of Impact of Human Rights, 2013, p. 60. http://apps.who.int/iris/bitstream/10665/84203/1/9789241505420_eng.pdf.; Benagiano G et al. Contraception: a social revolution. European Journal of Contraception and Reproductive Health Care, 2007, 12: 3-12
[326] Marston C, Cleland J, Relationships between contraception and abortion: A review of the evidence. *International Family Planning Perspectives, 2003, 29(1):6–13*

Figure 29
Rates of voluntary termination of pregnancy and use of oral contraceptives among women of reproductive age, Italy, 1978-2002



Source: WHO, Women and Children's Health: Evidence of Impact of Human Rights, 2013, p. 60. http://apps.who.int/iris/bitstream/10665/84203/1/9789241505420_eng.pdf

Gender equality can affect the risk of abortion by a variety of means, for example, by shifting social expectations for more couple conversations about contraception[327], by the repeal of discriminatory laws such as spousal notification/authorization laws or through stronger laws that reduce the threat of intimate-partner violence.[328]

Although there have been declines in abortion rates across all world regions between 1996 and 2003, the most significant decline was within Europe[329] (see Figure 30), reflecting relatively high rates of abortion in Eastern Europe in 1996, and steep declines in those rates by 2003. Abortion has been much lower and relatively stable over time in Western Europe.

Low rates of abortion in Western Europe reflect widespread access to contraceptive knowledge and methods, including comprehensive sexuality education for young people (see Box on the Netherlands, below), as well as high gender equality. These factors have created an enabling environment for the use of contraception, and lower abortion rates.

States should strive to eliminate the need for abortion by providing universal access to comprehensive sexuality education starting in adolescence, and sexual and reproductive health services, including modern methods of contraception, to all persons in need; by providing widespread affordable access to male and female condoms, and timely and confidential access to emergency contraception; by implementing school and media programmes that foster gender-

[327] Do, M., & Kurimoto, N. (2012). Women's empowerment and choice of contraceptive methods in selected African countries. *International Perspectives on Sexual and Reproductive Health*, *38*(1), 23-33; **M**osha, I. H., & Ruben, R. (2013). Communication, knowledge, social network and family planning utilization among couples in Mwanza, Tanzania. *African Journal of Reproductive Health*, *17*(3), 57-69.;
Bawah, AA. (2002). Spousal Communication and Family Planning Behavior in Navrongo: A Longitudinal Assessment. *Studies in Family Planning*. 33(2):185-194; De Silva, W. Indralal (1994) Husband-wife communication and contraceptive behaviour in Sri Lanka. *Journal of Family Welfare* 40(2): 1-13

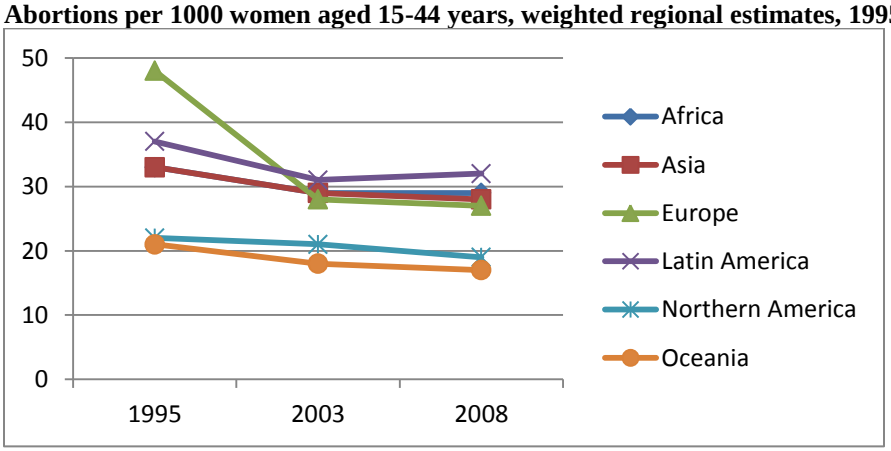
[328] Ely GE, Otis MD (2011) An examination of intimate partner violence and psychological stressors in adult abortion patients: *J Interpers Violence*, 26:3248., published online 30 January 2011; Kaye DK, Mirembe FM, Bantebya G, Johansson A, Ekstrom AM (2006) Domestic violence as risk factor for unwanted pregnancy and induced abortion in Mulago Hospital, Kampala, Uganda. *Tropical Medicine & International Health*, 11(1):90-101.; T.W. Leung, W.C. Leung, P.L. Chan, P.C. Ho, (2002) A comparison of the prevalence of domestic violence between patients seeking termination of pregnancy and other general gynecology patients, *International Journal of Gynecology & Obstetrics*, 77(1): 47-54; Kaye D (2001) Domestic violence among women seeking postabortion care. *International Journal of Gynecology and Obstetrics* 75, 523–5.; Ipas " Youth perspectives reveal abortion stigma and gender inequity are barriers to education on safe abortion" http://www.ipas.org/en/News/2013/October/Youth-perspectives-reveal-abortion-stigma-and-gender-inequity-are-barriers-to-education-on.aspx.

[329] Sedgh G et al., Induced abortion: incidence and trends worldwide from 1995 to 2008, *Lancet*, Vol 379, Feb 18, 2012.

equitable values and couple negotiations over issues of sex and contraception; and by respecting, protecting and promoting human rights through the enforcement of laws that allow women and girls to live free from gender based violence.

Figure 30

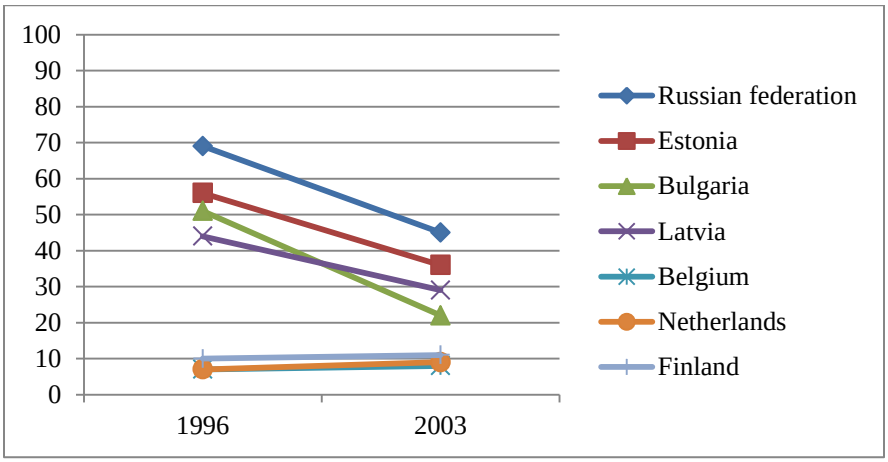
Abortions per 1000 women aged 15-44 years, weighted regional estimates, 1995, 2003, 2008



Source: Figures based on data reported in Sedgh G et al., "Induced abortion: incidence and trends worldwide from 1995 to 2008," *Lancet*, Vol 379, Feb 18, 2012.

Figure 31

Abortions per 1000 women aged 15-44 years in select European countries where abortion is legally available, 1996, 2003



Source: Figure based on data reported Gilda Sedgh et al "Induced abortion: Incidence and trends worldwide from 1995-2008; www.thelancet.com Vol. 379 February 18 2012

Table 1
Measures of legal abortion where reporting is relatively complete, 2001-2006

Country	*Year of last available estimate*	*Abortion Rate (abortions per 1,000 women 15-44)*	*Abortion Ratio (abortions per 100 live births)*
Cuba	2004	57	109
Russian federation	2003	45	104
Estonia	2003	36	82
Belarus	2003	35	91
Latvia	2003	29	69
Hungary	2003	26	57
Bulgaria	2003	22	52
United States	2003	21	31
New Zealand	2003	21	33
Australia	2003	20	34
Sweden	2003	20	34
Puerto Rico	2001	18	28
England and Wales	2003	17	29
France	2003	17	26
Slovenia	2003	16	40
Lithuania	2003	15	38
Denmark	2003	15	24
Norway	2003	15	25
Canada	2003	15	31
Singapore	2003	15	31
Israel	2003	14	14
Czech republic	2003	13	29
Slovakia	2003	13	31
Scotland	2003	12	23
Italy	2003	11	25
Finland	2003	11	19
Netherlands	2003	9	14
Germany	2003	8	18
Belgium	2003	8	14
Switzerland	2003	7	15
Tunisia	2000	7	9
South Africa	2003	6	6
Nepal	2006	5	4

Source: Data compiled from Gilda Sedgh et al "Legal Abortion Worldwide: Incidence and Recent Trends" Journal: International Family Planning Perspectives 2007, 33(3):106-116

The decline in abortion rates in Eastern Europe reflects increasing availability and use of modern family planning services and commodities after the breakup of the Soviet Union. However, the persistence of comparatively higher rates of abortion in recent estimations (Russian Federation (45), Estonia (36),

Belarus (35), Bulgaria (26), Latvia (29) 2001-05),[330] coinciding with rates of modern contraception use that are comparable to Western Europe (Contraceptive Prevalence Rates (CPR) any year available from 2000-2006; Russian Federation (64.6), Estonia (57.9), Belarus (56), Bulgaria (40.1), Latvia (55.5)),[331] suggest a lag in effective use behaviour or possible contraceptive failure. A similar discordance is evident in Cuba, which has among the highest abortion rates worldwide (57 per 1,000 women 15-44),[332] and yet comparatively high reported rates of modern contraceptive use (CPR: 72.1 in 2000 and 71.6 in 2006).[333] These cases underscore that access to contraception is necessary, but may not be sufficient, to reduce abortion, and other cultural behaviours may demand understanding and intervention, including the social and symbolic meaning associated with the use of contraception in certain relationships, norms for communication between partners, social expectations of sexual practice, the local meaning associated with abortion, and the risk of forced sex.

Important gains have been made in reducing deaths due to unsafe abortion since 1994, most notably in countries that have undertaken complementary and comprehensive changes in both law and practice to treat abortion as a public health concern (see example from Uruguay, below). Nonetheless, the number of abortion-related deaths has held steady in recent years even as maternal deaths overall have continued to fall. As of 2008, an estimated 47,000 maternal deaths were attributed to unsafe abortion, a decline from 69,000 deaths in 1990.[334] But given that the number of deaths due to unsafe abortion has declined more slowly than the overall number of maternal deaths, unsafe abortions appear to account for a growing proportion of maternal deaths globally.[335]

Case study: Eliminating maternal deaths resulting from unsafe abortions

Uruguay[336]

Since 2001 Uruguay has achieved important progress in the reduction of maternal deaths resulting from unsafe abortions through the implementation of the "Health initiatives against unsafe abortion" programme (HIAUA). HIAUA is based on commitments to fulfil the ICPD Programme of Action (1994). The model aims to reduce the risks and morbidities caused by unsafe abortions, which accounted for 42 per cent of maternal deaths in 2001, 28 percent in 2002 and 55 per cent in 2003.

The model is based on three pillars: respect for a woman's decision; confidentiality and committed professional practice; and treating abortions as a public health issue rather than a legal or criminal matter. All women, including adolescents, have access to a multidisciplinary team of gynecologists, midwives, psychologists, nurses and social workers who provide pre- and post-abortion information, counseling and care, including information on alternatives to abortion, existing abortion methods and their risks, within a comprehensive health care approach that includes the management of complications, rehabilitation, and access to contraception. A key to success is the fact that all sexual and reproductive health professionals are trained to provide pre and post abortion counseling.

Encouraging results were observed shortly after the implementation of the model. From 2004 to 2007 Uruguay registered a maximum of 2 cases of maternal deaths from unsafe abortion, and from 2008-11

[330] Gilda Sedgh et al " Legal Abortion Worldwide: Incidence and Recent Trends"International Family Planning Perspectives 2007, 33(3):106-116.
[331] CPR data from MDG Indicators database; mdgs.un.org/unsd/mdg/data.aspx
[332] Gilda Sedgh et al " Legal Abortion Worldwide: Incidence and Recent Trends"International Family Planning Perspectives 2007, 33(3):106-116.
[333] Contraceptive Prevalence Rate data from MDG Indicator Database: mdgs.un.org/unsd/mdg/data.aspx
[334] Ahman, E and Shah, I, New estimates and trends regarding unsafe abortion mortality, International Journal of Gynecology and Obstetrics, 2011 doi:10.1016/j.ijgo.2011.05.027.
[335] Ringheim K. "Sexual and Reproductive Health and Rights Thematic Report" Background Document for ICPD Beyond 2014 Review (June 2013)
[336] República Oriental del Uruguay - Ministerio de Salud Pública, "Modelo Uruguayo de Prevención de Riesgo y Daño", 2013.

reached zero maternal deaths from unsafe abortion. According to WHO, this model can be adapted and replicated in country's abortion laws.

In 2012, Uruguay became the third country in Latin America after Cuba and Guyana to decriminalize abortion through the Law on the Voluntary Termination of Pregnancy, which guarantees a woman's right to safe abortion during the first twelve weeks of pregnancy, and fourteen weeks in case of rape. Adolescents are included in this law under the notion of "progressive autonomy", based on the Child and Adolescent Code Act. 8, which refers to the development process of the evolving capacities of each individual to enable the fulfilment of all rights.

Both initiatives, along with the Law on the Protection of the Right to Sexual and Reproductive Health Care (2008), which requires public and private health providers to provide comprehensive sexual and reproductive health services, including private and confidential counseling, and access to free, quality contraception in public services, and the Sexuality Education Act (2009), which institutionalizes sex education at all levels of formal education, from kindergarten to teacher training, have contributed to Uruguay's attainment of the lowest maternal mortality rate in Latin America and the third lowest in the Americas. In the last year for which data is available, 2012, the maternal mortality ratio, in Uruguay, was 10.3/100,000 live births.

Nearly all abortions in Africa (outside of Southern Africa) and in Central and South America remain unsafe (97 per cent).[337] But even this masks dramatic differences in the risk of death due to abortion, which is 15 times higher in Africa than in Latin America and the Caribbean.[338] It is also in Africa where the number of deaths due to unsafe abortion have declined least since 1990.[339] The estimated decline in deaths in Latin America was from 80 to 30 per 100,000 abortions, whereas in Africa it declined from a staggering rate of 680 to 460 deaths per 100,000 abortions (and to 520 per 100,000 in sub-Saharan Africa). [340]

The Programme of Action acknowledged that unsafe abortion was a major public health concern, and that Governments had a responsibility to provide for post abortion care and counseling. In 1995, WHO elaborated technical recommendations to improve the quality of abortion-related services where such services were legal, and the urgent care of women arriving with post abortion complications, of particular relevance to countries where abortion is not legal.[341] In 1999, with the five year review of the ICPD[342] WHO began a series of consultations that resulted in the publication of "Safe Abortion: Technical and Policy Guidance for Health Systems," which was eventually approved in July 2003, and published in numerous languages, both official and non-official WHO languages.[343] Several agencies attribute the recent decline in abortion-related case fatalities to the growing use of these WHO guidelines.

States should take concrete measures to urgently reduce abortion-related complications and deaths by increasing access to non-discriminatory post-abortion care for all women suffering from

[337] Gilda Sedgh et al " Induced abortion: Incidence and trends worldwide from 1995-2008"; www.thelancet.com Vol. 379 February 18 2012
[338] Ahman, E and Shah, I, New estimates and trends regarding unsafe abortion mortality, International Journal of Gynecology and Obstetrics, 2011 doi:10.1016/j.ijgo.2011.05.027
[339] WHO, Safe abortion, technical and policy guidance for health systems. Second edition. Geneva: WHO, 2012
[340] WHO, Safe abortion, technical and policy guidance for health systems. Second edition. Geneva: WHO, 2012
[341] Paul F. A. Van Look, Jane Cottingham, "WHO's Safe Abortion Guidance Document," American Journal of Public Health, April 2013 (103)(4), pp. 593-6.
[342] ICPD + 5 review, Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development (1999), paras. 63 i, ii.
[343] World Health Organization, Department of Reproductive Health and Research, *Safe abortion: technical and policy guidance for health systems*, 2nd ed., (Geneva, 2003, 2012), retrieved from http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf

complications of unsafe abortion and ensure that all providers take action in line with the WHO "Technical and Policy Guidelines for Access to Safe Abortion", to deliver quality care and remove legal barriers to services. States should remove legal barriers preventing women and girls from access to safe abortion, including revising restrictions within existing abortion laws, in order to safe guard the lives of women and girls, and where legal, ensure that all women have ready access to safe, good-quality abortion services.

The Global Survey found that only 50 per cent of countries addressed the issue of "providing access to safe abortion services to the extent of the law" during the past five years. A larger proportion of countries (65 per cent), however, address the issue of "preventing and managing the consequences of unsafe abortion". The proportion of governments addressing this issue is inversely proportional to the wealth of the countries. Thus while 69 per cent of the lowest income countries address this issue via policy, budget and concrete actions, only 29 per cent of the wealthiest do the same. This may reflect the higher prevalence of unsafe abortions in low-income countries.

Access to safe and comprehensive abortion services and to the management of abortion complications varies widely across and within countries and regions. Regarding management of abortion complications, evidence based on MNPI data underscore that women dwelling in rural areas have significantly less access to such services across most developing countries.[344]

When grouping countries by the current status of their abortion laws (*Most, Less, Least Restrictive*[345]), the proportion of countries that address the issue of "preventing and managing the consequences of unsafe abortion" is lowest (72 per cent) among countries with the most restrictive laws. Likewise, only 48 per cent of countries with the most restrictive laws address the issue of "access to safe abortion to the extent of the law."

Human rights elaborations since the ICPD: Abortion

Other soft law: Since 1994 human rights standards have evolved to strengthen and expand States' obligations regarding abortion. In a series of *Concluding Observations*, treaty monitoring bodies have highlighted the relationship between restrictive abortion laws, maternal mortality, and unsafe abortion[346]; condemned absolute bans on abortion[347]; and urged states to eliminate punitive measures against women and girls who undergo abortions and providers who deliver abortion services.[348] Further, treaty monitoring bodies have emphasized that, at a minimum, state should decriminalize abortion and ensure access to abortion when the pregnancy poses a risk to a women's health or life, where there is severe fetal abnormality, and where the pregnancy is the result of rape or incest.[349] However, the Human

[344] Analysis based on data from Maternal and Neonatal Program Effort Index (MNPI), http://www.policyproject.com/pubs/mnpi/getmnpi.cfm
[345] U.N. Population Division, World Abortion Policy, 2013.
[346] CEDAW, *Concluding Observations: Paraguay*, para 31(a), U.N. Doc. CEDAW/C/PRY/CO/6 (2011); *Chile*, para 20, U.N. Doc. CEDAW/C/CHI/CO/4 (2006); ESCR Committee, *Concluding Observations: Philippines*, para 31, U.N. Doc. E/C.12/PHL/CO/4 (2008); Human Rights Committee (HRC), *Concluding Observations: Zambia*, para. 18, U.N. Doc. CCPR/C/ZMB/CO/3 (2007).
[347] CAT, *Concluding Observations: Nicaragua*, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009); HRC, *Concluding Observations: El Salvador*, para. 10, U.N. Doc. CCPR/C/SLC/CO/6 (2010); ESCR Committee, *Concluding Observations: Chile*, paras. 26, 53, U.N. Doc. E/C.12/1/Add.105 (2004).
[348] CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, para. 14, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) at 358 (2008); HRC, *Concluding Observations; Costa Rica*, para. 11, U.N. Doc. CCPR/C/79/Add.107 (1999); CRC Committee, *Concluding Observations: Nicaragua*, para. 59(b), U.N. Doc CRC/C/NIC/CO/4 (2010).
[349] CRC Committee, *Concluding Observations: Chad*, para.30, U.N. Doc. CRC/C/15/Add.107 (1999); *Chile*, para. 56, U.N. Doc. CRC/C/CHL/CO/3 (2007); *Costa Rica*, para. 64(c), U.N. Doc. CRC/C/CRI/CO/4 (2011); HRC, *Concluding Observations: Guatemala*, para. 20, U.N. Doc. CCRP/C/GTM/CO/3 (2012); ESCR Committee, *Concluding Observations: Dominican Republic*, para. 29, U.N. Doc E/C.12/DOM/CO/3 (2010); *Chile*, para. 53, U.N. Doc. E/C.12/1/Add.105 (2004).

Rights Committee noted that such exceptions might be insufficient to ensure women's human rights, and that where abortion is legal it must be accessible, available, acceptable and of good quality.[350] Regardless of legal status, treaty bodies have highlighted that states must ensure confidential and adequate post-abortion care.[351]

(a) Abortions among young women

Forty-one per cent (8.7 million) of all unsafe abortions occurred among young women aged 15-24 years in developing countries in 2008, of this number 3.2 million unsafe abortions were among 15-19 year olds.[352] Young adolescents face a higher risk of complications from unsafe abortions, and women under the age of 25 account for almost half of all abortion deaths.[353] Evidence points to the fact that adolescents are more susceptible to delay seeking an abortion, and even in countries where abortion may be legal, they resort to unsafe abortion providers due to fear, lack of knowledge and financial resources.[354] Closer examination of policy and practice in low-abortion countries such as the Netherlands may offer valuable lessons on reducing unwanted pregnancies in other countries.

Case study: Effective family planning strategies result in very low abortion rates

The Netherlands

The Netherlands provides an excellent example of a country where a pragmatic and comprehensive approach to family planning – especially for young people - has resulted in one of the lowest abortion rates worldwide. By the late 1960s family doctors in the Netherlands offered family planning services. In 1971, family planning was included in the national public health insurance system, providing free contraceptives. Sexual education is universal and comprehensive, and women's empowerment is among the highest worldwide. Sexually active young people display some of the highest rates of contraceptive use of any youth population, and as a consequence, the Dutch abortion rate fluctuates between 5 and 9 per 1000 women age 15-44, one of the lowest rates in the world. Abortion in the Netherlands is legal, safe, easily accessible and rare.[355]

Governments committed themselves in the Programme of Action to place the highest priority on preventing unwanted pregnancies, and thereby making "every attempt to eliminate the need for abortion". Closer examination of policy and practice in low-abortion countries such as the Netherlands may offer valuable lessons on reducing unwanted pregnancies in other countries.

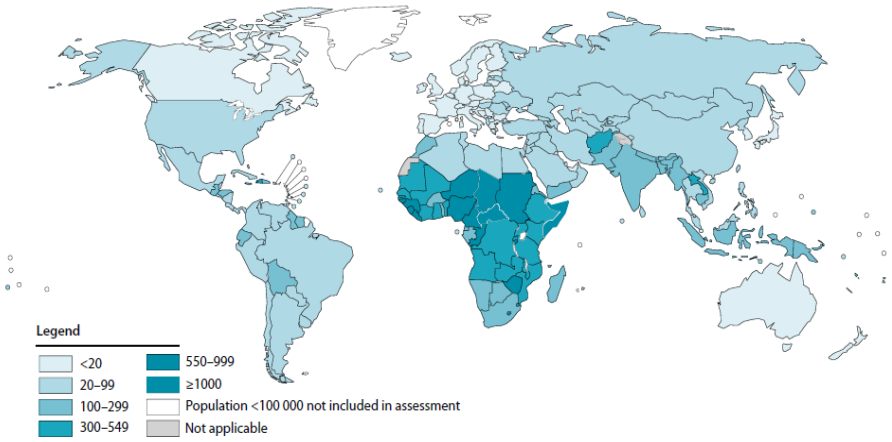
5. Maternal mortality

Of all sexual and reproductive health indicators, the greatest gains since 1994 have been made in the maternal mortality ratio (MMR). In 1994, more than half a million women died each year from largely preventable causes related to pregnancy and childbirth, and by 2010 the maternal mortality ratio had declined by 47 per cent from 400 in 1990 to 210 maternal deaths per 100,000 live births.[356]

[350] HRC, *Concluding Observations: Poland*, para. 8, U.N. Doc. CCPR/CO/82/POL (2004).
[351] ESCR Committee, *Concluding Observations: Slovakia*, para. 24, U.N. Doc. E/C.12/SVK/CO/2 (2012); CEDAW Committee, *Concluding Observations: Chile*, para. 20, U.N. Doc. CEDAW/C/CHI/CO/4 (2006).
[352] Shah I., Ahman E, Unsafe abortion Differentials in 2008 by age and developing country region: High burden among young women: Reproductive Health Matters 2012;20(39):169–173
[353] World Health Organization (WHO), *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008*, sixth ed., Geneva: WHO, 2011.
[354] Shah, I and Ahman, E, Unsafe abortion differentials in 2008 by age and developing country region: high burden among young women. Reproductive Health Matters, 2012 20 (39);169-173.
[355] Sexual and Reproductive Health: The Netherlands in International Perspective. 2009. http://www.rutgerswpf.org/sites/default/files/Sexual-and-reproductive-health.pdf
[356] UNFPA, UNICEF, WHO, World Bank. (2012). Trends in Maternal Mortality: 1990-2010. World Health Organization, Geneva, 2012. Retrieved from: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf.

However, an estimated 800 women in the world still die from pregnancy or childbirth-related complications each day, and the differences between developed and developing regions remain stark. In 2010, developing countries accounted for 99 per cent of all maternal deaths globally.[357] Women in the developed world have only a one in 3800 lifetime risk of dying of maternal causes, while the lifetime risk for those in developing regions is one in 150, and in sub-Saharan Africa, the lifetime risk is one in 39.[358] While still short of reaching the MDG goal 5a[359] globally, by 2010 ten countries had reached this goal, with another nine on track to reach MDG goal 5a by 2015.[360] However, twenty-six countries have experienced an *increase* in maternal deaths since 1990, in large part due to deaths related to HIV, and in sub-Saharan Africa, HIV and maternal causes now compete as the two predominant causes of women's premature death. [361]

Figure 32
Maternal Mortality Ratio by country, 2010
(death per 100,000 live births)



Source: WHO, UNICEF, UNFPA and the World Bank estimates, Trends in maternal mortality 1990-2010. World Health Organization, Geneva, 2012.

Note: 40 countries had high MMR in 2010. Of these countries, only Chad and Somalia had extremely high MMR at 1100 and 1000, respectively. The other eight highest MMR countries were: Central African Republic (890), Sierra Leone (890), Burundi (800),Guinea-Bissau (790), Liberia (770), Sudan (730), Cameroon (690) and Nigeria (630). Although most sub-Saharan African countries had high MMR, Mauritius (60), Sao Tome and Principe (70) and Cape Verde (79) had low MMR, while Botswana (160), Djibouti (200), Namibia (200), Gabon (230),Equatorial Guinea (240), Eritrea (240) and Madagascar (240) had moderate MMR. Only four countries outside the sub-Saharan African region had high MMR: Lao People's Democratic Republic (470), Afghanistan (460), Haiti (350), and Timor-Leste (300).

Countries with unacceptably high maternal mortality ratios remain concentrated in developing regions, predominantly in sub-Saharan Africa, where numerous factors, including poverty and fragile health systems perpetuate higher rates of maternal death.[362]

Postpartum hemorrhage (PPH), sepsis, obstructed labour, complications of unsafe abortion and

[357] UNFPA, UNICEF, WHO, World Bank. (2012). Trends in Maternal Mortality: 1990-2010. World Health Organization, Geneva, 2012. Retrieved from: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf.
[358] UNFPA, UNICEF, WHO, World Bank. (2012). Trends in Maternal Mortality: 1990-2010. World Health Organization, Geneva, 2012. Retrieved from: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf.
[359] MDG Target 5.A. Reduce by three quarters the maternal mortality ratio.
[360] Bangladesh, Cambodia, China, Egypt, Equatorial Guinea, Eritrea, Lao PDR, Nepal and Vietnam. Independent Expert Review Group on Information and Accountability for Women's and Children's Health, Every Woman, Every Child: From Commitment to Action, Geneva: WHO, 2012.
[361] UNFPA, UNICEF, WHO, World Bank. (2012). Trends in Maternal Mortality: 1990-2010. World Health Organization, Geneva, 2012. Retrieved from: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf.
[362] UNFPA, UNICEF, WHO, World Bank. (2012). Trends in Maternal Mortality: 1990-2010. World Health Organization, Geneva, 2012. Retrieved from: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf.

hypertensive disorders, all preventable, are among the leading causes of maternal deaths.[363] Wealth and spatial inequalities in women's access to adequate emergency obstetric care for the management of these conditions abound within countries, highlighting the inadequate reach of skilled providers and quality health services for many poor women, especially in rural or remote areas.

Gains in maternal survival over the past 20 years can be attributed, in part, to advances in the use of antenatal care, skilled attendance at delivery, emergency obstetric care, and family planning among select sectors of society, yet the majority of developing countries are not on target to achieve Millennium Development Goal 5 (improving maternal health), with the targets a) to reduce the maternal mortality ratio by three-quarters between 1990 and 2015; and b) achieve, by 2015, universal access to reproductive health; in no region is the gap more pronounced than in sub-Saharan Africa.[364]

States should eliminate preventable maternal mortality and morbidity as urgently as possible by strengthening health systems and thereby ensuring universal access to quality prenatal care, skilled attendance at birth, emergency obstetric care, and postnatal care for all women, including those living in rural and remote areas.

Human rights elaborations since the ICPD: Maternal mortality

Intergovernmental human rights outcomes: The Human Rights Council has passed multiple resolutions declaring that maternal mortality violates human rights, including *Resolution 18/2 Preventable Maternal Mortality and Morbidity and Human Rights* (2011) which recognizes that, "a human rights-based approach to eliminate preventable maternal mortality and morbidity is an approach underpinned by the principles of, inter alia, accountability, participation, transparency, empowerment, sustainability, non-discrimination and international cooperation" and "encourages States and other relevant stakeholders, including national human rights institutions and non-governmental organizations, to take action at all levels to address the interlinked root causes of maternal mortality and morbidity, such as poverty, malnutrition, harmful practices, lack of accessible and appropriate health-care services, information and education, and gender inequality, and to pay particular attention to eliminating all forms of violence against women and girls."

(a) Maternal morbidity and reproductive cancers

For every woman who dies of pregnancy related causes, an estimated 20 others experience a maternal morbidity,[365] including severe and long-lasting complications. The underlying causes of maternal morbidity are the same as the underlying causes of maternal death[366] – including poverty and lack of skilled care. Most of these, including obstetric fistula, are entirely preventable with skilled care at birth, and emergency obstetric care as a backup.

Obstetric fistula represents the face of failure as a global community to protect the sexual and reproductive health and rights of women and girls, and achieve equity in the distribution and access to comprehensive sexual and reproductive health services. An estimated 2-3.5 million women live with obstetric fistula in the developing world, mostly in sub-Saharan Africa and Asia where adolescent births are highest and access to emergency obstetric care is low, and between 50,000 and 100,000 new cases

[363] Patton, C, Coffey, C, Sawyer, S, Viner, R, Haller D, Bose, Vos, T, Ferguson, J and Mathers, C, Global patterns of mortality in young people: a systematic analysis of population health data. Lancet, 2009. 374:881-892.
[364] Ahman, E and Shah, I, New estimates and trends regarding unsafe abortion mortality, International Journal of Gynecology and Obstetrics, 2011 doi:10.1016/j.ijgo.2011.05.027; WHO, UNICEF, UNFPA and The World Bank, Trends in maternal mortality: 1990 to 2010, World Health Organization, Geneva, 2012. Retrieved from: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf.
[365] UNFPA, Maternal morbidity. Surviving childbirth but enduring chronic ill health. www.unfpa.org/publi/mothers/pid/4388 accessed 4/22/2103.
[366] WHO, Maternal health. www.who.int/topics/maternal_health/en/ accessed 4/22/2013

develop each year. All but eliminated from the developed world, obstetric fistula continues to affect the poorest of the poor: women and girls living in some of the most under-resourced regions in the world. [367] **States should implement measures to ensure the elimination of obstetric fistula through the provision of high quality maternal health care to all women, and provide for the rehabilitation and reintegration of fistula survivors into their communities.**

Maternal morbidity should be utilized as an indicator of quality sexual and reproductive health services and the progressive realization of women's right to health.

The Programme of Action included commitments to address infertility, and cancers of the reproductive systems. Infertility is not only a great personal sadness for many women and couples, but in many parts of the world, a woman's inability to become pregnant is cause for social exclusion and even divorce. The Programme of Action called for prevention and treatment of sexually transmitted infections, a leading cause of secondary infertility, as well as for treatment of infertility where feasible. About two per cent of women globally are unable to conceive (primary infertility) and nearly 11 per cent are unable to conceive another child after having at least one (secondary infertility). In low-income countries, infertility is often caused by sexually transmitted infections and complications from unsafe abortion.[368] Infertility is highest in some countries of South Asia (up to 28 per cent) and sub-Saharan Africa (up to 30 per cent), but primary infertility has declined in South Asia, and both types of infertility have declined in sub-Saharan Africa. Due to population growth, the number of couples affected by infertility globally rose from 42 million in 1990 to 48.5 million in 2010.[369]

More than a half million women each year develop cervical cancer, the second most common cancer among women ages 15 to 44 worldwide. More than 275,000 women die of the disease each year, the great majority (242,000) in developing regions, especially sub-Saharan Africa. While the Global Survey was carried out before widespread appreciation of the impact of the human papilloma virus (HPV) vaccine, and therefore did not include questions on this topic, this advancing technology has significant promise for curtailing cervical cancer.[370]

Breast cancer was, and remains, the most common cancer among women in high-income countries, currently affecting 70 per 100,000 women. Incidence is less than half in low-income countries, but because of poor access to diagnosis and treatment, mortality in the developing world is similar to that in developed countries.[371]

States should recognize and address the rising burden of reproductive cancers associated with rising life expectancy, especially breast and cervical cancer, by investing in routine screening at primary care, and referral to skilled cancer providers at higher levels of care.

(b) Antenatal care

The percentage of pregnant women who had at least one antenatal care visit increased globally from 63

[367] Wall, L, Arrow smith, S, Briggs, N et al,. The obstetric vesicovaginal fistula in the developing world, in Obstetrics and Gynecological Survey, 2005. Vol 60. no 7, Supplement 1.; Bernstein, S and Hansen, C, Public Choices, Private Decisions, Achieving the Millennium Development Goals. New York: Millennium Project, 2006.; Campaign to End Fistula. ww.endfistula.org.; Osotimehin, B, Obstetric fistula: ending the health and human rights tragedy. Lancet 381(9879):1702-3, May 18, 2013

[368] WHO, Women and Health, Today's Evidence, Tomorrow's agenda. Geneva: WHO, 2009.

[369] Mascarenhas, M, Flaxman, S, Boerma, T, et al, National, Regional and Global trends in infertility prevalence since 1990: A systematic analysis of 277 health surveys. PLOS Medicine, Dec 2012. Vol 9, Issue 12. e1001356.

[370] WHO, Human Papillomavirus and related cancers. Summary Report Update Nov. 15, 2010. International Agency for Research on Cancer, www.Globocan.iarc.fr

[371] WHO, Women and Health: Today's Evidence Tomorrow's Agenda, 2009. Retrieved from: http://whqlibdoc.who.int/publications/2009/9789241563857_eng.pdf

per cent in 1990 to 80 per cent in 2010, an overall improvement of approximately 30 per cent. Again, these accomplishments mask regional disparities:[372] Southern Africa had achieved 94 per cent coverage of antenatal care by 2010, whereas in West Africa only 67 per cent of pregnant women had at least one antenatal care visit. In Latin America, nearly all women now have at least one antenatal care visit (96 per cent) and 88 per cent have at least four.[373]

According to the Global Survey, 88 per cent of countries have addressed the issue of "increasing access to antenatal care" in the past five years. On average, countries addressing this issue (green solid line, see Annex I, Figure 10) have MMR levels higher than countries that did not report addressing it (orange solid line), suggesting targeted attention by governments with higher MMR levels at the time of the survey. Furthermore, we can associate higher government attention with a steeper decline in MMR, as is most clearly visualized among low-income countries.

In spite of a high proportion of countries addressing the issue of antenatal care reported, a reduced proportion of countries have adopted policies, budgets and implementation measures to "provide adequate food and nutrition to pregnant women" (71 per cent) during the past five years, and even fewer report addressing the issue of "providing social protection and medical support for adolescent pregnant women" (65 per cent).

(c) Skilled attendance at birth

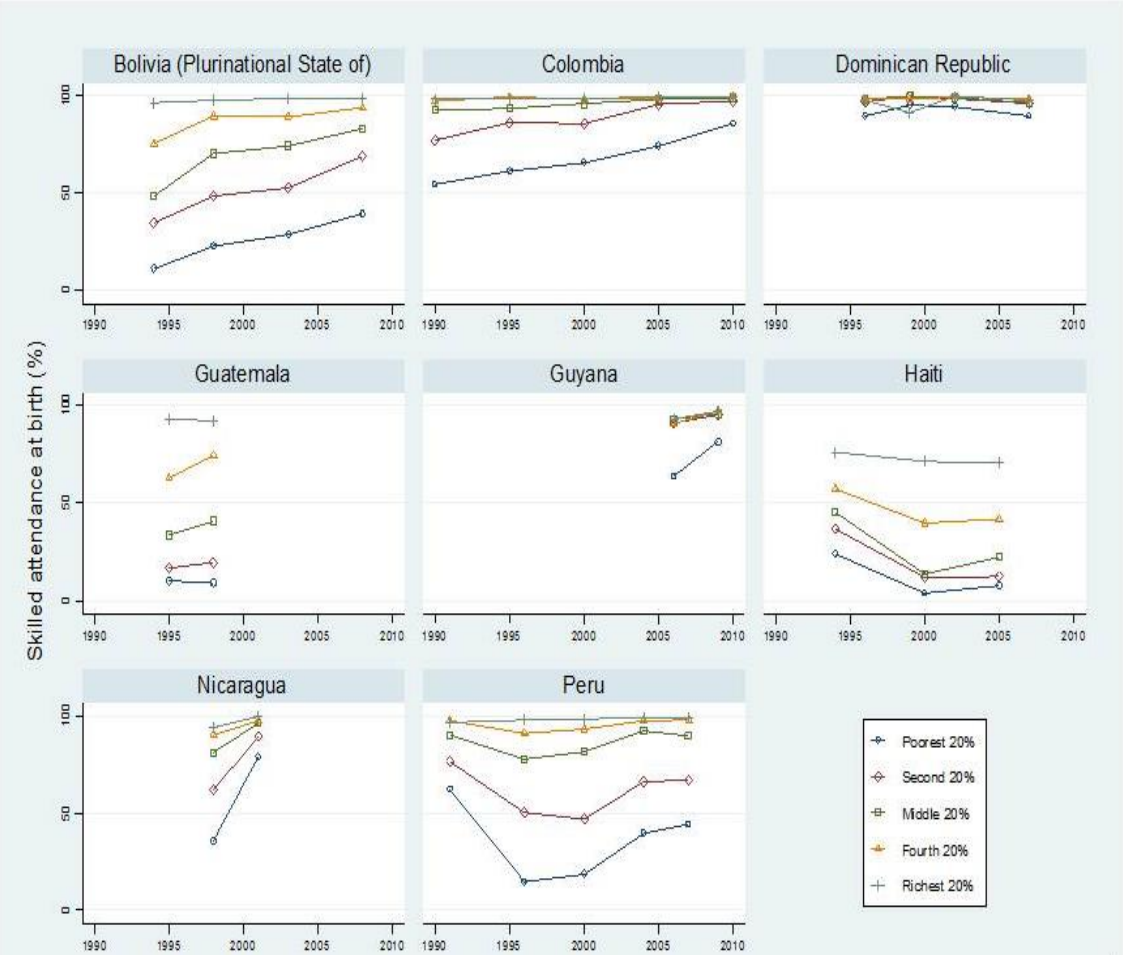
The proportion of deliveries attended by skilled health personnel rose in developing countries from 56 per cent in 1990 to 67 per cent in 2011.[374] Despite the positive trends, access to good maternal health care remains highly inequitable across regions and within countries between poor and wealthier women. Skilled attendance at birth shows the greatest inequity according to wealth, as illustrated by the differential progress within countries when stratified by wealth quintiles (Figure 33 through Figure 36).

Comparing Figure 33 through Figure 36 to Figure 24 through Figure 27 reveals that the distribution of CPR by wealth quintiles is more equitable than the distribution of skilled birth attendance, with greater reach to the poor. Indeed, contraception is operationally far easier for weak health systems to offer than skilled birth attendance, as pill or condom distribution does not rely on the availability of skilled health workers to respond urgently to a woman in need – and can be passively provided long in advance of actual need. Disparities in skilled attendance highlight the limited capacity of many existing health systems to provide fundamental SRH care to poor women.

Differences in access among urban and rural women are also strikingly inequitable – with rural women much less likely than urban women to have a skilled attendant during delivery. This is driven in part by a profound health worker shortage in the 58 countries in which 91 per cent of maternal deaths occur. In the aggregate, little progress was seen in skilled birth attendance in sub-Saharan Africa as a region, where fewer than half of all births are attended by skilled personnel.[375]

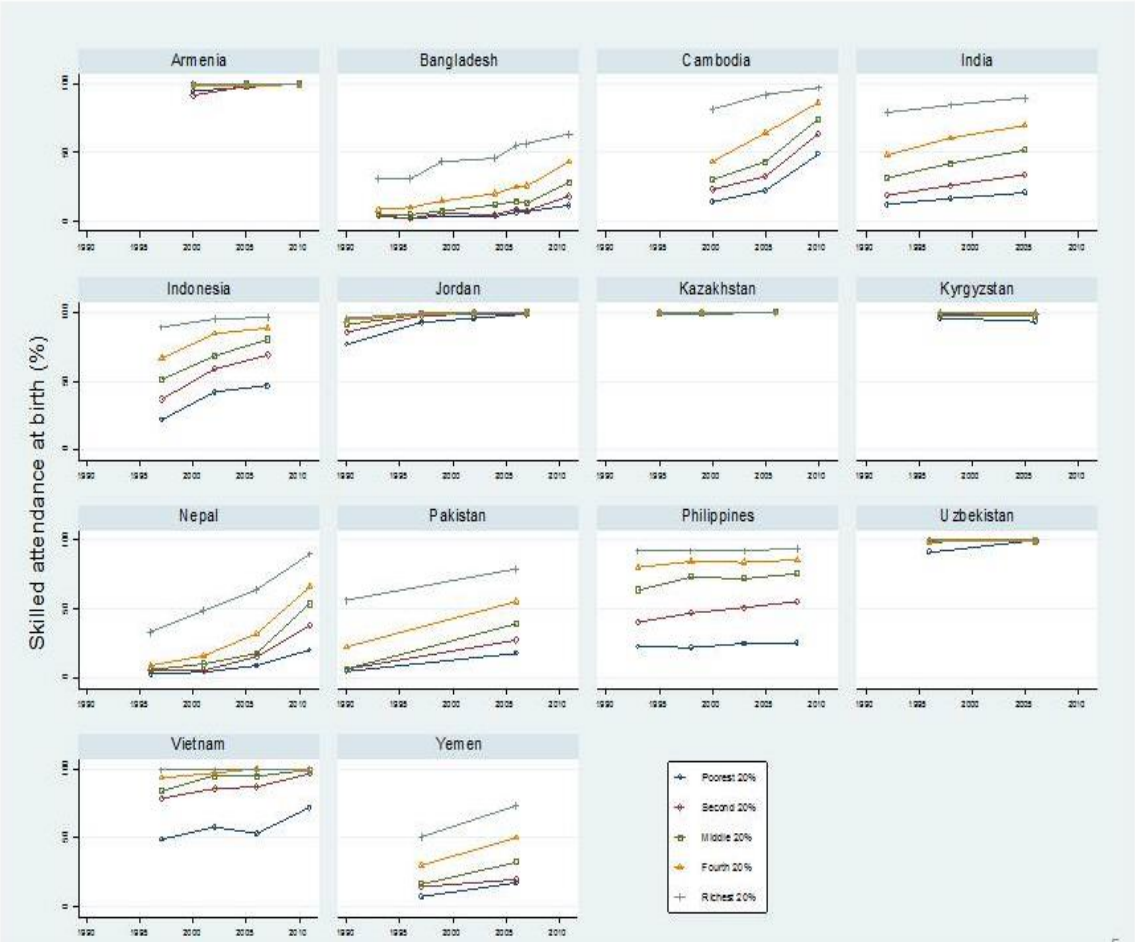
[372] International Federation of Red Cross and Red Crescent Societies, Eliminating health inequities. Every women and every child counts, The Partnership for Maternal, Child and Newborn Health, WHO: Geneva, 2011; UN, Millennium Development Goals Report 2012. New York: United Nations, 2012.
[373] International Federation of Red Cross and Red Crescent Societies, Eliminating health inequities. Every women and every child counts, The Partnership for Maternal, Child and Newborn Health, WHO: Geneva, 2011; UN, Millennium Development Goals Report 2012. New York: United Nations, 2012.
[374] United Nations, 2013. Millennium Development Goals, targets and indicators, 2013: statistical tables.
[375] UNFPA, The State of the World's Midwifery, 2010. Delivering Health, Saving Lives, p 29-30.

Figure 33
Trends in skilled attendance at birth in the Americas by wealth quintiles



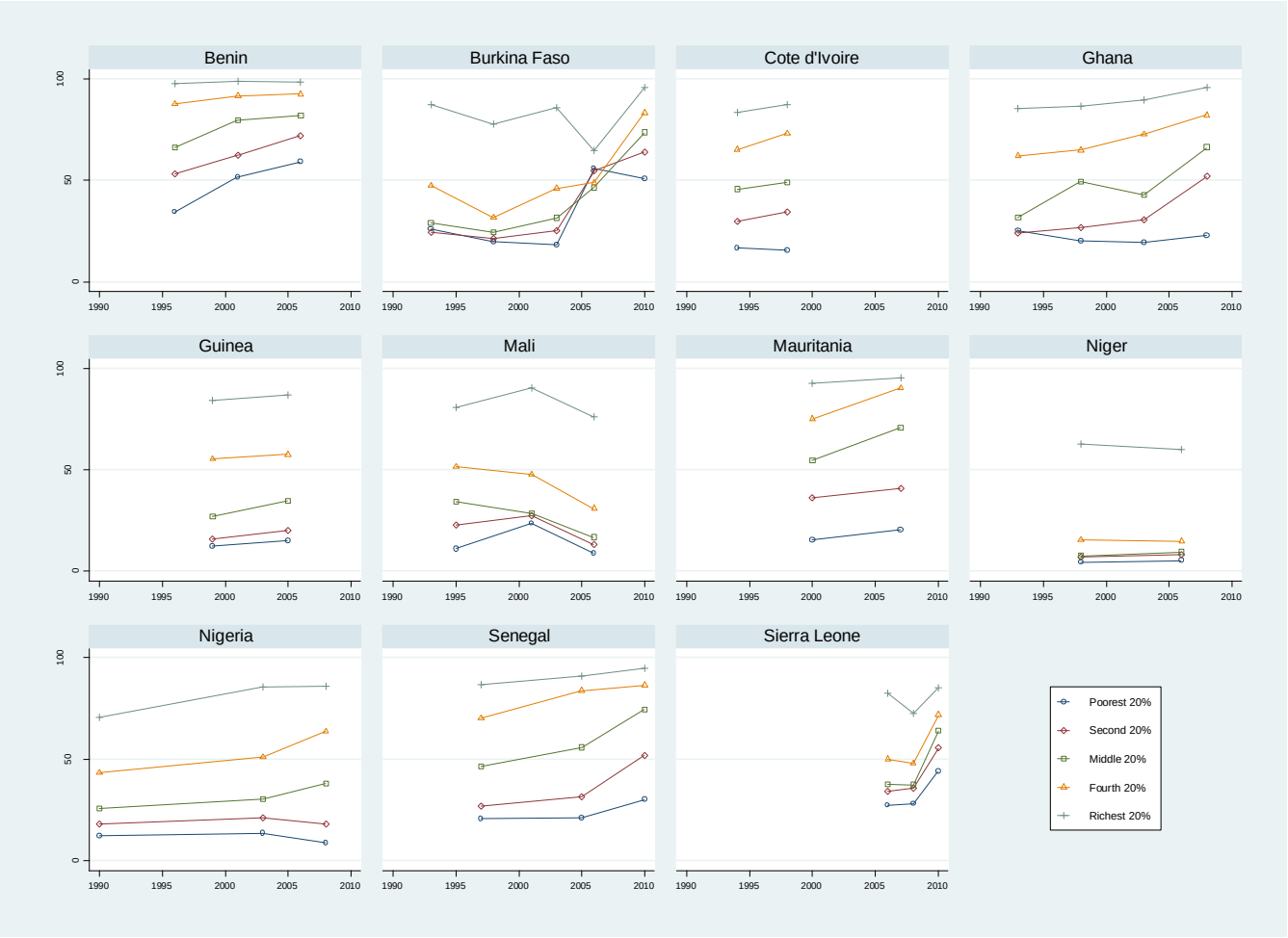
Source: Demographic and Health Surveys, all countries with available data for at least 2 timepoints, retrieved from www.measuredhs.com on 15 June 2013; Multiple Indicator Cluster Surveys, retrieved from http://www.unicef.org/statistics/index_24302.html on 15 June 2013

Figure 34
Trends in skilled attendance at birth in Asia by wealth quintiles



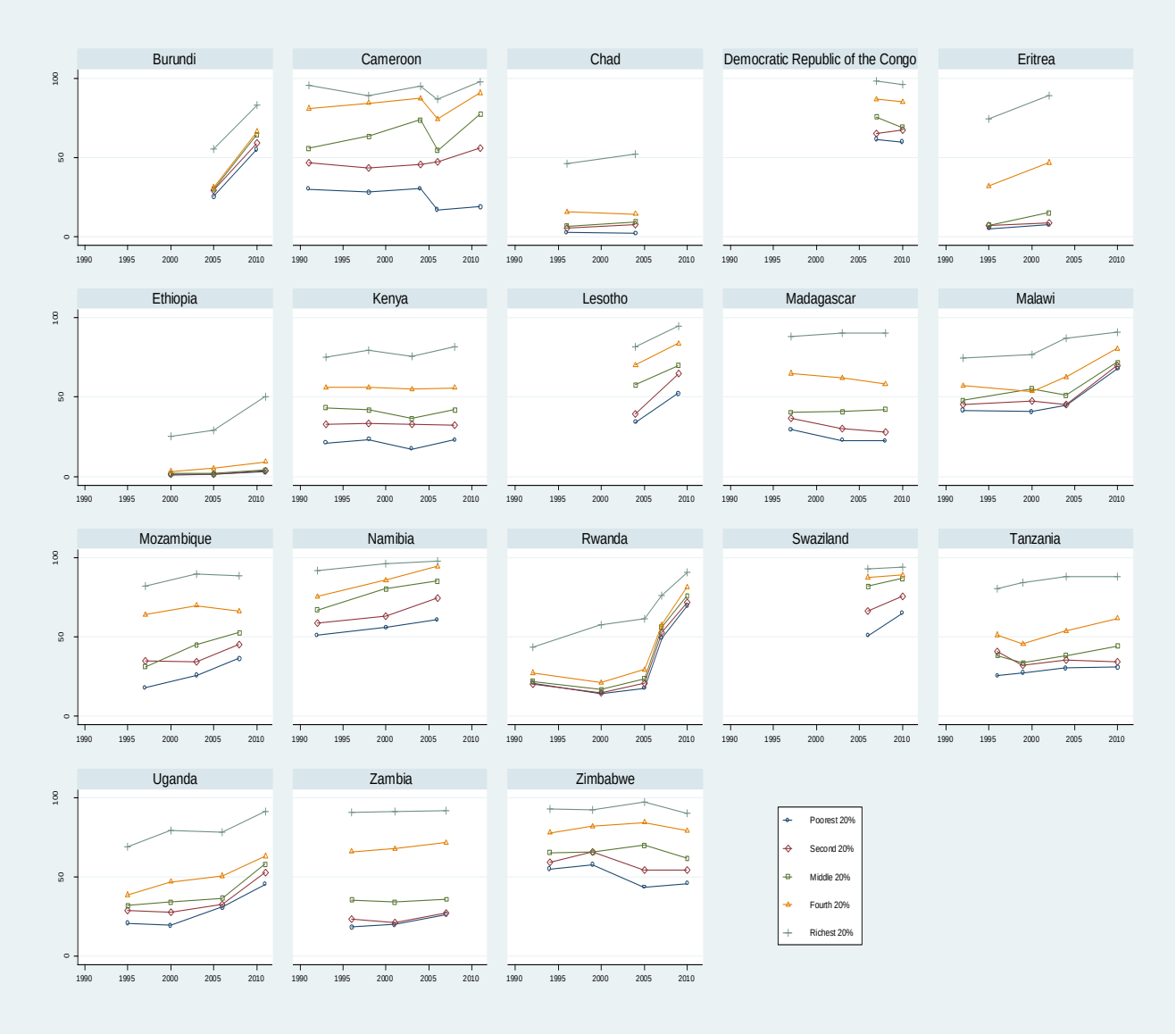
Source: Demographic and Health Surveys, all countries with available data for at least 2 timepoints, retrieved from www.measuredhs.com on 15 June 2013; Multiple Indicator Cluster Surveys, retrieved from http://www.unicef.org/statistics/index_24302.html on 15 June 2013

Figure 35
Trends in skilled attendance at birth in Northern and Western Africa by wealth quintiles



Source: Demographic and Health Surveys, all countries with available data for at least 2 timepoints, retrieved from www.measuredhs.com on 15 June 2013; Multiple Indicator Cluster Surveys, retrieved from http://www.unicef.org/statistics/index_24302.html on 15 June 2013

Figure 36
Trends in skilled attendance at birth in Eastern, Middle and Southern Africa by household wealth quintiles



Source: Demographic and Health Surveys, all countries with available data for at least 2 timepoints, retrieved from www.measuredhs.com on 15 June 2013; Multiple Indicator Cluster Surveys, retrieved from http://www.unicef.org/statistics/index_24302.html on 15 June 2013

The availability and accessibility of skilled attendance at birth provided by adequately trained health care personnel ensures a safe normal delivery for every woman, significantly reducing the risks of delivery complications and thus the need for emergency obstetric care (EmOC). For this reason, the use of skilled birth attendance is not only cost-effective, but also a valuable indicator of the maturity and sophistication of a health system, indicating its accessibility and responsiveness to all, particularly the poor.

(d) Emergency obstetric care

Even in the context of skilled attendance at birth, delivery complications arise in approximately 15 per cent of all pregnancies, a majority of which can be managed if quality emergency obstetric care (EmOC)

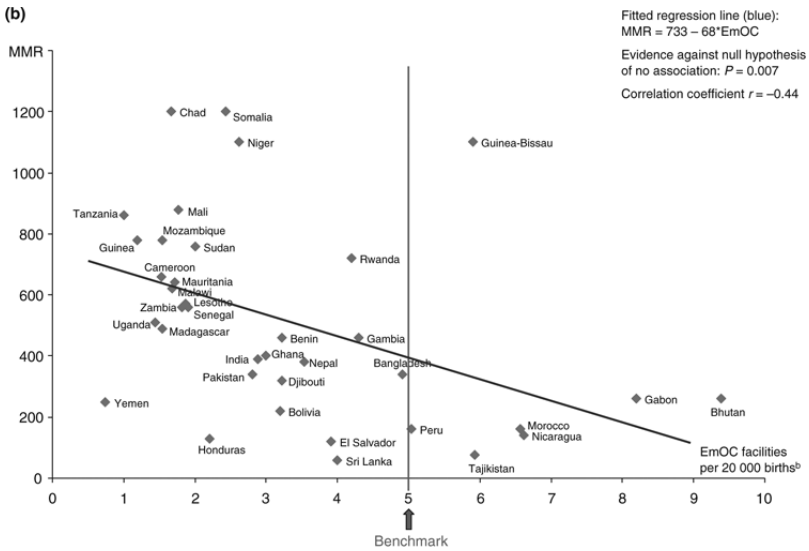
is available and rapidly accessible to all women.[376] Yet in 2010 approximately 287,000 women died from pregnancy complications.[377] with millions more women suffering chronic morbidities – a testimony to the lack of equitable access to emergency health care for women.[378]

All five of the major causes of maternal mortality – postpartum hemorrhage (PPH), sepsis, unsafe abortion, hypertensive disorders and obstructed labour – can be managed when well-trained staff with adequate equipment are available to provide the necessary emergency obstetric care.[379] Basic EmOC services include the ability to: administer parenteral antibiotics, uterotonic drugs, and parenteral anticonvulsants for pre-eclampsia and eclampsia; remove placenta and retained products; and provide assisted vaginal delivery and basic neonatal resuscitation. Comprehensive EmOC services also include surgical skills to perform caesarean sections (C-sections) and blood transfusions. A minimum of five EmOC facilities, including at least one that provides comprehensive EmOC, per 500,000 population is recommended for adequate coverage.[380]

Since 1994 EmOC has become a key component of global maternal mortality reduction initiatives. Yet in developing countries EmOC coverage remains inadequate, with an insufficient number of basic EmOC facilities in countries that have high and moderate levels of maternal mortality. Further, a majority of facilities that offer maternal care are unable to provide all services required to be classified as an EmOC facility.

Figure 37

Association between EmOC facility density per 20,000 births and maternal mortality



Source: Gabrysch S, Zanger P, Campbell OMR. (2012). Emergency contraceptive care availability: A critical assessment of the current indicator. *Tropical Medicine and International* Health, 17(1): 2-8

Notes: Figure created by authors using data from WHO, UNICEF, UNFPA and World Bank estimates, Trends in maternal mortality 1990-2010, MMR from UN Maternal Mortality 2000-2008 estimates. EmOC facility estimates calculated from Countdown 2015 (UNICEF 2008) and Paxton *et al.* (2006) using national CBRs from UNdata (http://data.un.org). Benchmark of five EmOC per 20,000 births represented by the vertical line.

[376] UNFPA, Emergency Obstetric care checklist for planners. www.unfpa.org/uplad/lib_pub_file/150_fileneame_checklist.MMU.pdf. Accessed May 6, 2013
[377] Millennium Development Goals 2013 Fact Sheet, Target 5.A. Reduce by three quarters the maternal mortality ratio. Retrieved from: http://www.un.org/millenniumgoals/maternal.shtml.
[378] UNFPA, Setting standards for emergency obstetric and newborn care. http://www.unfpa.org/public/home/mothers/pid/4385 Accessed Dec. 12, 2013
[379] UNFPA. Emergency Obstetric Care. Retrieved from: http://www.unfpa.org/public/home/mothers/pid/4385.
[380] WHO, UNFPA, UNICEF, AMDD. (2009). Monitoring emergency obstetric care: a handbook. World Health Organization, Geneva, Switzerland.

Figure 37 (above) highlights the relationships between maternal mortality and density of EmOC facilities when measured per 20,000 births. The corresponding authors of this analysis advocate for the value of this measure of EmOC density.[381]

While EmOC is unavailable for many women, C-sections that are possibly medically unnecessary appear to command a disproportionate share of global economic resources and "excess" C-sections have important negative implications for health equity both within and across countries. A study undertaken by WHO on the number of C-sections performed in 137 countries, accounting for approximately 95 per cent of global births for that year, found that a total of 54 countries showed underuse of C-sections (rates below 10 per cent), whereas 69 countries showed over use (rates above 15 per cent) with the remainder of countries falling in between. The study estimated that in 2008, 3.18 million additional C-sections were needed, while at the same time 6.20 million unnecessary C-sections had been performed. The cost of the global "excess" C-sections was estimated to amount to approximately US $2.32 billion in health care costs, while the cost of the global "needed" C-sections was approximately US $432 million.[382]

Where EmOC facilities are available, sociocultural factors, geographic and financial accessibility of care, and quality of service issues continue to act as barriers to EmOC.[383] The uneven distribution of EmOC facilities between rural and urban areas exacerbates disparities experienced by rural women who are more likely to give birth at home and to have long distances and poor roads to travel should complications occur.[384] Data on the proportion of women with access to services for the management of PPH in 2005 highlight these disparities in access between rural and urban women (see through Figure 40) and the high variability between countries.[385]

These persistent barriers and gaps in coverage illustrate the investments needed to realize the life-saving reproductive health care for women in many developing countries in order to bring skilled care and emergency obstetric services to women in need.

[381] Gabrysch S, Zanger P, Campbell OMR. (2012). Emergency contraceptive care availability: A critical assessment of the current indicator. *Tropical Medicine and International* Health, 17(1): 2-8

[382] WHO study (2010)"The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Sections Performed per Year: Overuse as a Barrier to Universal Coverage"

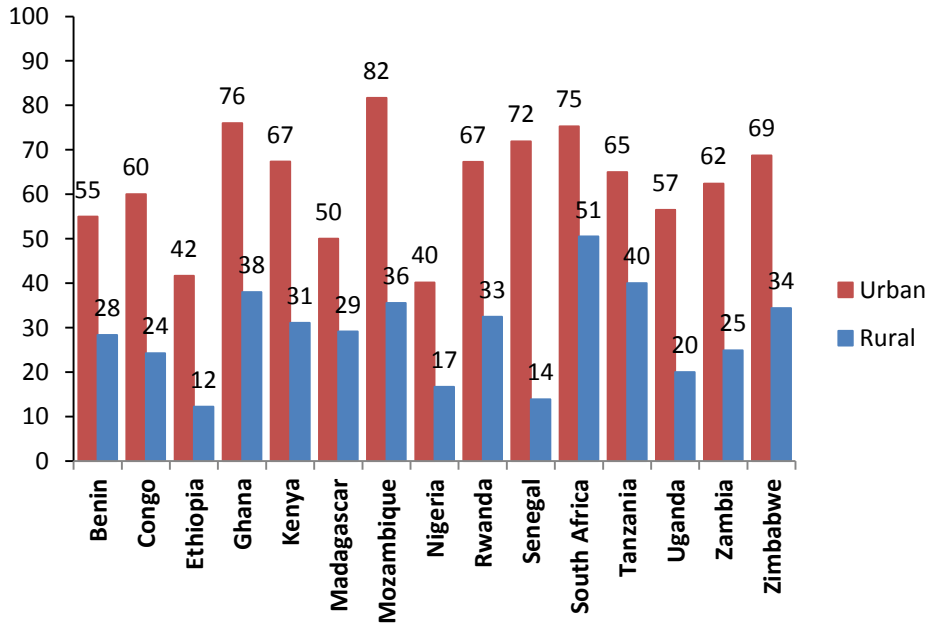
[383] UNFPA. Emergency Obstetric Care. http://www.unfpa.org/public/home/mothers/pid/4385 Accessed Dec.12, 2013

[384] UNFPA. (2012). Urgent Response: Providing Emergency Obstetric and Newborn Care. Retrieved from: http://www.unfpa.org/webdav/site/global/shared/factsheets/srh/EN-SRH%20fact%20sheet-Urgent.pdf.

[385] MNPI is a metric developed by the Futures Group International, providing data from about 50 developing countries on 81 maternal and neonatal health service indicators in order to comparatively asses aspects of maternal and neonatal health services including; Capacity of health centers and district hospitals to provide maternal health services; Access to services in rural and urban areas; Maternal and neonatal health care received; Family planning provision; and Policy and support services.

Figure 38

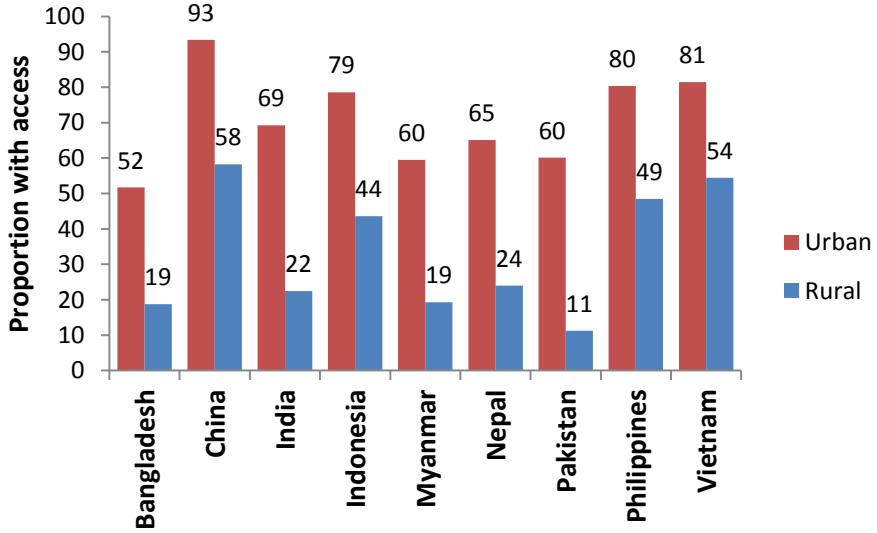
Estimated coverage of women with access to management of Postpartum Hemorrhage, urban-rural, select African countries, 2005



Source: Analysis based on data from the Maternal and Neonatal Program Effort Index (MNPI): http://www.policyproject.com/pubs/mnpi/getmnpi.cfm

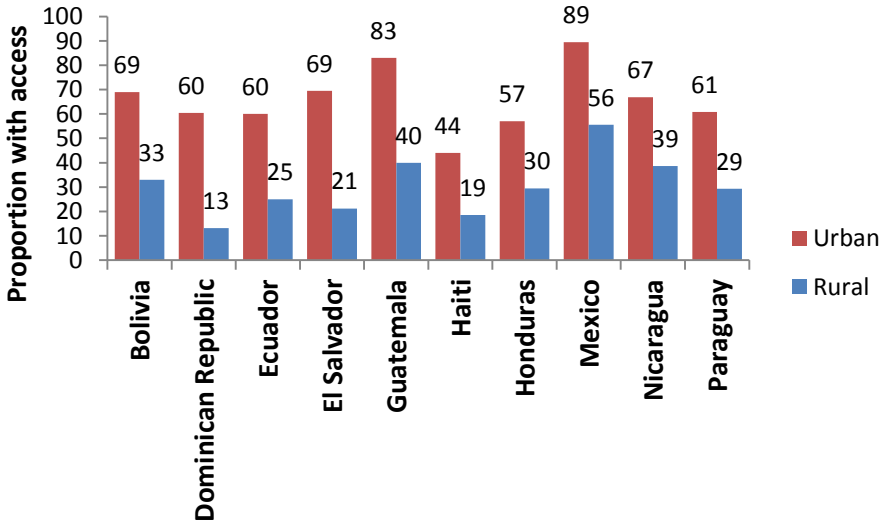
Figure 39

Estimated coverage of women with access to management of Postpartum Hemorrhage, urban-rural, select Asian countries, 2005



Source: Analysis based on data from the Maternal and Neonatal Program Effort Index (MNPI): http://www.policyproject.com/pubs/mnpi/getmnpi.cfm

Figure 40
Estimated coverage of women with access to management of Postpartum Hemorrhage, urban-rural, select Latin American and Caribbean countries, 2005



Source: Analysis based on data from the Maternal and Neonatal Program Effort Index (MNPI): http://www.policyproject.com/pubs/mnpi/getmnpi.cfm

Although 79 per cent of countries report in the Global Survey that they have addressed the issue of "providing referrals to essential and emergency obstetric care", the percentage of countries that report having an adequate geographic distribution of emergency obstetric care (EmOC) facilities ranged from 40 per cent in Africa to 97 per cent in Europe. Hence, actions fall short where health systems are most fragile, and where the numbers of skilled personnel are inadequate and mal-distributed in countries.

Distribution of health care services is strongly associated with maternal mortality ratios, in that 96 per cent of countries with the lowest maternal mortality ratios report having an adequate geographic distribution of EmOC facilities in the Global Survey, but this drops to 29 per cent in the case of countries with the highest maternal mortality ratios.

6. Sexually transmitted infections

New cases of sexually transmitted infections (STIs) appear to have increased significantly since 1994, driven in part by population growth among young people in areas of high incidence, including the Americas and sub-Saharan Africa. The highest rates of STIs are generally found among urban men and women in the most sexually active ages of 15 to 35 years.[386]

In 1995, WHO estimated 333 million cases of the four major curable sexually transmitted infections among 15 to 49 year olds: syphilis, gonorrhea, chlamydia and trichomoniasis. By 2008, this figure had grown to nearly half a billion (499 million) cases, largely due to a major rise in cases of trichomoniasis from 167 to 276.4 million cases (+65 per cent), and a rise in gonorrhea cases from 62 to 106 million (+71 per cent). These increases coincided with a 12 per cent decline in syphilis cases, from 12 to 10.6 million.[387]

While the decline in syphilis is notable, the remaining 10 million cases are a major reproductive health

[386] WHO, Global Prevalence and Incidence of Curable Sexually Transmitted Infections: Overview and Estimates, 2005. Geneva; WHO (2011) Prevalence and Incidence of Selected Sexually Transmitted Infections. World Health Organization, Geneva.
[387] WHO, Global Prevalence and Incidence of Curable Sexually Transmitted Infections: Overview and Estimates, 2005. Geneva; WHO (2011) Prevalence and Incidence of Selected Sexually Transmitted Infections. World Health Organization, Geneva.

burden; when syphilis occurs in pregnant women and is left untreated (it occurred in an estimated 1.3 million pregnancies in 2008), 21 per cent of those pregnancies will result in stillbirth and 9 per cent in neonatal death.[388] Many STIs contribute to infertility in both women and men, and untreated gonorrhea and chlamydia in pregnant women can lead to severe neonatal morbidities including blindness. Further, co-infection with STIs (including gonorrhea, chlamydia, syphilis, and herpes simplex virus (HSV)) increases susceptibility to HIV infection and likewise increases the infectivity of people living with HIV (PLWHIV). Human papilloma virus (HPV) is the principal cause of cervical cancer, which causes the deaths of approximately 275,000 women, over 85 per cent of whom live in resource-poor countries.[389] HPV has also been linked to cancers of the anus, mouth and throat.[390]

Not all post-ICPD investments to address sexual and reproductive health needs have been successful, and low-cost STI diagnostic interventions for women were a widely promoted intervention that yielded limited success, other than for syphilis. Widespread promotion of syndromic algorithms to diagnose STIs among women with vaginal discharge has not proven reliable and instead led to overtreatment, while these methods are far more successful in men.[391] Overall, because STIs are more symptomatic in men, diagnostic screening and treatment for males is a more cost-effective means to control population STIs and warrants further investment.[392]

Polymerase chain reaction (PCR) technologies have vastly improved STI diagnostics, but their expense limits widespread use. Inexpensive and accurate rapid diagnostic tests (RDT) would be helpful in low resource settings, but RDTs for syphilis are not yet widely available and a test for chlamydia is still under development.[393] Well-equipped laboratory systems are a critical component of referral-level health systems, valuable for STIs and a range of other conditions, and warrant further investment. The HPV vaccine has proven highly effective, and offers considerable promise for curtailing certain strains of the virus.

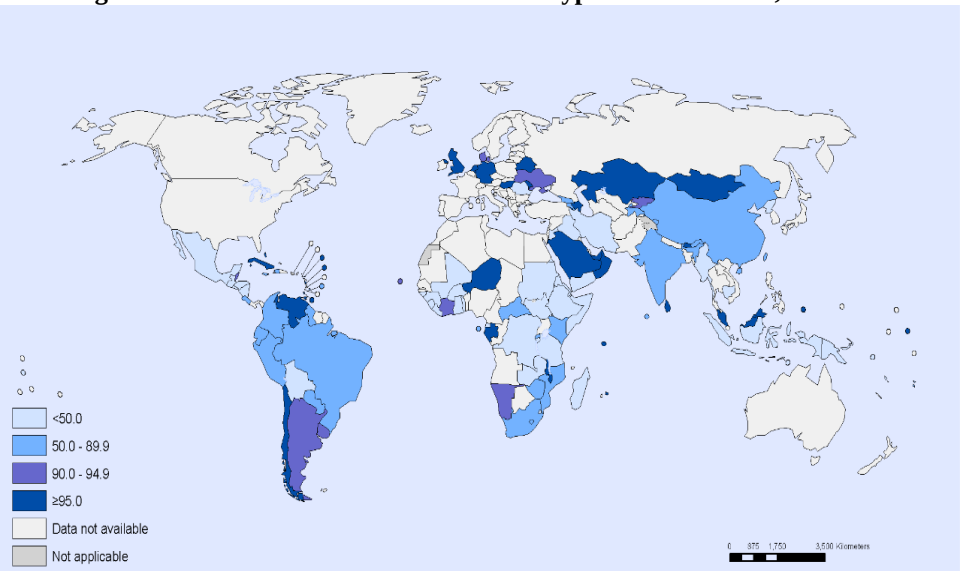
WHO undertakes global efforts to aggregate the best available reporting on STI data from countries, but the data reflect widespread weaknesses in surveillance outside select wealthy countries, and therefore global summary data must be interpreted cautiously.

In two recent reviews[394] WHO emphasizes the poor quality and limited coverage of data on STIs. There are no sentinel surveillance systems for collecting data on sexually transmitted infections globally. Data on syphilis and to a lesser extent drug resistant gonorrhea are collected through the Global AIDS Response Progress Report (GARPR), a collaborative effort of WHO, UNAIDS and UNICEF. Figure 41 (below) on the "percentage of antenatal care clients tested for syphilis on first visit" depicts both the paucity of available data on STI screening of pregnant women, a necessary first step for STI case identification and management, and where data are available, these highlight the low levels of screening at first antenatal visit across several countries in Africa, South America, the Middle East and parts of China. This may be reflective of insufficient sexual and reproductive health services in some of these regions; it is worthwhile to note that countries in North America and Europe have separate and more

[388] WHO (2011) Prevalence and Incidence of Selected Sexually Transmitted Infections. World Health Organization, Geneva.
[389] GAVI Alliance Human Papilloma Virus Factsheet, 2013.
[390] Center for Disease Control and Prevention CDC 24/7: Saving lives, Protecting People http://www.cdc.gov/hpv/cancer.html Accessed 12/20/2013. 9:02pm.
[391] WHO, Sexually transmitted infections, Fact Sheet N 110, Geneva: WHO, August, 2011; Snow, R and Bista, KP, International Consultative workshop on STI Case Management in South Asia, Kathmandu, Nepal, July, 2001. Meeting report, NCASC/ University of Heidelberg STI/HIV Control Project
[392] Dehne, KL, Snow, R and O'Reilly, KR, Integration of prevention and care of sexually transmitted infections with family planning services: What is the evidence for public benefits? Bulletin of the World Health Organization 78(5), Geneva: WHO, 2000.
[393] WHO's Global Strategy for the Prevention and control of sexually transmitted infections 2006-2015, Breaking the Chain of Transmission, Geneva: WHO, 2007; WHO, Sexually Transmitted Infections. Geneva: WHO, 2013.
[394] WHO Baseline Report on Global Sexually Transmitted Surveillance 2012
http://apps.who.int/iris/bitstream/10665/85376/1/9789241505895_eng.pdf

sophisticated surveillance systems which are not reflected.

Figure 41
Percentage of antenatal care attendees tested for syphilis at first visit, latest available data since 2005



Source: World Health Organisation: Map Production: Public Health Information and Geographic Information Systems (GIS) World Health Organisation retrieved from http://gamapserver.who.int/mapLibrary/app/searchResults.aspx

Figure 11, Annex I on "percentage of men who have sex with men (MSM) with active syphilis", showing almost no data from Africa and some data from South America and parts of Asia, similarly highlights the incompleteness of available data. It further emphasizes the lack of, and need for, a global STI surveillance system, and perhaps the need for improving access to SRH services tailored for this specific population.

In light of current needs, WHO and its partner agencies are calling for much needed concerted global effort to build systematic surveillance for STIs, including screening and effective case management. Urgent implementation of this proposal is necessary if we are to strengthen public health systems with improved data for STI estimations, and ultimately control the spread of STIs and limit the resultant morbidities.[395]

States and global health partners should commit to strengthening national and global surveillance of the incidence and prevalence of STIs, support the development and widespread use of accurate and affordable diagnostic tests for STIs, and promote greater access to quality STI diagnosis and treatment, including for men and boys.

7. HIV prevention

Globally, new HIV infections have declined 33 per cent from a high of 3.4 million per year in 2001 to 2.3 million in 2012. In 26 low- and middle-income countries new HIV infections decreased more than 50 per cent between 2001 and 2012. New HIV infections among adults in sub-Saharan Africa, where 70 per cent of all new infections occur, have decreased by 34 per cent since 2001. Yet new infections have risen in Eastern Europe and Central Asia in recent years, despite declines in Ukraine, and new infections continue to rise in the Middle East and North Africa.[396]

[395] WHO HRP 2013 Sexually Transmitted Infections (STIs) The Importance of a renewed commitment to STI prevention and control in achieving global sexual and reproductive health: http://apps.who.int/iris/bitstream/10665/82207/1/WHO_RHR_13.02_eng.pdf
[396] Joint United Nations Programme on HIV/AIDS (UNAIDS). (2013). UNAIDS Report on the Global Epidemic 2013. Retrieved from:

Declines in rates of new HIV infections among adults largely reflect a reduction in sexual transmission. Yet regional achievements in HIV prevention mask critical disparities within and between countries. For example, throughout Southern Africa, new HIV infections are occurring despite widespread knowledge and good access to condoms. In South Africa, the country with the highest absolute number of people living with HIV, the annual number of new infections declined rapidly after peaking in 1998, but the pace of decline slowed between 2004-2011, and HIV incidence remains high even after a substantial decline from 2011-2012.[397]

While "people who inject drugs account for an estimated 0.2-0.5 per cent of the world's population, they make up approximately 5-10 per cent of all those living with HIV."[398] In Eastern Europe and Central Asia preventing HIV among people who inject drugs and their sexual partners is a key priority, where people who inject drugs account for more than 40 per cent of new infections in some countries. In countries where high intravenous drug use-related HIV, governments have yet to show a strong political commitment and lack adequate data systems for monitoring the epidemic.[399]

Globally, female, male and transgender sex workers are at a higher risk of acquiring HIV, with female sex workers 13.5 times more likely to be living with HIV compared to other women. Yet funding for prevention among sex workers remains disproportionately low given their risk. Men who have sex with men (MSM) are also at an increased risk of acquiring HIV, accounting for a disproportionate number of new infections in the Americas and Asia, with young and homeless MSM at the highest risk among MSM. Sex workers, MSM, and other key populations with an increased risk of acquiring HIV continue to face stigma, discrimination, and in many cases punitive laws that compound vulnerabilities and serve as a barrier to critical prevention, treatment, care and support efforts.[400]

Ninety-two per cent of governments in the Global Survey report having addressed the issue of "increasing access to STI/HIV prevention, treatment and care services for vulnerable population groups and populations at risk" in the past five years – but with varying degrees of success.

Prevention of new HIV infections depends on behavioural change to a considerable extent. The effectiveness of approaches to causing such change has differed from region to region. In several countries across Africa, sexual risk behaviours have also increased from 2000 to 2012, with evidence of significant increases in the number of sexual partners (Burkina Faso, Congo, Cote d'Ivoire, Ethiopia, Gabon, Guyana, Rwanda, South Africa, Uganda, the United Republic of Tanzania, and Zimbabwe), and declines in condom use (Cote d'Ivoire, Niger, Senegal, and Uganda).[401] Understanding and addressing the persistence of sexual risk-taking in the face of widespread knowledge and access to condoms and its links to gender norms and structural inequality is a major public health challenge for the coming decade.

There is the need for a major UN meeting of governments, experts, and civil society organizations to address this uneven success, the failure of behaviour change in some parts of the world, and the evidence that prevention behaviour is declining in many high risk countries.

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http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf.

[397] Joint United Nations Programme on HIV/AIDS (UNAIDS).AIDSinfo Online Database, "HIV incident rates-Ages 15-49%"

[398] Joint United Nations Programme on HIV/AIDS (UNAIDS). (2013). UNAIDS Report on the Global Epidemic 2013. Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf.

[399] Joint United Nations Programme on HIV/AIDS (UNAIDS). (2013). UNAIDS Report on the Global Epidemic 2013. Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf.

[400] Joint United Nations Programme on HIV/AIDS (UNAIDS). (2013). UNAIDS Report on the Global Epidemic 2013. Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf.

[401] Joint United Nations Programme on HIV/AIDS (UNAIDS). (2013). UNAIDS Report on the Global Epidemic 2013. Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf.

States and global health partners should address the stark disparities in the success of HIV prevention in different parts of the world, and among different population groups; undertake research to understand the underlying causes of such disparities; and share proven policy lessons to reduce HIV infections in high incidence populations.

Human rights elaborations since the ICPD: HIV and AIDS

Intergovernmental human rights outcomes: Since 1994 there have been considerable elaborations of human rights protections as they relate to persons living with HIV and AIDS. The General Assembly has issued three declarations on HIV and AIDS, including *Resolution 65/277 Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS* (2011), which reaffirms "That the full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV epidemic." The Commission on Human Rights issued a series of resolution on protecting the human rights of persons living with HIV including, *Resolution 2005/85 The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)* (2005).

Other soft law: In 1997, the *International Guidelines on HIV and AIDS and Human Rights* presented a framework for promoting the rights of persons living with HIV and AIDS. Since the ICPD, human rights treaty bodies have increasingly addressed the rights of people living with HIV including in *General Comments* and *Concluding Observations.* Treaty bodies have established that states must guarantee people living with HIV the equal enjoyment of their human rights,[402] and that antiretroviral treatment should be available, affordable, and accessible,[403] with states taking action to eradicate barriers to access.[404] Appropriate resources must be allocated to HIV and AIDS programmes,[405] and monitored for effectiveness.[406] States are also urged to take action to counter stigma and discrimination related to HIV and AIDS.[407] States should ensure that people living with HIV can make informed and voluntary decisions about reproduction.[408] Treaty monitoring bodies have also advised states to address certain populations such as young women, people in rural areas, ethnic minority groups, older persons, and other groups facing vulnerabilities.[409]

8. HIV and AIDS-related treatment, care and support

What was soon to become an HIV pandemic had not fully emerged at the time of the ICPD in 1994. In 1993, an estimated 14 million people were living with HIV – but it was following the conference that the pandemic exploded.[410] Within a decade (2003), an estimated 31.7 million people were living with HIV, with three-quarters residing in Africa.[411] The response of governments and aid institutions

[402] CEDAW Committee, *Concluding Observations; Ethiopia*, para. 161, U.N. Doc. A/51/38 (1996).
[403] ESCR Committee, *General Comment No. 14: The right to the highest attainable standard of health (Art.12)*; ESCR Committee, *Concluding Observations: United Kingdom of Great Britain and Northern Ireland, the Crown Dependencies and the Overseas Dependent Territories*, para. 40, U.N. Doc. E/C.12/1/Add.79 (2003); Human Rights Committee, *Concluding Observations; Kenya*, para. 15, U.N. Doc. CCPR/CO/83/KEN (2005).
[404] ESCR Committee, *Concluding Observations; Honduras*, paras. 26, 47, U.N. Doc. E/C.12/1/Add/57 (2001); Zambia, para. 30, U.N. Doc. E/C.12/1/Add.106 (2005).
[405] CRC Committee, *General Comment No. 3: HIV/AIDS and the Rights of the Child* (32nd Sess., 2003)
[406] CRC Committee, *Concluding Observations: Zambia*, para. 51(d), U.N. Doc. CRC/C/15/Add.206 (2003).
[407] CRC Committee, *Concluding Observations: Viet Nam*, para. 46, U.N. Doc. CRC/C/BTN/CO/2 (2008); *Kazakhstan*, para. 54(d), U.N. Doc. CRC/C/KAZ/CO/3 (2007).
[408] CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999).
[409] CEDAW Committee, *Concluding Observations: Republic of Moldova*, para. 31, U.N. Doc. CEDAW/C/MDA/CO/3 (2006); *Myanmar*, para. 96, U.N. Doc. A/55/38 (2000); Human Rights Committee, *Concluding Observations: Lithuania*, para. 12, U.N. Doc. CCPR/CO/80/LTU (2004); ESCR Committee, *Concluding Observations: People's Republic of China, Hong Kong and Macao,* para. 60, U.N. Doc. E/C.12/1/Add.107 (2005); CEDAW Committee, *Concluding Observations: Zambia*, para 36(a), U.N. Doc. CEDAW/C/ZAM/CO/5-6 (2011); *Uganda*, para. 46, U.N. Doc. CEDAW/C/UGA/CO/7 (2010).
[410] Joint United Nations Programme on HIV/AIDS (UNAIDS), AIDSInfo Online Database. "All countries, People living with HIV – Number." Retrieved from: http://www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx. Data downloaded 05 December 2013.
[411] Joint United Nations Programme on HIV/AIDS (UNAIDS), AIDSInfo Online Database. "All countries, People living with HIV – Number." Retrieved from: http://www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx. Data downloaded 05 December 2013.

followed, but not before deaths from AIDS had reached a peak of 2.3 million per year in 2005.[412] In terms of global burden of disease, HIV rose from the 33rd largest cause of disability-adjusted life years lost (DALYS) in 1990 to the 5th largest in 2010. And while deaths due to AIDS have declined sharply to an estimated 1.6 million in 2012,[413] AIDS remains the leading cause of death in women of reproductive age (15 to 49 years) worldwide.[414] In Sub-Saharan Africa, both deaths due to AIDS and those resulting from maternal causes are leading causes of death in women of reproductive age.[415]

Under the newly revised WHO 2013 treatment guidelines, the 9.7 million people receiving ART in 2012 represents only 34 per cent of treatment eligible persons.[416] Changes in treatment guidelines were made in response to new evidence on the benefits of beginning ART earlier in the natural history of HIV infection. Consequently, despite expanding access to ART, the proportion of eligible persons receiving it falls far short of the MDG6 target of universal access to ART by 2015.[417] While treatment programmes have been successfully rolled out in many countries, delivery remains challenging where health systems are weak and under-staffed, and stigma creates obstacles for testing and care. Notably, ART coverage among children reached only 34 per cent globally, compared to 65 per cent coverage of all treatment eligible adults, and scale up continues to favour adults.[418]

The percentage of pregnant women living with HIV who have access to ART has risen dramatically due to the sustained scale up of vertical transmission programmes, with coverage reaching 63 per cent globally in 2012. Yet there is considerable variation in prevention of mother-to-child transmission of HIV (PMTCT) coverage among world regions, with coverage exceeding 90 per cent in Eastern and Central Europe and the Caribbean, while remaining at less than 20 per cent in the Pacific and the Middle East and North Africa. Among countries with generalized epidemics, 13 countries provided ART to less than 50 per cent of pregnant women living with HIV, while 13 countries reached PMTCT coverage levels of 80 per cent.[419] Differentials in PMTCT coverage among countries with a generalized epidemic do not appear to reflect differences in underlying national HIV prevalence (see Annex I, Figure 12).[420]

While PMTCT has increased access to treatment among pregnant women, pregnant women still receive ART for their own health at lower levels than the general population.[421] Additionally, sex differentials persist in access to and use of HIV testing and counseling services,[422] as well as treatment[423]. Gains in

[412] UNAIDS. (2013). UNAIDS Report on the Global Epidemic 2013. Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf

[413] Joint United Nations Programme on HIV/AIDS (UNAIDS). (2013). UNAIDS Report on the Global Epidemic 2013. Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf.

[414] World Health Organization. *Women's Health Fact Sheet Number 334.* September 2013. Retrieved from: http://www.who.int/mediacentre/factsheets/fs334/en/.

[415] UNFPA, UNICEF, WHO, World Bank. (2012). Trends in Maternal Mortality: 1990-2010. World Health Organization, Geneva, 2012. Retrieved from: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf.

[416] Joint United Nations Programme on HIV/AIDS (UNAIDS). (2013). UNAIDS Report on the Global Epidemic 2013. Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf.

[417] Joint United Nations Programme on HIV/AIDS (UNAIDS). (2013). UNAIDS Report on the Global Epidemic 2013. Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf.

[418] Joint United Nations Programme on HIV/AIDS (UNAIDS). (2013). UNAIDS Report on the Global Epidemic 2013. Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf.

[419] Joint United Nations Programme on HIV/AIDS (UNAIDS). (2013). UNAIDS Report on the Global Epidemic 2013. Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf.

[420] Joint United Nations Programme on HIV/AIDS (UNAIDS). AIDSInfo Online Database. "All countries – Coverage of pregnant women who receive ARV for preventing MTCT (per cent)" and "HIV Prevalence." Retrieved from: http://www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx.

[421] Joint United Nations Programme on HIV/AIDS (UNAIDS). (2013). UNAIDS Report on the Global Epidemic 2013. Retrieved from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf.

[422] Glick, P., Sahn, D. (2007). Changes in HIV/AIDS knowledge and testing behavior in Africa: How much and for whom? *Journal of Population and Economics*, 20(2):383-422.; Mitchell, S., Cockcroft, A., Lamothe, G., Andersson, N. (2010). Equity in HIV testing: Evidence from a cross sectional study in ten Southern African countries. *BMC International Health and Human* Rights, 10(23).; Snow, R.C., Madalane, M., Poulsen, M. (2010). Are men testing? Sex differentials in HIV testing in Mpumalanga Povince, South Africa. *AIDS* Care, 22(9): 1060-1065.; Yawson, A.E., Dako-Gyeke, P., Snow, R. (2013). Sex differences in HIV testing in Ghana, and policy implications. *Aids Care: Psychological and Socio-Medical Aspects of AIDS/HIV*, 24(9): 1181-1185.

[423] Braitstein P, Boulle A, Nash D, Brinkhof MW, Dabis F, Laurent C, Schechter M, Tuboi SH, Sprinz E, Miotti P, Hosseinipour M, May M, Egger M, Bangsberg DR, Low N; Antiretroviral Therapy in Lower Income Countries (ART-LINC) study group. (2008). Gender and the use of antiretroviral treatment

PMTCT coverage have translated into decreased transmission of HIV from mothers to their children. In 2012, 260,000 children were newly infected in low- and middle-income countries, representing a 35 per cent decline since 2009, and preventing more than 670,000 children from acquiring HIV.

States should ensure universal access to HIV information, education and counseling services, including voluntary and confidential HIV testing with a particular focus on young persons, and persons with increased risk of HIV; and commit, in the shortest time possible, to providing universal access to antiretroviral therapy with the aim of eliminating mother-to-child transmission of HIV, follow up of HIV-exposed infants, improving the life-expectancy and quality of life of mothers and all people living with AIDS, and protecting all people living with HIV from stigma, discrimination and violence.

Regarding the "Eliminating of mother-to-child transmission of HIV and treatment for improving the life expectancy of HIV-positive mothers", the Global Survey shows that 86 per cent of countries report addressing this issue during the past five years, and among the 38 countries that UNAIDS identifies as suffering from a "high impact" of HIV and AIDS, 97 per cent of countries reported addressing this issue during the same time period. Although goals are not yet met, this indicates a greater concentration of efforts in the countries of greatest need.

E. Non-communicable diseases

Since the ICPD the importance of non-communicable diseases (NCDs) to the burden of disease in the developing world has become far more prominent. There has been a 30 per cent increase in the number of deaths related to NCDs (most prominently, cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes) globally between 1990 and 2010.[424] In all regions except Africa, deaths from NCDs exceed those caused by maternal, perinatal, communicable, and nutritional disorders combined.[425] NCD mortality rates are higher in the more developed regions and especially Eastern Europe, where older persons represent a higher proportion in the population. However, age standardized NCD death rates show that people living in Africa have the highest risk of death due to NCDs than in any other region[426]. Deaths from non-communicable causes are expected to increase by 44 per cent between 2008 and 2030 worldwide, with the burden of disease highest among low- and middle-income countries where population growth rates are higher and longevity is increasing.[427]

About half of all NCDs can be attributed to high blood pressure, (13 per cent of global deaths), tobacco use (9-10 per cent), elevated cholesterol and glucose, (6 per cent); physical inactivity (6-7 per cent) and obesity (5-7 per cent). [428] It is therefore important to reach young people early in life by educating adolescents, youth and parents, about the importance of a healthy diet and exercise, and the risks of harmful alcohol use and smoking.

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in resource-constrained settings: Findings from a multicenter collaboration. *Journal of Women's Health*, 17(1): 47-55.; Dako-Gyeke, P., Snow, R., Yawson, AE. (2012). Who is utilizing anti-retroviral therapy in Ghana: An analysis of ART service utilization. *International Journal of Equity in Health*, 11(62).; Muula, A.S., Ngulube, T.J., Siziya, S., Makupe, C.M., Umar, E., Prozesky, H.W., Wiysonge, C.S., Mataya, R.H. (2007). Gender distribution of adult patients on highlight active anti-retroviral therapy (HAART) in Southern Africa: A systematic review. *BMC Public Health*, 7:63.

[424] Lozano Rafael, Mohsen Naghavi, Kyle Foreman et al, 2012. Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease Study 2010. In *The Lancet* - 15 December 2012 (Vol. 380, Issue 9859, Pages 2095-2128) DOI: 10.1016/S0140-6736(12)61728-0

[425] WHO, 2011. Global Status report on noncommunicable diseases 2010. World Health Organization 2011 Reprinted 2011.Geneva

[426] United Nations, 2012. Population Ageing and the Non-communicable Diseases. Population Facts No.2012/1. Department of Economic and Social Affairs, Population Division.

[427] WHO, 2011. Global Status report on noncommunicable diseases 2010. World Health Organization 2011 Reprinted 2011Geneva

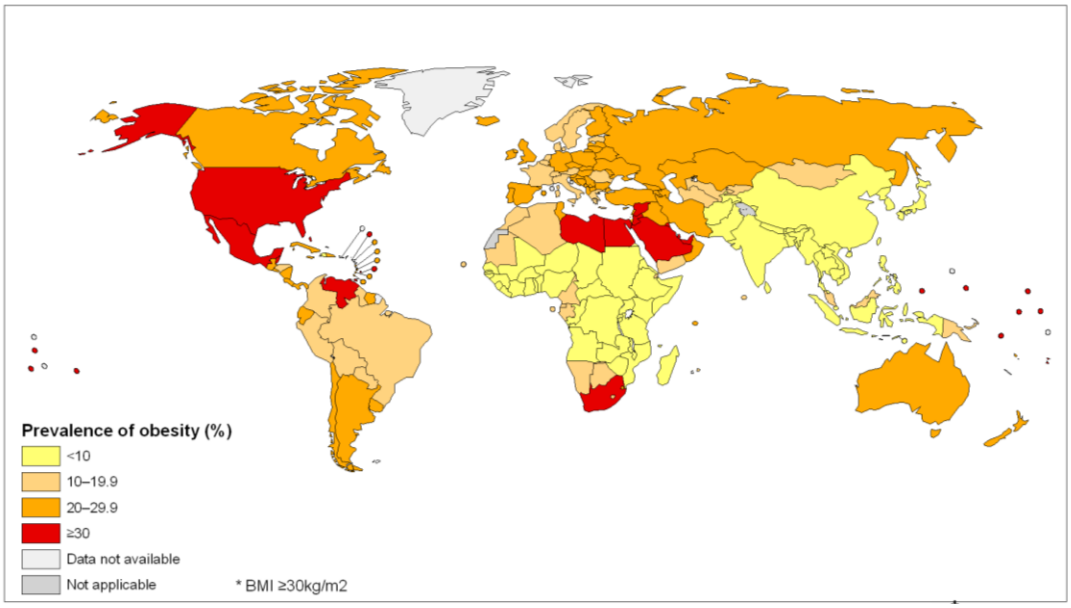
[428] Sawyer, S, Afifi, R, Bearinger, L, Blakemore, SJ, Dick, B, Ezeh, A, and Patton, G, Adolescence: A foundation for future health. Lancet 2012. Vol 379 Issue 9826, pp 1630-1640; WHO, Global Status report on noncommunicable diseases, Geneva: 2010.

(a) NCDs and inequity

While NCD-related behaviours and risk factors are commonly associated with those living in higher income countries, a "globalization of unhealthy lifestyles" is taking place.[429] For example, the worldwide prevalence of obesity almost doubled between 1980 and 2008, and is high in countries from both developed and less developed regions (Figure 42).

Figure 42

Prevalence of obesity, ages 20 and over, age standardized, both sexes, 2008



Source: WHO Map Production, Public Health Information and Geographic Information Systems, 2011, retrieved from http://www.who.int/gho/map_gallery/en/index.html on 25 October 2013

In all regions, women are more likely to be obese than men.[430] Obesity among young children has increased in all regions, but is rising most rapidly in low- and middle-income countries, where it is projected to double by 2015 from its level in 1990.[431] The poor may be predisposed to NCDs from such factors as low weight at birth, poor nutrition during childhood, and exposure to second-hand smoke. NCDs are largely chronic diseases which affect work attendance, remove people from the labour force and take an economic toll in terms of lost economic productivity as well as in health care costs.

In the developing world, illness and deaths from NCDs are occurring earlier ages, and affecting adults in their prime income-generating years.[432] A much greater proportion of NCD-related deaths occur among people less than 60 years of age in low- and middle-income countries (29 per cent) compared to high-income countries (13 per cent), and the poor are more likely to die prematurely than those who are better off.[433]

(b) Mental illness

Mental illness is a key NCD affecting hundreds of millions of people globally, and is the leading cause of disability-adjusted life years (DALYs) lost from NCDs.[434] Depressive disorders account for about a third of this toll, affecting 154 million globally, and are measurably more common among women,

[429] Bloom, D, et al, The global economic burden of non-communicable diseases. Geneva: World Economic Forum, 2011.
[430] WHO, World Health Statistics, 2012. www.info/gho/publications/world_health_statistics/EN_WHO
[431] WHO, Global Status report on noncommunicable diseases, Geneva: 2010., p 24
[432] Baldwin, W. Global Burden of Noncommunicable Diseases, PRB Fact Sheet, July, 2012. Washington DC: Population Reference Bureau.
[433] WHO, Global Status report on noncommunicable diseases, Geneva: 2010.
[434] Bloom, D, et al, The global economic burden of non-communicable diseases. Geneva: World Economic Forum, 2011.

especially young women. According to Alzheimer's Disease International, 44 million people currently live with the disease, a number which will grow to 135 million by 2050. In addition, by 2050, 71 per cent of the cases will be in low- and middle-income countries[435].

Mental illness and poverty are mutually reinforcing: the conditions of poverty increase exposure to stress, malnutrition, violence, and social exclusion, while mental illness increases the likelihood of becoming or remaining poor.[436] Mental health conditions, along with cardiovascular diseases, account for 70 per cent of lost economic output, and the global economic burden of NCDs is expected to double between 2010 and 2030.[437] Although the largest economic toll will occur in high-income countries, improving mental health in low- and middle-income countries should be a development priority.[438]

(c) Preventing NCDs: Start in adolescence

Most NCDs and about 70 per cent of premature deaths among adults are strongly associated with four behaviours that begin or are reinforced in adolescence: smoking, harmful alcohol use, inactivity and overeating or poor nutrition.[439] For example, smoking is typically begun in adolescence and is responsible for one in six NCD-related deaths.[440] Reducing both the supply and demand for tobacco would avert an estimated 5.5 million deaths over 10 years in 23 low- and middle-income countries with a high burden of NCDs.[441] Furthermore, evidence from Europe and low- and middle-income countries suggest that there is rising alcohol consumption among youth, beginning at a young age.[442]

Lifelong health education should begin with young people, both within the school curricula, and in concert with comprehensive sexuality education (CSE), as many life habits relating to long-term health are initiated and formed at young ages, and are intertwined with aspects of identity formation and aspirations for adulthood.

States should reduce risk factors for NCDs through the promotion of healthy behaviours among children and adolescents through school programmes, public media, and within comprehensive sexuality education, including skills to resist tobacco use and other substance abuse, healthy eating and nutrition, movement and exercise, and stress management and mental health care.

F. Changing patterns of life expectancy

At global level, life expectancy at birth for both sexes increased from 64.8 years in 1990-95 to 70 years by 2010-2015, a gain of 5.2 years, reflecting changes in female life expectancy at birth from 67.1 to 72.3 years, and from 62.5 to 67.8 years over the same period for men.[443]

All regions of the world experienced gains in life expectancy and the progress was steady in almost all of them, except in Africa and Europe. In Africa, life expectancy had a slow increase in the 1990s, as mortality in a number of countries soared due to HIV and AIDS or conflict, but regained momentum in the 2000s. As a result, during the last two decades, Africa gained 6.5 years in life expectancy. Similarly, in Europe, the increase in life expectancy in the 1990s was slow, due to a number of successor states of

[435] Alzheimer's Disease International. Policy Brief. The Global Impact of Dementia, 2013-2050. http://www.alz.co.uk/research/G8-policy-brief
[436] Lund, C, DeSilva, M, Plagerson, S et al, Poverty and mental disorders: breaking the cycle in low-income and middle-income countries. The Lancet Vol 378, Issue 9801:1502-1514, 2011.
[437] Bloom, D, et al, The global economic burden of non-communicable diseases. Geneva: World Economic Forum, 2011.
[438] Editorial, Mental health- the economic imperative. Lancet 378 issue 9801 p 1440, October 22, 2011.
[439] Resnick, M, Catalano, R, Sawyer, S et al, Seizing the opportunities of adolescent health, Lancet 6736(12):60472-73; Published online April 25, 2012.
[440] Beaglehole, R, Bonia, R, Horton, R, et al, Priority actions for the non-communicable disease crisis. Lancet 377:1438-47, 2011.
[441] Beaglehole, R, Bonita, R, Horton, R, et al, Priority actions for the non-communicable disease crisis. Lancet 377:1438-47, 2011.
[442] Beaglehole, R, Bonita, R, Horton, R, et al, Measuring progress on the NCDs: one goal and five targets. Lancet 380((850):1283-1285, October, 2012.
[443] UN DESA, Population Division, World Population Prospects: the 2012 revision, 2013, retrieved from http://esa.un.org/wpp/ on 3 November 2013

the former Soviet Union countries that experienced rising mortality, but it also accelerated again in the 2000s. Currently, sub-Saharan Africa has the lowest life expectancy of 56 years, 14 years lower than the world average. In fact, all countries of the world with life expectancy lower than 60 years (a total of 30 countries) are in Africa, including six with levels below 50 years: Sierra Leone, Botswana, Swaziland, Lesotho, Democratic Republic of the Congo, and Central African Republic.[444]

While aggregate analysis highlights the well-known view that women, on average, live longer than men, national, sub-national and trend analyses show that this pattern is hardly fixed, as the extent of the gender gap varies significantly between populations, and has been changing over time.[445] Countries at early stages of their demographic and epidemiological transitions have life expectancy differentials favouring women by approximately 2-3 years. In these contexts, unclean water, infections, inadequate nutrition, lack of access to health care, and other structural conditions, cause high mortality across all age-groups, in particular during childhood. These same conditions make women vulnerable during pregnancy and childbirth, and drive higher rates of fertility as a means of protection against high infant and child mortality, which in turn increase women's lifetime maternal mortality risk.[446]

The growing HIV epidemic reversed gains in life expectancy seen in many African countries in the 1970s,[447] with a greater impact on women, due in part to women's higher AIDS-related mortality, which reflects women's higher risk of acquiring HIV sexually through both greater biological risk, as well as disempowerment in sexual relationships.[448] In select countries in Africa men currently have greater life expectancy than women.[449]

Women have a marked advantage over men in life expectancy (10 years or more) in former Soviet Republics, exacerbated as male life expectancy declined in the late 1980s and beginning of the 1990s.[450] Life expectancy among males increased marginally, but has since stagnated. The causes of men's decline in life expectancy are debatable, but are attributed, in part, to increased stress, heart disease, and alcohol-related causes of death associated with political change. These changes in life expectancy illustrate the influence of social and political context on health and longevity.[451]

In high-income, industrialized countries women have higher life expectancy (4-7 years) than men. These gender differentials peaked in the 1970s, due largely to men's high rates of smoking in the preceding decades. The contraction of the gender gap seen in recent years is attributed, in part, to the decrease in smoking among males over the past 20 years.[452]

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[444] United Nations Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, 2013. *World Population Prospects: The 2012 Revision. DVD Edition.* Accessed at http://esa.un.org/unpd/wpp/Excel-Data/mortality.htm.

[445] Geronimus AT and Snow RC. (2013). The mutability of women's health with age: The sometimes rapid and often enduring, health consequences of injustice. In *Women & Health* eds. Marlene B. Goldman, Rebecca Troisi, and Kathryn M. Rexrode. Elsevier: London, UK.

[446] Geronimus AT and Snow RC. (2013). The mutability of women's health with age: The sometimes rapid and often enduring, health consequences of injustice. In *Women & Health* eds. Marlene B. Goldman, Rebecca Troisi, and Kathryn M. Rexrode. Elsevier: London, UK.

[447] Adjtunji J, Bos ER. Levels and trends in mortality in sub-saharan Africa: An overview. In: Jamison DT, Feachem RG, Makgoba MW et al. editors. Disease and mortality in sub-Saharan Africa. Washington: World Bank; 2006.

[448] Higgins JA, HHoffman S, Dworkin SL. Rethinking gender, heterosexual men, and women's vulnerability to HIV/AIDS. *American journal of Public Health* 2010; 100(3): 435-445.

[449] Geronimus AT and Snow RC. (2013). The mutability of women's health with age: The sometimes rapid and often enduring, health consequences of injustice. In *Women & Health* eds. Marlene B. Goldman, Rebecca Troisi, and Kathryn M. Rexrode. Elsevier: London, UK.

[450] Shkolnikov V, McKee M, Leon DA. Changes in life expectancy in Russia in the mid-1990s. *Lancet* 2001: 357(9260): 917-921.; Leon DA, Chenet L, Shkolnikov VM, Sakharov S, Shapiro J, Rakhmanova G et al. Huge variation in Russian mortality rates 1984-94: artefact, alcohol or what? *Lancet* 1997; 350(9075)383-388.

[451] Geronimus AT and Snow RC. (2013). The mutability of women's health with age: The sometimes rapid and often enduring, health consequences of injustice. In *Women & Health* eds. Marlene B. Goldman, Rebecca Troisi, and Kathryn M. Rexrode. Elsevier: London, UK.

[452] Pampel F. Cigarette use and the narrowing sex differential in mortality. Popul Deve Revi 2006; 28(10: 77-104.; United Nations. Sex differentials in life expectancy and mortality in developed countries: An analysis by age group and causes of death from recent and historical data. Population Bulletin of the United Nations, No 25 ST/ESA/SERN/25; 1988.; Geronimus AT and Snow RC. (2013). The mutability of women's health with age: The sometimes rapid and often enduring, health consequences of injustice. In *Women & Health* eds. Marlene B. Goldman, Rebecca Troisi, and Kathryn M. Rexrode. Elsevier: London, UK.

Inequalities in life expectancy are dynamic – they change over time – both within and between populations, reflecting variable political, economic and epidemiological contexts. Because a central obligation of states is to respect, promote and protect the human rights of its people, life expectancy is an aggregate indicator of the extent to which states fulfil this obligation, and adequately invest in the capabilities, health, social protection, and resilience of its citizens.

G. Unfinished agenda of health system strengthening

Despite decades of unprecedented medical advances and innovations in health care, stark inequalities in the accessibility and quality of health systems persist across and within countries. Sub-Saharan Africa and to a lesser extent South Asia continue to have some of the least accessible and most fragile health systems, as measured by operations indicators such as health worker density, coverage of critical services, commodity stock-outs, record keeping, or by health outcomes. Within select middle and high-income countries, pockets of weak and poor health system coverage or quality abound for select areas or populations, such as for indigenous peoples, urban slums, the uninsured and undocumented groups.

1. Impact of HIV and AIDS on health systems

International HIV aid was largely directed towards developing vertical HIV-specific programmes rather than building services into existing health systems. This approach was meant to allow for the rapid and urgently-needed roll out of HIV services, while ideally causing spill-over effects that would strengthen health systems more broadly. Yet, vertical structures that did not integrate HIV and AIDS within broader health systems have been faulted for diverting resources, crowding out other services from the health system, and compromising overall health systems strengthening for a single-disease approach.[453] While urgently fatal health emergencies require priority action and resource mobilization, nonetheless, there is a need to maximize benefits and strengthen health systems to provide long-term and far-reaching health prevention and care throughout the life-course.

HIV and SRH are intimately related with 80 per cent of HIV cases transmitted sexually and 10 per cent transmitted during pregnancy, childbirth or breastfeeding.[454] Yet in the years following the ICPD, SRH funding remained stagnant in many countries, while HIV aid increased dramatically.[455]

There has been much debate yet little decisive evidence indicating whether increased funding and scale up of HIV programmes have had spill-over effects on SRH service delivery. However, a recent economic analysis used Demographic and Health Surveys and OECD Creditor Reporting System data to investigate the impact of HIV donor aid per capita on maternal health service provision across sub-Saharan Africa from 2003-2010. Comparing annual health outcomes with HIV aid disbursements from

[453] Yu D, Souteyrand Y, Banda MA, Kaufman J and Perriëns JH. (2008). Investments in HIV/AIDS programs: Does it help strengthen health systems in developing countries? *Globalization and Health*, 4(8).; International Center for AIDS Care and Treatment Programs, Mailman School of Public Health, Columbia University. (2008). Leveraging HIV Scale-up to Strengthen Health Systems in Africa, Bellagio Conference Report, September 2008. Retrieved from: http://www.iasociety.org/Web/WebContent/File/ICAP%20Bellagio%20Report%20-%20Leveraging%20HIV%20Scale-up%20to%20Strengthen%20Health%20Systems%20in%20Africa.pdf.; El-Sadr WM, Abrams E. (2007). Scale-up of HIV care and treatment: Can it transform healthcare services in resource-limited settings? *AIDS*, 21:S65-S70.; Grepin, KA. (2012). HIV donor funding has both boosted and curbed the delivery of different non-HIV services in sub-Saharan Africa. *Health Affairs*, 31(7): 1406-1414.; Buve A, Kalibala S, McIntyre J. (2003). Stronger health systems for more effective HIV/AIDS prevention and Care. *The International Journal of Health Planning and Management*, 18(Suppl 1): S41-S51/.

[454] Askew I, Berer M. (2003). The contribution of sexual and reproductive health services to the fight against HIV/AIDS: A review. *Reproductive Health* Matters, 11(22):51-73. Duce N, Nolan A. (2007). Seizing the big missed opportunity: Linking HIV and maternity care services in sub-Saharan Africa. *Reproductive Health Matters*, 15(30): 190-201.

[455] Yu D, Souteyrand Y, Banda MA, Kaufman J and Perriëns JH. (2008). Investments in HIV/AIDS programs: Does it help strengthen health systems in developing countries? *Globalization and Health*, 4(8).; Shiffman J. (2008). Has donor prioritization of HIV/AIDS displaced aid for other health issues? *Health Policy and Planning*, 23:95-100.; Grepin, KA. (2012). HIV donor funding has both boosted and curbed the delivery of different non-HIV services in sub-Saharan Africa. *Health Affairs*, 31(7): 1406-1414.

the previous year, the study showed that HIV development assistance had little impact on rates of maternal health service provision (mothers reporting antenatal care visits or skilled attendance at birth). However, in areas with low health worker density and low HIV prevalence, HIV funding had a stronger effect on building maternal health services, suggesting that AIDS dollars have multiplier effects on the more under-resourced health systems, and especially where HIV and AIDS are less acute.[456]

States should implement full integration of HIV and other SRH health services, through greatly expanding access to quality services for diagnosis and treatment of STIs, including HIV testing; integrating HIV counseling within better SRH counseling for all people, including for adolescents and youth; strengthening continuity of care from pre-pregnancy, prenatal to post-natal and child health for all women and children, irrespective of HIV status; and addressing the contraceptive needs of all persons, including HIV-positive persons.

2. Human resources for health

According to the latest numbers from the recent WHO and Global Health Workforce Alliance publication "A Universal Truth: No health without a workforce" the 2013 global health workforce shortfall stands at 7.2 million with an estimation that this number could reach 12.9 million by 2035.[457] A marked increase from the 2006 estimated workforce shortfall of roughly 4.3 million workers across 57 countries facing critical shortages.[458] At the time health worker shortfalls were most serious in 36 countries in Africa, and in Southeast Asia, dominated by the needs of Bangladesh, India and Indonesia (see Table 2). Currently the mix of countries grouped as having low human resource for health density and/or low service coverage has since changed. Among the original 57 countries facing critical shortages, 46 have available data which show increases in the numbers of physicians, nurses and midwives. However these net gains are outpaced by population growth over time, which further exacerbates the health worker shortfalls.[459]

Using the estimated thresholds (22.8, 34.5 and 59.4 per 10 000 populations) of skilled health professionals (midwives, nurses and physicians), developed to demonstrate global availability patterns, the recent Report reveals the following findings:[460]

a) "83 countries fall below the threshold of 22.8 skilled health professionals per 10 000 population"; this represents the lowest numbers of doctors, nurses and midwives needed to provide basic health services.
b) "100 countries fall below the threshold of 34.5 skilled health professionals per 10 000 population";
c) "118 countries fall below the threshold of 59.4 skilled health professionals per 10 000 population";
d) "68 countries are above the threshold of 59.4 skilled health professionals per 10 000 population".

These findings highlight the continued imbalance in the distribution of health workers across countries; further these health worker shortfalls remain most acute in sub-Saharan Africa and parts of Asia. [461]

[456] Grepin, KA. (2012). HIV donor funding has both boosted and curbed the delivery of different non-HIV services in sub-Saharan Africa. *Health Affairs*, 31(7): 1406-1414.
[457] WHO A Universal Truth: No Health without a workforce. Executive summary 2013 http://www.who.int/workforcealliance/knowledge/resources/hrhreport2013/en/index.html
[458] WHO World Health Report 2006, Chapter one: Health workers: A global profile http://www.who.int/whr/2006/06_chap1_en.pdf
[459] WHO A Universal Truth: No Health without a workforce. Executive summary 2013 http://www.who.int/workforcealliance/knowledge/resources/hrhreport2013/en/index.html
[460] WHO A Universal Truth: No Health without a workforce. Executive summary 2013 http://www.who.int/workforcealliance/knowledge/resources/hrhreport2013/en/index.html
[461] WHO A Universal Truth: No Health without a workforce. Executive summary 2013 http://www.who.int/workforcealliance/knowledge/resources/hrhreport2013/en/index.html

Table 2
Estimated critical shortages of doctors, nurses and midwives by region, 2006

WHO region	Number of countries		In countries with shortages		
	Total	With shortages	Total stock	Estimated shortage	Percentage increase required
Africa	46	36	590 198	817 992	139
Americas	35	5	93 603	37 886	40
South-East Asia	11	6	2 332 054	1 164 001	50
Europe	52	0	NA	NA	NA
Eastern Mediterranean	21	7	312 613	306 031	98
Western Pacific	27	3	27 260	32 560	119
World	**192**	**57**	**3 355 728**	**2 358 470**	**70**

NA, not applicable.

Source: WHO, The World Health Report 2006—Working Together for Health, p. 13, www.who.int/whr/2006/whr06_en.pdf

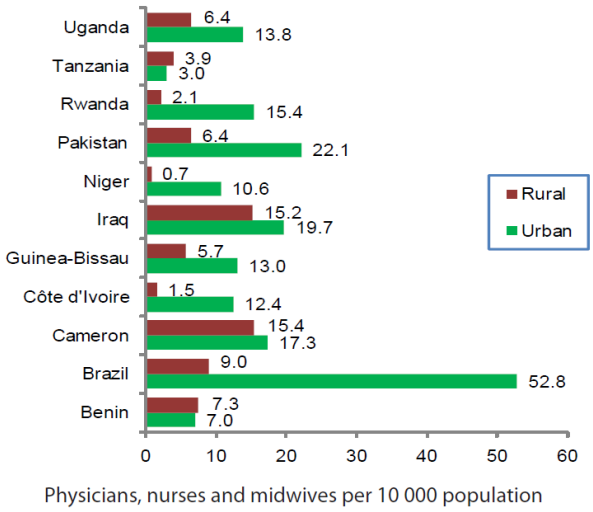
The global distribution of health workers is such that countries with the greatest need and highest disease burdens have the lowest absolute numbers of health workers and health worker densities (i.e. health workers per unit of population). Europe has a health worker density of 18.9 health workers per 1000 population, which is roughly eight times that of Africa, where health worker density is 2.3 per thousand.[462] The Americas bear roughly 10 per cent of the global burden of disease, and 37 per cent of the world's health workforce, while Africa bears over 24 per cent of the global burden of disease, and has 3 per cent of the global workforce. Among the 49 countries with the lowest per capita income (World Bank), only 5 meet the minimum WHO threshold of 23 doctors, nurses and midwives per 10,000 population.[463]

Beyond the shortfall in overall health worker numbers in many countries, shortages are exacerbated by spatial mal-distribution within countries, with a greater proportion of health workers, especially the most highly skilled, concentrated in urban centres.[464] Many countries, wealthy and poor, have incentive programmes to address mal-distribution, with varying degrees of success.[465] India, for example, is currently experimenting with a rural service programme wherein doctors are rewarded with post-graduate training opportunities following service in a remote or rural area.[466]

[462] WHO World Health Report 2006, Chapter one: Health workers: A global profile http://www.who.int/whr/2006/06_chap1_en.pdf
[463] WHO World Health Report 2006, Chapter one: Health workers: A global profile http://www.who.int/whr/2006/06_chap1_en.pdf
[464] Lincoln Chen et al, Human resources for health: overcoming the crisis. Lancet 2004; 364: 1984-90; WHO Health workforce "Achieving the health related MDGs. Its takes a workforce" http://www.who.int/hrh/workforce_mdgs/en/index.html
[465] Monitoring the geographical distribution of the health workforce in rural and undeserved areas. Spotlight on Health Workforce Statistics, Issue 8. Retrieved from: http://www.who.int/hrh/statistics/spotlight_8_en.pdf; Norbert Dreesch et al. An approach to estimating human resource requirements to achieve Millennium development goals.
[466] Monitoring the geographical distribution of the health workforce in rural and undeserved areas. Spotlight on Health Workforce Statistics, Issue 8. Retrieved from: http://www.who.int/hrh/statistics/spotlight_8_en.pdf; Norbert Dreesch et al. An approach to estimating human resource requirements to achieve Millennium development goals.

Figure 43

Density of physicians, nurses and midwives, urban-rural, selected countries, 2005



Source: WHO, Department of Human Resources for Health, Monitoring the geographical distribution of the health workforce in rural and undeserved areas, Spotlight on Health Workforce Statistics, Issue 8, 2008. http://www.who.int/hrh/statistics/spotlight_8_en.pdf

The HIV epidemic placed enormous strain on weak health systems, highlighting and exacerbating critical shortages of health workers at the very time that human resources for health were most desperately needed. The HIV epidemic increased the need for health workers to rapidly scale up treatment, with upper estimates of approximately 120,000 health workers needed to reach the WHO target of providing 3 million people with ART by 2005.[467] At the same time, poor working conditions created risks for occupational transmission, and increased workload, poor compensation, and extremely limited access to essential medicines contributed to low morale and high rates of attrition. Some health workers transitioned to the private sector, which many have argued siphoned critical human resources away from public sector programmes.[468] However, the human resource crisis has generated political will to train and retain health workers, and led to the implementation of strategies to relieve pressures on the health workforce, such as task-shifting and scaling up community health worker programmes.[469]

The evidence illustrates a strong correlation between low health worker density and poor health outcomes, including the inability to achieve the MDGs.[470] While most regions have seen significant advancements in the professionalization of birthing care since 2000, the least progress has been made in sub-Saharan Africa (see Figure 44), where laypersons and traditional birth attendants attend the majority of births. Fewer than 55 per cent of women in Africa deliver with a skilled birth attendant, compared to more than 80 per cent of women in the other regions,[471] with Africa falling far short of the targets set for the proportion of births assisted by skilled attendants in the ICPD Key Actions for Future Implementation (1999).[472] A study of 58 countries in which 91 per cent of all maternal deaths occur

[467] Hirschhorn LR, Oguda L, Fullem A, Dreesch N, Wilson P. (2006). Estimating health workforce needs for antiretroviral therapy in resource-limited settings. *Human Resources for Health*, 4(1), doi: 10.1186/1478-4491-4-1

[468] Samb R, Calletti F, Holloway J, van Damme W, de Cook KM, Dybul M. (2007). Rapid expansion of the health workforce in response to the HIV epidemic. *New England Journal of Medicine*, 357(24):2510-2514.; Yu D et al. (2008). Investment in HIV/AIDS programs: Does it strengthen health systems in developing countries? *Globalization and Health*, 4:8.

[469] Rasschaert F, Pirard M, Philips MP, Atun R, Wouters E, Assefa Y, Criel B, Schouten EK, van Damme W. (2011). Positive spill-over effects of ART scale up on wider health systems development: Evidence from Ethiopia and Malawi. *Journal of the International AIDS Society*, 14(Suppl1):S3.

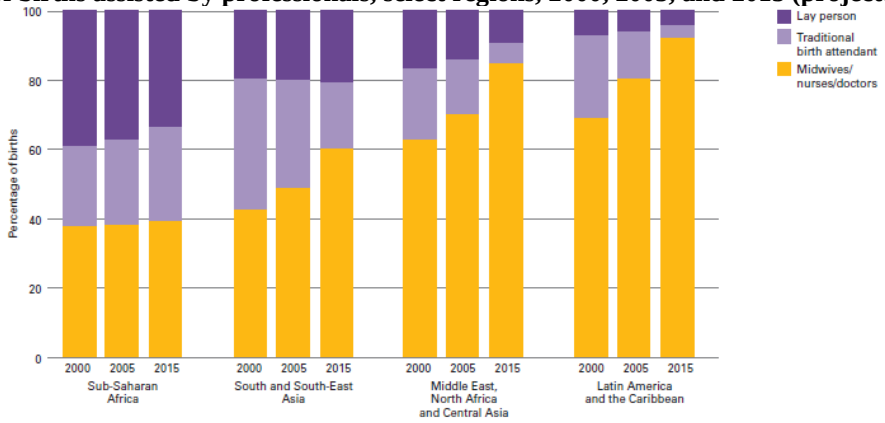
[470] WHO background Paper "Reassessing the relationship between human resources for health, intervention coverage and health outcomes.

[471] United Nations, The State of the World's Midwifery, 2011. New York: UNFPA, 2011.

[472] ICPD Key Actions for Future Implementation para. 64 states, *"countries should use the proportion of births assisted by skilled attendants as a benchmark indicator. By 2005, where the maternal mortality rate is very high, at least 40 per cent of all births should be assisted by skilled attendants; by 2010 this figure should be at least 50 per cent and by 2015, at least 60 per cent. All countries should continue their efforts so that globally, by 2005, 80 per cent of all births should be assisted by skilled attendants, by 2010, 85 per cent, and by 2015, 90 per cent."*

found an acute shortage of health workers, and nine countries needed to increase their midwifery workforce by 6-15 times to meet the MDG target. If the number of trained midwives were doubled in these 58 countries, an estimated 20 per cent of maternal deaths could be averted.[473]

Figure 44
Percentage of births assisted by professionals, select regions, 2000, 2005, and 2015 (projected)



Source: Adapted from WHO, 2005, in UNFPA, State of the World's Midwifery 2011, p. 18, retrieved from http://www.unfpa.org/sowmy/resources/docs/main_report/en_SOWMR_Full.pdf

Many poor countries have responded to the shortage of health workers by "task-shifting", that is, training lower level staff to assume higher-level functions.[474] Analysts have also increasingly recognized that the adequacy of any national health workforce is a legacy of long-standing dynamics, including the capacity, traditions and adaptability of training institutions, professional incentives and licensing regulations that may be outdated, country-to-country partnerships that may facilitate brain drain, and the institutional culture of health staff.

National in-depth and comparative assessments of human resources for health (HRH) are proving valuable, and are reflected in recent work by WHO, the World Bank, and UNFPA, each of which have been working on HRH in select high burden countries. H4+ High Burden Countries Initiative (HBCI) is embarking on a series of assessments in 8 countries to analyze the midwifery workforce, with the ultimate goal of enhancing access to and quality of midwifery services at the community level in a bid to accelerate progress towards the MDGs and achieve sustainability of health systems.[475]

Health worker assessments, country-by-country, are sorely needed to provide human resources for health policy diagnostics, and the opportunity for scaled planning and redressing health worker shortfalls, and to improve the equitable distribution of care.

States should urgently undertake the necessary long-term investments in training, recruiting and rewarding health care workers to increase their numbers and strengthen their capacity, with a focus on ensuring that human resources are available to provide universal access to quality SRH services, including by conducting national appraisals, and if necessary strengthening health training institutions to address the full range of needed SRH services; improving health worker capacity, retention and supervision; investing in midlevel cadres with SRH skills, such as

[473] United Nations, The State of the World's Midwifery, 2011. New York: UNFPA, 2011.
[474] WHO HIV AIDS programme, Strengthening Health Services to fight HIV/AIDS. Taking Stock; Task shifting to Tackle Health worker shortages WHO/HSS/2007.03 http://www.who.int/healthsystems/task_shifting_booklet.pdf; Sherr, K, Pfeiffer, J, Mussa, A, et al, The role of non-physician clinicians in the rapid expansion of HIV care in Mozambique, Journal of Acquired Immune Deficiency Syndrome, 52:pp S20-23, November, 2009
[475] United Nations Secretariat and Technical Working Group: H4+ High Burden Country Initiative (HBCI): Operational guidance and assessment framework. April 2012

midwives; and improving compensation and career incentives to address geographic mal-distribution of health workers.

3. Health management information systems

Another persistent shortfall in the health systems of poor countries are the management information systems that maintain patient records, health statistics, and operational data on occupancy rates, outpatient demand, stock flows, and reimbursements, enabling managers to evaluate interventions and provider performance, and ultimately ensure an evidence-base for planning, managing and improving the health system.[476]

As wealthier countries with extensive computer and web access have progressed from paper or e-based management information systems, most poor countries rely on paper-based information systems, interrupting the continuity of care for patients, and reducing the efficient use of data. One of the notable changes in health systems since 1994, particularly in the last decade, has been the rapid evolution of internet capability, making the possibility for a major shift from paper-based to electronic medical record (EMR) systems, or e-based HMIS, increasingly feasible.[477]

Several recent investments to electronic medical records in poor countries were prompted by HIV and AIDS. The number of untraceable HIV affected patients highlighted the incredible weakness of health information and medical records systems in many countries. A study of PMTCT programmes in 18 countries found that only 9 per cent of infants born to mothers living with HIV were identified at their first immunization visit.[478] As the global community scaled up efforts to deliver antiretroviral therapy (ART) in poor counties, HIV and AIDS programmes received targeted investments to track those enrolled in treatment, in order to ensure adherence.[479] Thus, specialized HIV surveillance and adherence monitoring are contributing to the expansion of EMR systems in Africa, yet with limited evidence as to whether such developments are being translated across the health sector.[480] **States should reorient the health system to enable *continuity of care*, through the development of health management information systems that facilitate the mobility of health records, and reliable integration of community-based, primary and referral care, with adequate regard for confidentiality and privacy.**

Recognizing the potential of EMR for the health sector more broadly, select countries are working to integrate these systems beyond HIV monitoring, but challenges include lack of qualified technical personnel, sustained internet coverage, and power outages.[481]

Paper and non-internet computer-based HMIS systems, while less efficient in many cases, can still have substantial value for health system improvements and accountability. For example, the maternal death surveillance response (MDSR) links health information systems with quality improvement efforts. The implementation of MDSR depends heavily on a functioning MIS system, but has potential to reduce maternal mortality irrespective of the form through which such information systems are collected or

[476] Allen C, Jazayeri D et al. (2007) Experience in implementing the OpenMRS medical record system to support HIV treatment in Rwanda. Stud Health Technol Infor. 129 (pt 1): 382-6

[477] WHO. AbouZhar C, Boerma T. Health information systems: the foundations of public health Bull World Health Organ. 2005 Aug;83(8):578-83. Epub 2005 Sep 22. Measurement and Health Information Systems, World Health Organization, Geneva, Switzerland. abouzahrc@who.int

[478] Ginsbug AS, Hoblitzelle CH, Sripipatana TL, Wilfer CM. (2007). Provision of care following prevention of mother-to-child HIV transmission services in resource limited settings. *AIDS*, 21: 2529-2532.

[479] Forster M. et al. Electronic medical records systems, data quality and loss to follow: Survey of antiretroviral therapy programmes in resource limited settings. Bulletin of WHO, 86:939-947 (2008)

[480] Yu D, Souteyrand Y, Banda MA, Kaufman J and Perriëns JH. (2008). Investments in HIV/AIDS programs: Does it help strengthen health systems in developing countries? *Globalization and Health*, 4(8).

[481] WHO report on management information systems. Executive Summary, 2009.

summarized.[482]

Rapid advances in mobile technology since 1994 include global mobile cell coverage of 85.5 per cent in 2011[483] and emerging new opportunities for integration of mobile health information (mhealth) systems have potential for linking and improving care in remote settings. With 70 per cent of all mobile phone users in low- and middle-income countries, the possibilities of reaching the most remote and rural parts of the globe via mhealth holds promise.[484] Multiple initiatives are underway, from weekly maternal death reporting in Cambodia using mhealth systems, to monitoring stock outs of reproductive commodities and use of mobile phones to conduct verbal autopsies in high maternal death countries. There remains a substantial need for standardization and established guidelines to enhance interoperability across ehealth systems, but the growth in technology offers a genuine possibility for health systems to make major advances in both the operations and utility of their HMIS in the coming decade.[485]

4. Reproductive health commodity security

Indeed, the poor operational systems for HMIS and overall management inefficiencies cause routine bottlenecks that limit chances for quality health service delivery, whether for SRH or other health needs. Commitments to family planning, STI screening and maternal health tend to assume the availability of necessary supplies and technologies, yet in conditions of constrained resources, inefficient HMIS, and weak programme management, many countries and health systems lack steady funding for supplies, and poor planning that leads to stock outs of reproductive health commodities.[486]

In the mid-1990s UN agencies, ministries and donors recognized the need to adopt a developmental approach to supply chain and commodity security for family planning and reproductive health – and institutionalized their shared concern for Reproductive Health Commodity Security (RHCS). RHCS is achieved when all individuals can obtain and use affordable, quality reproductive health commodities of their choice, whenever they need them. A series of targeted initiatives were launched, including the 2001 Supply Initiative, the 2004 establishment and subsequent expansion of the Reproductive Health Supplies Coalition, UNFPA's 2004 RHCS Thematic Fund and its 2007 Global Programme to Enhance RHCS (GPRHCS).[487] Additionally, the UN Commission on Life-Saving Commodities for Women and Children[488] and the Family Planning 2020 initiative[489] will continue to address RHCS issue in a coordinated and coherent manner.

The principal focus in commodity security efforts has been on the supply side, encompassing forecasting, procurement and extending to infrastructure, including vehicles and trained and motivated personnel. Despite increasing recognition of the need to increasingly stimulate demand for commodities and improve indicators thereof, a clear strategy is yet to be implemented.

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[482] WHO Maternal Death Surveillance Response Technical Guidance: Information for Action to prevent maternal Death 2013. http://www.who.int/maternal_child_adolescent/documents/maternal_death_surveillance/en/index.html

[483] Global ICT developments, 2001-2013; ITU Statistics (http://www.itu.int/ict/statistics)

[484] WHO report on mHealth: Executive Summary, 2009

[485] WHO mHealth: New horizons for health through mobile phone technologies: Based on findings from the second global survey on eHealth. Global Observatory for e health series-Volume 3 2011.

[486] UNFPA The Global Programme to enhance Reproductive Health Commodity Security Annual Report 2010: http://www.unfpa.org/public/home/publications/pid/6437

[487] Solo J. Reproductive Health Commodity Security: Leading from behind to forge a global movement. The Reproductive Health Supplies Coalition 2011: http://www.rhsupplies.org/fileadmin/user_upload/Access/JulieSolo.pdf

[488] Every woman every child: Un Commison on Life saving Commodities http://www.everywomaneverychild.org/resources/un-commission-on-life-saving-commodities

[489] Family Planning 2020 Countries with Greatest Family Planning Needs Lead Progress to Expand Access to Contraceptives http://www.familyplanning2020.org/images/content/FP2020_ICFP_Release_13-Nov-2013_FINAL.pdf

5. Universal health coverage

An estimated 150 million people suffer financial catastrophe and another 100 million fall under the poverty line each year as a result of out of pocket spending on health care. Even worse, high rates of maternal and infant mortality as well as deaths and disabilities from other preventable causes persist because people are unable to access health care. [490]

Universal Health Coverage (UHC) has garnered increasing international support in recent years. In 2005, the World Health Assembly adopted a resolution encouraging countries to transition to UHC. The 2010 World Health report focused on financing alternatives to achieve UHC, and in 2013, the spotlight was also on research around universal health coverage. Most developed nations except notably the United States of America, have universal health coverage, however among developing nations with significant disease burdens the challenge of sustainably financing universal health coverage schemes appears daunting.[491]

Discussion of what will constitute the package of SRH services that would need to be covered in select settings is increasingly urgent given the emerging global policy interest in UHC. It is necessary to identify the core components of essential rights-based sexual and reproductive health services – both in total, and what might be included in stages, through the progressive realization of a UHC system, as affirmed by the ICPD Beyond 2014 Review Expert Meeting on Women's Health (2013).[492]

There is widespread understanding that health resources go further in a context where both the financing mechanisms and the provision of services prioritize prevention and primary care. And given that much of SRH is best located within prevention and primary care, namely CSE, contraception, antenatal care, skilled delivery, among others, prospects are good for UHC to include and promote universal access to key elements of SRH. The role of NGO providers may nonetheless be crucial to the provision of comprehensive coverage of SRH, to ensure the provision of key services such as abortion. As such, it will be important to ensure the availability of evidence-based assessments of effectiveness, costs, and feasibility for all SRH-related dimensions of care, especially in a diverse range of settings.[493]

Some success stories of UHC in poor countries include the roll out of the Mutuelles Community Based Health Insurance scheme in Rwanda.[494] Utilizing bottom up and top down financing arrangements that are tailored to the specific needs of the country have resulted in marked improvements in health insurance coverage, concurrent with a 50 per cent reduction in under-five mortality and a rise in use of modern contraceptive methods from 10 per cent to 45 per cent.[495] Similar examples suggest enhanced use of SRH services after the removal of user fees in Burundi, Ghana, Nigeria and Mexico.[496]

In establishing universal health care systems (UHC), states should ensure mechanisms for: a) the fair and affordable participation of all potential beneficiaries in their country; b) the inclusion of essential SRH services within emerging UHC packages and the progressive realization of comprehensive SRH care, especially for young people and the poor; and c) the assurance of

[490] Xu K, Evans DB, Carrin G et al. Protecting Households from catastrophic health spending Health Affairs, 2007; 26:972-983
[491] WHO. The world Health Report: Research on Universal Health Coverage 2013. http://apps.who.int/iris/bitstream/10665/85761/2/9789240690837_eng.pdf; Ingun p. et al. The role of information systems in achieving universal health care. Technical brief series, brief No.10 WHO Health Systems Financing. The path to universal health coverage. 2010
[492] ICPD Beyond 2014 Review Expert Meeting on Women's Health (Mexico 2013).
[493] WHO. The world Health Report: Research on Universal Health Coverage 2013. http://apps.who.int/iris/bitstream/10665/85761/2/9789240690837_eng.pdf
[494] Chuling Lu et al. (2012) Towards Universal Health Coverage: An Evaluation of Rwanda Mutuelles in Its first eight years. PlosOne, 18 June 2012.
[495] WHO 2011, Success Stories, Building from the bottom, steering and planning from the top. Rwanda.
[496] Varatharajan D. et al. Ghana's approach to social health protection. WHO Background paper 2. Health systems financing; the path to universal health coverage http://www.who.int/healthsystems/topics/financing/healthreport/GhanaNo2Final.pdf

fairness and equality through the participation of civil society, independent commissions, and advocacy groups in the oversight of allowable procedures, providers and reimbursements.

Although challenges remain, useful lessons learned from new country roll-outs of UHC include the need to ensure that the elaboration of service packages are localized, target the poor but monitor the situation of all, pay close attention to the spatial demands of care, and include the anticipation of human resources, infrastructure and commodity needs and gender inequality and other forms of discrimination. The importance of closely linking sound evidence on population dynamics, including population health data and factors that limit access to health care, to UHC planning cannot be overemphasized.[497]

6. Quality assurance

Globally, there is greater recognition of the linkages between the quality of health services, utilization rates, and health outcomes, as well as the economic returns from upgrading quality.[498] While variations in health care quality exist within and across world regions, the comparatively worse sexual and reproductive health indicators in low- and middle-income countries (LMIC) underscore the need to urgently focus on quality in these regions.

Quality assurance systems measure, monitor, control, optimize, and modify (where necessary) all components of the health system at all levels of service delivery. Quality assurance is also an essential component of WHO's "Health for All" strategy. Prior to 1994, Bruce (1990)[499] proposed seven elements of quality in family planning programmes, highlighting the urgent need for client-centred counseling and services at a time when many family planning programmes were still structured to meet contraceptive targets. The two decades since the ICPD have generated numerous frameworks, many of which build on Bruce's proposal, through which sexual and reproductive health service quality may be conceptualized, measured and monitored.[500] For example, networks of providers and beneficiaries undertake peer-like reviews of other comparable facilities in their level of care, often with excellent results at low cost, and measurable improvements in health worker motivation, a significant factor in the quality of care.[501] The Programme of Action placed due emphasis on the formal engagement of civil society in accountability systems, which may extend to quality assurance.

A patient's experience while receiving care is an important predictor of the future utilization of such services and has an impact on the care seeking behaviour of other members of her family and community.[502] Numerous studies undertaken in sexual and reproductive health services report that women place high value on feeling comfortable and respected over other aspects of care, such as convenience or waiting times.[503] Client characteristics, including differences in socioeconomic status, were associated with levels of client satisfaction; for instance, a study in Argentina reported substantial variation in satisfaction rates among native residents and immigrants in all clinics surveyed.[504]

[497] Varatharajan D. et al. Ghana's approach to social health protection. WHO Background paper 2. Health systems financing; the path to universal health coverage http://www.who.int/healthsystems/topics/financing/healthreport/GhanaNo2Final.pdf

[498] WHO 2011; Quality of care in the provision of sexual and reproductive health services: evidence form a World Health Organization Research Initiative. 2011. http://whqlibdoc.who.int/publications/2011/9789241501897_eng.pdf

[499] Bruce J. Fundamental elements of Quality of Care : A simple framework. Population Council. Studies in Family Planning Vol 21 No.2 1990.

[500] Germain A "Meeting Human Rights Norms for the Quality of Sexual and Reproductive Health Information and Services" Background document for ICPD Beyond 2014 Review Expert Meeting on Women's Health (Mexico 2013).

[501] Creel L, Sass J, Yinger N. Overview of quality of care in reproductive health: definitions and measurements of quality. No. 1. Population Council and Population Reference Bureau. New perspectives on quality of care. Mickle, Helena, 2002

[502] WHO Quality of care in the provision of sexual and reproductive health services: evidence from a World Health Organization research initiative. 2011. http://whqlibdoc.who.int/publications/2011/9789241501897_eng.pdf

[503] Turan JM, Bulut A, Nalbant H et al. The quality of hospital-based antenatal care in Istanbul, Studies in Family Planning, 2006, 37:49–60

[504] Cerrutti M, Freidin B. Analyzing quality of family planning services in Buenos Aires. Convergence and discrepancy between users' and experts' views, unpublished report, 2004

Low quality care in poorer countries is often attributed to the lack of resources, yet research shows high quality care can be achieved in resource constrained settings. Notably, a study in Indonesia attributed only 37 per cent of perinatal deaths to low resources and over 60 per cent to poor process of service delivery, while another study in Jamaica revealed that improvements in process alone, without added funding, was significantly linked to increased birth weights.[505]

Numerous studies [506] emphasize the need for effective and ongoing quality assurance systems particularly where resource constraints, health worker shortages, and infrastructural limitations exacerbate the strain on health systems. A strategy that maximizes resources with systematic quality assurance can break through to new performance levels in health quality and management.

There do not appear to be "magic bullets" to assure equity and quality in service delivery. In order to produce lasting and sustainable improvements, particularly in regions of the world with the worst health outcomes, transformational investments in systems level approaches are needed. Health systems must be holistically strengthened, and founded on the right to quality care.

States should give the highest priority to strengthen the structure, organization and management of health systems, including the development and maintenance of necessary infrastructure such as roads, electricity, clean water, facilities, equipment and commodities, to ensure fair and equal access of all persons to comprehensive, integrated and quality primary care, that includes sexual and reproductive health care, and proximity to referral centres of excellence for higher levels of care, with a commitment to providing universal access to quality health care to all rural, remote and poor populations, indigenous peoples, and all those living without adequate health care today.

7. Sexual and reproductive health services and rights for refugees and IDPs

In 1994, the Women's Commission for Refugee Women and Children [507] published a report documenting the lack of sexual and reproductive health services for refugees and others affected by crises. In the same year the specific reproductive health needs of refugees and internally displaced persons (IDPs) were recognized in the Programme of Action, the Inter-agency Working Group (IAWG) on Reproductive Health in Crises[508] was formed to strengthen access to quality SRH services for persons affected by humanitarian crises, such as conflicts and increasingly, natural disasters.[509]

A 2002-04 IAWG review found significant progress had been made in raising awareness and advancing SRH for conflict-affected populations, particularly in stable refugee camp settings. Nonetheless, critical gaps were noted, especially for gender based violence (GBV) and HIV and AIDS, and SRH services for IDPs were severely lacking.

Standardized tools now provide normative guidelines for SRH programming in crises, including the *Interagency Field Manual on Reproductive Health in Humanitarian Settings* (IAFM) [510]; and the Minimum Initial Service Package (MISP) for Reproductive Health, which was integrated into the 2004 and 2011 Sphere standards that provide universal minimum standards for humanitarian response. The

[505] Jamison DT, Berman JG et al " Disease control priorities in developing countries; Chp 70 Improving the Quality of Care in Developing Countries" World Bank 2006
[506] WHO Quality of care in the provision of sexual and reproductive health services: evidence from a World Health Organization research initiative. 2011. http://whqlibdoc.who.int/publications/2011/9789241501897_eng.pdf
[507] Now the Women's Refugee Commission
[508] Formerly the "Inter-agency Working Group on Reproductive Health for Refugee Situations"
[509] Today the IAWG has grown to include over 450 broad-based member agencies, including roughly 1,500 individuals from UN agencies, governments, NGO's, universities and donor organizations.
[510] UNHCR. Inter Agency Working Group on Reproductive Health in Crises: Refocusing Family Planning In Refugee Settings: Findings and Recommnedations froma Multi-Country Baseline Study. 2011.

MISP is now part of the numerous high-level policy documents and guidelines for crisis settings,[511] and a 2013 MISP assessment in Zaatri refugee camp and Irbid City in Jordan suggests that priority reproductive health services are integrated into the response to the Syrian crisis.[512]

Need has not abated. An estimated 44 million people worldwide are currently displaced by conflict, and an additional 32 million displaced by natural disasters. Today, more than half of the refugees served by the United Nations High Commissioner for Refugees (UNHCR) live in urban areas, as opposed to camp settings, and IDPs often live in host communities, or are dispersed over large geographical areas. Such changes in spatial distribution of IDPs raise new service challenges, prompting a recent review, to advise on future programming.

Lack of integration or mainstreaming of sexual and reproductive health into acute emergency responses remains a challenge. In complex emergencies, SRH often takes a back seat, and the quality and range of SRH services suffers. While the latest review by IAWG finds services more available today than ten or twenty years ago, the services are often not comprehensive, and selected components of the MISP are implemented rather than the comprehensive package. There are gaps in the availability of contraceptive methods with no long-term or permanent methods or no contraceptive services available for adolescents or unmarried people, while services addressing gender based violence (GBV), safe abortion care, post-abortion care, STIs, and adolescent SRH are still limited.

Global efforts are necessary to ensure that SRH services for refugees and internally displaced persons comprehensively respond to identified gaps, including services to address gender based violence, greater access for unmarried and young people, and the provision of multiple types of contraception.

A stronger evidence base is needed. In addition, increased and enhanced monitoring is needed to document the outcomes and impact of existing programmes. Preliminary results from a recent study by Research for Health in Humanitarian Crises (R2HC),[513] found that existing evidence on health needs and services in crisis settings is generally weak, including for sexual and reproductive health.

8. Government priorities: Sexual and reproductive health and rights[514]

Global SRH priorities	
SRH services for adolescents and youth	**56 per cent of governments**
Maternal and child health	**51 per cent**
HIV and STI related services	**43 per cent**
Family planning services	**38 per cent**
Reproductive cancers	**36 per cent**

Africa region – SRH priorities	
Maternal and child health	**71 per cent of governments**

[511] Including the Inter-agency Standing Committee (IASC) GBV *Guidelines for Prevention and Response*; IASC *Gender Handbook*; IASC revised HIV/AIDS guidelines and the *Health Cluster Guide*.
[512] UNHCR. Inter Agency Working Group on Reproductive Health in Crises: Reproductive Health Services for Syrian refugees in Zaatri refugee Camp and Irbid City Jordan. An Evaluation of the Minimum Initial Service Package 2013
[513] Funded by DFID and the Wellcome Trust.
[514] See Annex II for full table of government priorities by region including definitions of each priority.

HIV and STI related services	**56 per cent**
SRH services for adolescents and youth	**56 per cent**
Family planning services	**46 per cent**
Reproductive cancers	**42 per cent**

Americas region – SRH priorities

SRH services for adolescents and youth	**74 per cent of governments**
Maternal and child health	**42 per cent**
HIV and STI related services	**42 per cent**
Maximize social inclusion, equal access and rights to SRH	**42 per cent**
Family planning services	**32 per cent**

Asia region – SRH priorities

SRH services for adolescents and youth	**56 per cent of governments**
Maternal and child health	**54 per cent**
Family planning services	**46 per cent**
Reproductive cancers	**37 per cent**
Maximize social inclusion, equal access and rights to SRH	**27 per cent**
HIV and STI related services	**27 per cent**

Europe region – SRH priorities

HIV and STI related services	**55 percent of governments**
Maximize social inclusion, equal access and rights to SRH	**48 per cent**
SRH services for adolescents and youth	**45 per cent**
Maternal and child health	**39 per cent**
Reproductive cancers	**35 per cent**

Oceania region – SRH priorities

Family planning services	**58 per cent of governments**
SRH services for adolescents and youth	**42 per cent**
Violence	**33 per cent**
Maximize social inclusion, equal access and rights to SRH	**33 per cent**
Develop SRH policies, programmes and laws	**33 per cent**

Notably, the most frequently mentioned SRH priority by 57 per cent of governments worldwide was the "provision of SRH services for adolescents and youth." Given that today's youth cohort far exceeds those of previous generations, it is critical that their needs, particularly their SRH needs, are addressed. The second most frequently mentioned priority "Maternal and child health" was largely driven by the numbers of African and Asian countries where maternal mortality and morbidity remain markedly prevalent and constitute significant health concerns. Interestingly, "reproductive cancers," which includes breast and cervical malignancies, coming in fifth place globally, was highlighted by comparatively more high-income non-OECD countries (50 per cent) and low-income countries (41 per cent) than countries in other income groupings.

When countries were grouped by income, "SRH for adolescents and youth," "maternal and child

health," and "family planning" were more frequently mentioned as priorities by governments of low- and lower middle-income countries whereas "social inclusion, equality of access and rights" and "HIV and STI related services" stood out as a priority among high income OECD countries, mentioned by 61% of their governments.

The above patterns reiterate the inextricable linkages between health and wealth. Developing countries still lack essential building blocks of strong health systems that are necessary for the provision of basic maternal and child health services. This is evident in the persistently high maternal and infant mortality and morbidity rates seen in these countries. The survey results highlight the recognition by governments of the necessity to prioritize those dimensions of SRH services for which there is the greatest need.

CSO Priorities regarding sexual and reproductive health and reproductive rights

A recent survey (2013) among 198 civil society organizations from three regions that work in sexual and reproductive health and reproductive rights shows that in Africa, 26 per cent of CSOs identify the "development of programmes, policies, strategies, laws and the creation of institutions" as the *one top priority issue* for public policy for the next 5 to 10 years. In contrast, "abortion" is the most frequently cited issue by CSOs in the Americas (29 per cent) and Europe (25 per cent). In that latter region, 20 per cent of CSOs identify "targeted sexual and reproductive health for adolescents and youth", that is, information, counseling and services as the *one top priority issue* for public policy in the near future.

H. Health: Key areas for future action

1. Accelerate progress towards universal access to quality sexual and reproductive health services and fulfilment of sexual and reproductive rights.

An alarmingly high proportion of people continue to live without access to sexual and reproductive health services, particularly the poor. Economic growth, by itself, is insufficient to ensure universal, equitable coverage, and therefore countries must dedicate resources to ensure that all persons have access to affordable, quality care. Current discussions give considerable weight to "universal health coverage" as a means to assure that all persons have access to health care without financial hardship.

a. The highest priority should be to strengthen primary health care systems to make integrated, comprehensive quality sexual and reproductive health services, with adequate referrals, accessible to where people are living, especially to rural, remote and resource limited populations including the urban poor. These efforts should ensure the availability of the widest range of technologies and commodities, as well as the strengthening of health management information systems.

b. Special attention should be directed towards ensuring that human resources are available and accessible to provide comprehensive, quality SRH services, including by investing in the capacity of health workers, particularly mid-level cadres such as midwives, addressing mal-distribution and strengthening health training institutions.

c. Improved availability and accessibility must be coupled with improved quality of SRH services to support each person in a holistic and integrated way, protect the human rights of all persons, and ensure the privacy and confidentiality of services and information regarding patient rights.

2. Protect and fulfil the rights of adolescents and youth to accurate information, comprehensive

sexuality education, and health services for their sexual and reproductive well-being, and lifelong health.

Rates of STI and HIV infection and AIDS-related mortality; abortion-related deaths; and maternal deaths among young people reveal the urgent need to address of the inadequate access to information and services currently experienced by the largest generation of adolescents and youth in history.

Greater investment must be made in information and services so they are accessible and acceptable to adolescents and youth. Programme monitoring and evaluation should explicitly assess the extent to which adolescents are being reached, and which interventions bring the greatest long-term health and well-being for young people.

a. The SRH of adolescent girls requires ending gender inequality in education, passing and enforcing a legal minimum age of marriage of 18 years, eradicating FGM/C and other harmful practices, and eliminating all forms of discrimination and violence against girls. Such protections of adolescents and youth are essential to create a society in which they can build their capabilities, expand their education and enter freely into marriage and child-bearing.

b. To realize sexual and reproductive health and rights, adolescents and youth, both in and out of school, should receive comprehensive sexuality education that emphasizes gender equality and human rights, including attention to gender norms, power and the social values of equality, non-discrimination, and non-violent conflict resolution. Such programmes can also empower young people to adopt healthy behaviors with lifelong benefits for themselves and for society at large.

c. All programmes serving adolescents and youth, in and out of school, must provide referral to reliable, quality, sexual and reproductive health counselling and services, as well as other health services including mental health. Legal, regulatory and policy barriers limiting young people's access to SRH services should be removed.

3. Strengthen specific SRH services.

Contraception

The availability and accessibility of the widest possible range of contraceptive methods, including emergency contraception, with adequate counselling and technical information, to meet individuals' and couples' contraceptive needs and preferences across the life course is essential for reproductive health and reproductive rights. Yet, some countries provide only a few methods, or do not make options or information widely available that would enable individuals to exercise free and informed choice, especially where health systems are weak, for example in rural areas. Decisions about what contraceptive mix to provide must be calibrated to the capacity of health service providers, while also building the health system and capacity of health workers to provide a range of methods to meet the needs and preferences across the life course for everyone.

Abortion

With increasing access to safe abortion and post-abortion care, abortion rates as well as rates of abortion-related deaths have decreased globally, with significant regional variation. Yet progress is inadequate as death rates resulting from unsafe abortion remain unacceptably high in Africa and South Asia with more than half of these deaths occurring among young women under 25 years. Concrete measures are urgently needed to:

a. Reduce unplanned pregnancies by increasing access to contraception and fulfilling the rights of women and girls to remain free from forced or coerced sex and other forms of gender based violence.

b. Ensure access to quality post-abortion care for all persons suffering from complications of unsafe abortion.

c. Take action as indicated in the WHO "Technical and Policy Guidance for Access to Safe Abortion", to remove legal barriers to services.

d. Ensure that all women have ready access to safe, good-quality abortion services.

Maternity care

Ninety per cent of maternal deaths are preventable and the elimination of all preventable deaths requires a well-functioning and integrated primary health care system that is close to where women live; effective referral mechanisms to respond to complications of pregnancy and delivery; and the availability and accessibility of functioning basic and comprehensive emergency obstetric care (EmOC). To achieve universal availability and accessibility of quality maternity care requires health system strengthening, particularly in Sub-Saharan Africa and South Asia.

For each woman who dies of a pregnancy-related complication, an estimated 20 women suffer serious and often life-long morbidities such as obstetric fistula, uterine prolapse, incontinence, and severe anemia. Maternal morbidity and case fatality rates should be increasingly utilized as indicators of the quality of SRH services and the progressive realization of women's right to health.

Sexually transmitted infections (STIs), including HIV

Evidence suggests a 40% increase in the annual incident cases of STIs since the ICPD, yet data reflect widespread weakness in surveillance. Despite the fact that STIs have serious consequences for women's health and fertility, contribute to miscarriage and low birth weight and can cause congenital disorders, these infections remain among the most poorly monitored, diagnosed or treated SRH conditions worldwide. Enhanced global commitment towards strengthening STI surveillance and increasing access to effective prevention, diagnosis and treatment of STIs for all persons, particularly young people is sorely needed.

Continued investment is also required to achieve universal access to HIV prevention, treatment and care, and to accelerate full integration of HIV and other SRH health services in a manner that will holistically strengthen health systems. Further, it is necessary to scrutinize and address the structural conditions that may be contributing to the persistence of new HIV infections in Southern Africa.

NCDs, including reproductive cancers

The prevalence, and attendant mortality and morbidity resulting from reproductive cancers further highlight the inadequacy and inequalities in access to SRH information, education and services globally.

More than half a million women each year develop cervical cancer, which is responsible for the death of over half that number of women, predominantly in developing countries, and which is preventable through screening and the HPV vaccine. Despite lower incidence of breast cancer in developing countries, mortality rates are higher due to a lack of access to screening and treatment.

In all regions of the world except Africa, where there is a double burden, deaths from non-communicable disease exceed those caused by maternal, perinatal, communicable, and nutritional disorders combined, and related mortality is occurring at earlier ages in developing countries. Cardiovascular diseases, cancers, diabetes, depression and chronic respiratory diseases are responsible for the majority of non-communicable illnesses and deaths. This changing burden of disease reflects significant changes in tobacco use, harmful use of alcohol, insufficient physical activity and unhealthy diet/obesity.

a. It is critical to address the rising burden of reproductive cancers, including breast, cervical and prostate cancers, by investing in prevention strategies including the HPV vaccine and routine screening, early treatment at the primary care, and reliable referrals to higher levels of care.

b. It is also necessary to reduce risk factors for NCDs through the promotion of healthy behaviours and lifestyle choices particularly among children, adolescents and youth.

III. Place and mobility

The importance of place to human security coincides with impressive evidence of our very human relationship with migration. We are neither migratory nor sedentary – we do not routinely or instinctively change our habitation with the seasons, but carry within us the uniquely human capacity for both deep attachment to place and the impulse to seek new and better places to make our homes. Our public policies, therefore, need to accommodate both human needs – for a secure place, and mobility.

Place is both social and spatial.[515] It includes our family, household, and community, which provide the moveable social fabric linking us to one other. And place includes the village, municipality, state and country we call our own—embedding us within a shared environmental niche and political structure.

A secure place is essential for human development, as human security – that is, freedom from hunger, fear, violence and discrimination – is a pre-condition for the development of children and the creative growth of all persons. The foundational human rights instruments protect rights related to human security through the "right of everyone to an adequate standard of living…including adequate food, clothing and housing, and to the continuous improvement of living conditions"[516], as well as to mobility, including a person's "right to liberty of movement and freedom to choose his residence", and the freedom to "leave any country."[517]

Increasing numbers of people around the world are moving, both within national border and internationally. A secure place for people on the move is essential, underscoring the importance of planning for rapidly growing cities that can integrate and support rural-urban migrants as well as the urban poor.

Yet the scale of the human population living day-to-day without a safe or reliable home underscores the urgency of enhanced global attention to human security. At the end of 2012, there were at least 15.4 million refugees,[518] 61.2 million internally displaced persons,[519], and an estimated 863 million were living in slums,[520] with a large but ultimately unknown population completely homeless. These challenges demand cooperative partnerships between governments for inclusive land use planning, linked urban and rural health systems, and commitments to fulfil the need for safe and secure housing.

This chapter reviews emerging changes in the structure of households, people's most immediate place. It gives prominence to internal and international mobility as they define people's prospects, as well as to urbanization as the dominant spatial transition currently underway in much of the world. It highlights some of the most vital threats to place, such as homelessness, displacement, and lack of access to land.

"[Human beings] have the right to an adequate standard of living for themselves and their families, including adequate food, clothing, housing, water and sanitation." (ICPD Programme of Action Principle 2)

"Countries should guarantee to all migrants all basic human rights as included in the Universal

[515] Gieryn T. F. (2000) A space for place in sociology. *Annual Review of Sociology.* 26:463-96.
[516] International Covenant on Economic, Social and Cultural Rights, Article 11.
[517] International Covenant on Civil and Political Rights, Article 12.
[518] UNHCR (2013) "*Global Trends 2012: Displacement, the new 21st Century Challenge"* [http://unhcr.org/globaltrendsjune2013/UNHCR%20GLOBAL%20TRENDS%202012_V05.pdf]
[519] Norwegian Refugee Council, Internal Displacement Monitoring Centre (NRC/IDMC), (2013) "Internal Displacement Global Overview 2012: People Displaced by Disaster"
[520] UN-Habitat (2012) State of the World's Cities 2012/2013., Nairobi

Declaration of Human Rights." (ICPD Programme of Action Principle 12)

"Governments should improve the management and delivery of services for the growing urban agglomerations and put in place enabling legislative and administrative instruments and adequate financial resources to meet the needs of all citizens, especially the urban poor, internal migrants, older persons and the disabled" (Key Actions for the Further Implementation of the Programme of Action of the ICPD, Para. 31)

Human rights elaborations since the ICPD: Freedom of movement

Other soft law: *General Comment No. 27: Freedom of Movement* (1999) of the Human Rights Committee states, "Liberty of movement is an indispensable condition for the free development of a person." The *General Comment* clarifies rights related to liberty of movement; freedom to choose one's place of residence; the freedom to leave any country, including one's own; the right to enter one's own country; and the exceptional circumstances under which the State can restrict these rights, noting that "the application of the restrictions permissible under article 12, paragraph 3, needs to be consistent with the other rights guaranteed in the Covenant and with the fundamental principles of equality and non-discrimination."

A. The changing structure of households

The Programme of Action of the ICPD called on member states to develop policies to provide better social and economic support to families, acknowledge the rising cost of child-rearing, and provide assistance to the rising number of single-parent households. The Programme of Action recognized that various forms of the family exist. However, little mention was made of prevailing trends in family or household structures at the time, other than the noted rise in single-parent households. It did not anticipate the growing instability of marital unions in many societies, or the growing heterogeneity of household structures and living arrangements, including one-person, single-parent, child-headed and grandparent-headed households that characterize many families today.

Hence, the principal objective of the Programme of Action to ensure that families and households have secure homes, that parents have the opportunity to give due attention to the well-being of their households, especially their children, needs to be reaffirmed in 2014 given that households are growing increasingly more diverse in structure, that a rising number of persons live alone, and that children worldwide are more likely to be raised by a single parent.[521]

1. The rise in one-person households

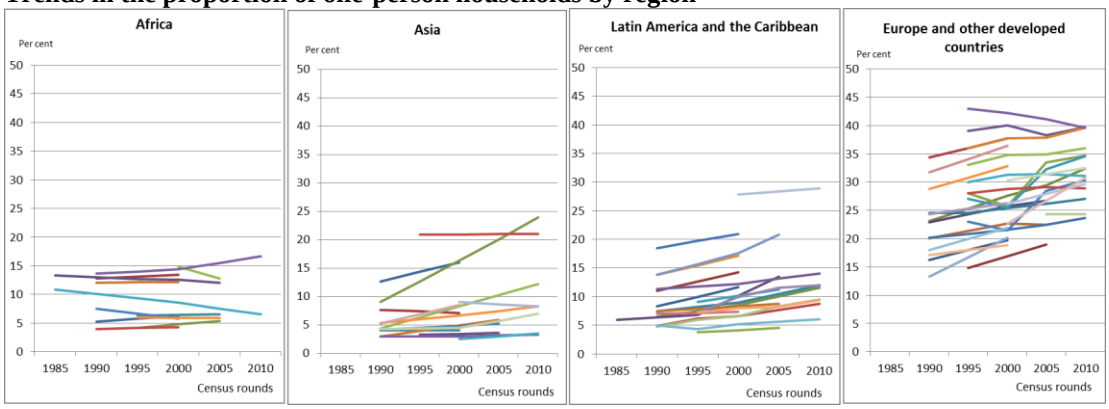
In the two decades since the ICPD, several converging social trends such as the rise in age at marriage, rates of divorce and proportions of persons who never marry, along with medical innovations, have led to increases in the number of one-person households, especially in European and other developed countries,[522] in a wide range of Latin American and Caribbean countries, and in select countries in Asia, notably the Republic of Korea, the Philippines, Singapore, Indonesia, Thailand and Vietnam (Figure 45).

[521] OECD, International Futures Programme, 2011. The Future of Families to 2030: A Synthesis Report. Paris; National Health and Family Planning Commission of China, September 2013. "The People's Republic of China Country Report on Population and Development," Chapter 6, Family Development; Olmstead, Jennifer C. (2011). Norms, economic conditions and household formation: A case study of the Arab world. *The History of the Family* 16:401-415; Esteve, Albert, Joan Garcia-Roman, Ron Lesthaeghe and Antonio Lopez-Gay (2012). The "Second Demographic Transition" Features in Latin America: the 2010 Update. IUSSP Paper.

[522] OECD, International Futures Programme, 2011. The Future of Families to 2030: A Synthesis Report. Paris.

There is very little evidence of a measurable rise in single-person households in African countries, outside of Kenya. The rise in single-person households has far-reaching implications for patterns of consumption, housing, long-term care of the elderly, inter-generational support, and therefore, demands on the State.

Figure 45
Trends in the proportion of one-person households by region

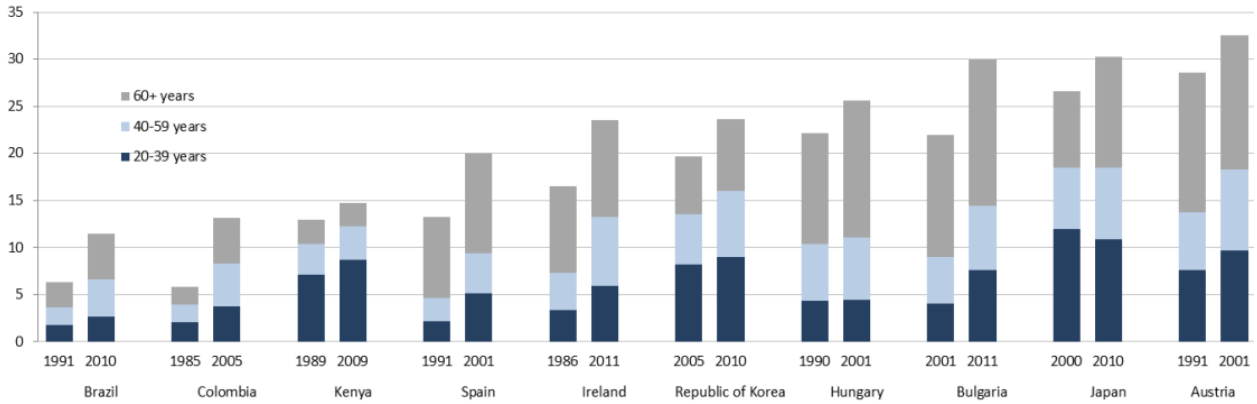


Source: UN, DESA, Statistics Division, Demographic Yearbook: Households by type of household, age and sex of head of household or other reference member, 1995 – 2013, retrieved from: http://unstats.un.org/unsd/demographic/products/dyb/dyb_Household/dyb_household.htm on 26 September 2013; UN, DESA, Statistics Division, Special data request/interagency communication, June 2013; Minnesota Population Center, Integrated Public Use Microdata Series (IPUMS), International: Version 6.2 [Machine-readable database], University of Minnesota, 2013, data retrieved on 23 September 2013; Socio-Economic Database for Latin America and the Caribbean (CEDLAS and the World Bank), 2013, Table: Household Structure, in "Statistics by gender", http://sedlac.econo.unlp.edu.ar/eng/statistics-by-gender.php; Eurostat, 2013, Statistics on Income and Living Conditions Database, Table: Income and Living Conditions / Private Households /Distribution of households by household type, 1997-2001 and 2003-2011, retrieved from http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/themes

Note: Data from censuses are organized in time periods centred on census rounds (plus/minus 2 years around 1985, 1990, 1995, 2000, 2005, 2010); data from surveys are averaged within each of the time periods

The rise in one-person households reflects social changes underway across the life course, that is, among both young adults and older persons, which shape the rise in single-person households to greater or lesser degrees in different regions. Figure 46 below shows that Spain, Hungary and Bulgaria have a relatively higher proportion of older persons (over 60 years) in one-person households (as a proportion of total households), which may reflect long-term health and independence, but may also foreshadow a future need for assisted living. Austria, Japan, Kenya and the Republic of Korea, by contrast, have a relatively higher proportion of one-person households among 20-39 year olds, suggesting delayed marriage, or bachelorhood, with heightened demand for single unit housing, entertainment, and select consumer goods.

Figure 46
Trends in the proportion of one-person households by age category



Source: UN, DESA, Statistics Division, Demographic Yearbook: Households by type of household, age and sex of head of household or other reference member, 1995–2013, retrieved from http://unstats.un.org/unsd/demographic/products/dyb/dyb_Household/dyb_household.htm on 26 September 2013; Minnesota Population Center, Integrated Public Use Microdata Series (IPUMS), International: Version 6.2 [Machine-readable database], University of Minnesota, 2013, data retrieved on 23 September 2013

Females are more likely than males to live in one-person households in Europe and other developed countries, but the reverse is true in countries from Africa, or Latin America and the Caribbean (see Annex I, Figure 14). Women form the majority of persons living in one-person households among older persons and among the widowed. On the other hand, in most countries men constitute the majority of persons living alone who were never married. Women remain underrepresented among young persons living alone, especially in the less developed regions. Only a small increase in their proportion was noted for countries from both developed and less developed regions.

A selection of 21 countries have data on one-person households by place of residence (urban/rural) and age of the household member (see Annex I, Figure 15). Among the seven African countries, one-person households are more common in urban areas, and especially those composed of young adults (20-39 years). In Latin America, Asia, and the three European countries, the pattern is more mixed regarding whether one-person households are predominant in rural or urban areas, but as in Africa, one-person households composed of young adults are more common in urban areas. Only in Argentina are young people living alone equally likely to live in either urban or rural areas. Conversely, older one-person households are more common in rural than in urban areas in the majority of countries.

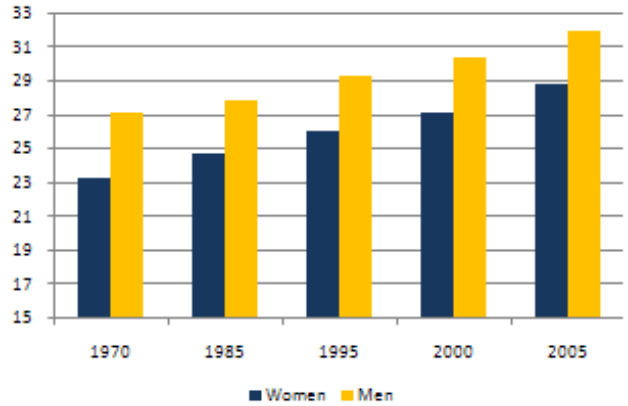
2. Delayed marriage

Among young adults, the rise in one-person households reflects, in part, the continuing global rise in the age at first marriage (Figure 47). The singulate mean age at marriage for women and men has increased in both more developed and less developed regions for the past 50 years, but more in the former.[523] When combined with an especially large cohort of young adults (15-24 years old) in Asia and the Americas (18.3 and 18.0 per cent of total population, respectively),[524] this contributes to an overall rise in single person households in young adulthood. And while young adult cohorts are a smaller proportion of the overall population in Europe (12.8 per cent, 2010),[525] here too there has been a measurable rise in the likelihood that young adults form independent and shared-peer households prior to marriage,[526] although many remain in their parents' home.[527]

[523] United Nations, 2011. World Fertility Report 2009. New York: Department of Economic and Social Affairs, Population Division.
[524] United Nations, Department of Economic and Social Affairs, Population Division (2013) *World Population Prospects: The 2012 Revision*
[525] United Nations, Department of Economic and Social Affairs, Population Division (2013) *World Population Prospects: The 2012 Revision*
[526] Heath S. (2009). Young, free and single? The rise of independent living. In Handbook of Youth and Young Adulthood: New Perspectives and Agendas. Ed. Andy Furlong. Routledge International Handbooks. London: Routledge.

Younger cohorts of adults (20-39 years old) represent the dominant group of one-person households in less developed countries. In fact, the small increase in the proportion of one-person households seen in Kenya is due to an increase in one-person households among young adults (see Figure 47). But the rise in single-person households also reflects at least three other social trends, including a decline in the proportion of persons who have "ever-married," a rise in divorce occurring in all regions, and gains in life expectancy that increase the probability that all older persons, and elderly women in particular, will spend more years living alone, whether after divorce or widowhood.

Figure 47
Singulate mean age at marriage by sex, 1970-2005



Source: United Nations, Department of Economic and Social Affairs, Population Division, Global Trends, *World Marriage Data 2012* (POP/DB/Marr/Rev2012), retrieved from http://www.un.org/en/development/desa/population/publications/dataset/marriage/wmd2012/MainFrame.html

3. Rise in proportion of the population who never marry

Historically, a rise in the proportion of persons who never marry has been observed among cohorts coming of age in wartime, due to the shortage of prospective marriage partners.[528] Looking exclusively at the proportion of women age 45-49 who have never married, census-based trends of the past 40 years suggest a persistent rise across a majority of countries of Europe, Africa, Oceania and the Americas[529] – most of which were not experiencing war or sustained conflict. Only in Asia is there a uniformly sustained low rate of never married middle-aged women. Statistics on non-marriage may reflect a competing rise in less formal unions such as cohabitation, which look very much like marriage (including lifetime security; raising a family), thereby suggesting greater changes to the social fabric than is actually occurring. The trends are notable nonetheless, contributing, in part, to the more significant rise in one-person households.

In Africa, an analysis of 9 countries, with trend data drawn from censuses, shows that the percentage of never married women aged 45-49 remains low (less than 10 per cent), but has increased significantly in the last two decades in 6 countries - Lesotho, Liberia, Libya, Mozambique, Niger and Sudan - but not in 3 countries - Burkina Faso, Egypt or Ethiopia.[530]

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[527] United Nations Department of Economic and Social Affairs, Population Division, Leaving home: independence, togetherness and income in Europe, Expert Paper No 2011/10; EuroStat EU-SILC database. "Share of young adults aged 18-34 living with their parents by age and sex." Retrieved from http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=ilc_lvps08&lang=en. Data Downloaded 11 December 2013.

[528] Abramitzky R, Delavande A, Vasconcelos L. (2011). Marrying Up: The role of sex ratio in assortative matching. *American Economic Journal: Applied Economics*, 3: 124-157; Rabinerd E. (2007). Uncounted costs of World War II: The effect of changing sex ratios on marriage and fertility of Russian Women. Retrieved from: http://web.williams.edu/Economics/faculty/brainerd-rfwomen.pdf.

[529] UNFPA, ICPD Secretariat (2013) Secondary analysis of United Nations, Department of Economic and Social Affairs, Population Division, Global Trends, *World Marriage Data 2012*.

[530] United Nations, Department of Economic and Social Affairs, Population Division, Global Trends, *World Marriage Data 2012*

In the Americas, the percentage of never married women aged 45-49 exceeds 10 per cent in all 12 countries where trend data are available, although it has remained constant in most countries for the past two or three decades.

In Asia the percentage of never married women aged 45-49 tends to be lower (around 5 per cent), with a few exceptions in countries such as Kuwait, Qatar and Singapore, where it exceeds 10 per cent, and has seen steep increases over the past 20 years.

Within the 25 European countries with trend data available, close to or over 20 per cent of women aged 45-49 have never married in Denmark, Finland, France, Germany, Ireland, the Netherlands, Norway and Sweden – and this proportion has increased steadily since the 1980s or 1990s. The proportion of never married women has been increasing for 20 years in Austria, Belgium, Iceland, Latvia and Switzerland, and is now between 10-20 per cent. The proportion ranges from 5 to 10 per cent in Albania, Belarus, Hungary and the Russian Federation, and has remained relatively constant over the past three decades.

Finally, in Oceania (Australia, New Zealand, Palau and Tonga), the proportion of never married women aged 45-49 has increased rapidly over the past 30 years, and is now approximately 10 per cent.

4. Rise in divorce

The proportion of persons divorced or separated has also increased in the last two decades,[531] and is evident in all regions to varying degrees. The proportion of women and men aged 45-49 who are currently divorced or separated is highest in European and other high-income countries, and has increased the most in the past 20 years. Countries in which at least 10 per cent of their respective populations aged 45-49 (male and female) are divorced or separated reveals high proportions: 67 per cent in Europe (29 of 43 countries); 45 per cent in the Americas (19 of 42 countries); 41 per cent in Africa (19 of 46 countries), and only 11 per cent in Asia (5 of 43 countries). Even in many countries where proportions are low (affecting less than 5 per cent of middle-age persons), upwards trends are recent, and steep. For example, while only 2.1 per cent of those 45-49 years old are divorced or separated in China, this represents a fivefold increase over the past 20 years. Similar increases in Eastern Europe and South Asia suggest a fairly recent loosening of historic restrictions (legal or social) on divorce, with rapid increases from zero or near zero in the last ten to twenty years.

In summary, the observed rise in one-person households globally reflects numerous social changes, which include delayed marriage, non-marriage, divorce and widowhood. Overall, more countries have had an increase in the proportion of one-person households due to a rising proportion of never married persons, young and old (23 of 52 countries with available data, from developed and less developed regions). Far fewer countries have observed a rise in one-person households due to divorce or separation (14 countries, mostly from developed regions). Still fewer countries (7 countries, 5 of which are from Latin America and Asia) have seen a rise in their proportion of one-person households due to widowhood. There is a very small proportion of one-person households composed of married individuals or individuals in union (suggesting sustained separation, possibly due to migrant labour), which has nevertheless increased in the countries of Senegal, Colombia, Chile, Bolivia (Plurinational State of), Republic of Korea, Bulgaria, and Switzerland.

5. Single-parent households

Single parents with children represent a significant proportion of all households in countries from all

[531] United Nations, 2013. World Marriage Data 2012. Department of Economic and Social Affairs, Population Division.

regions (Annex I, Figure 16). The highest prevalence is observed in Latin America and the Caribbean. Among the countries with available data, households of single parents with children are over 10 per cent in 7 of 12 countries in Latin America and the Caribbean, 5 of 17 countries in Europe, and 3 of 11 countries in Africa. However, these proportions are likely to be underestimated, as they do not include families of single parents with children that may co-reside with other family or non-family members in non-nuclear households (in extended or composite households).

Trends in the proportion of single-parent households have been mixed (Annex I, Figure 16). In Latin America and the Caribbean, almost all countries observed an increase, the largest being observed in Colombia, Ecuador, and El Salvador. Increases were also observed in some European countries (the Russian Federation and Ireland) and in some African countries (Cameroon, Rwanda, and the United Republic of Tanzania). Decreases in the proportion of single-parent households were observed in some countries from different regions, the highest being in Cambodia, Czech Republic, Malawi, South Africa and Viet Nam.

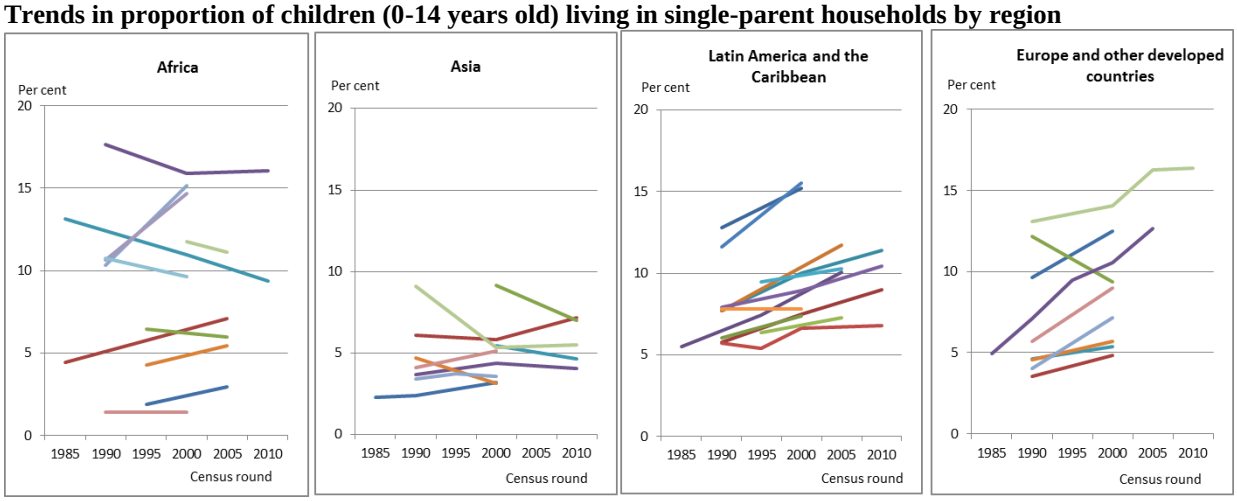
Most recent data available shows that the majority of single parents living with their children are women, ranging from slightly less than three quarters (Philippines, in 2000; Bermuda, 2010; Republic of Korea, 2010; Turkey, 2000; and Japan 2010) to more than 90 per cent (Rwanda, 2002; Malawi 2008).[532]

The proportion of single-parent households is higher in urban than in rural areas for about half of countries with available data, most of them located in Latin America and the Caribbean and in Europe, while higher in rural areas for about one-fifth of countries, most of them located in sub-Saharan Africa.[533] The increases observed for some countries in the proportion of single-parent households were due to changes in both urban and rural areas but mainly in the urban areas.

Children living in single-parent households may more often experience economic poverty and limited access to basic services of education and health. In the last two decades, the proportion of 0-14 year old children living in single-parent households has increased in most countries of Europe and other more developed regions, and Latin America and the Caribbean (Figure 48). Among the countries with the highest current values (over 10 per cent) are Austria, Ireland, the United States of America, Bolivia (Plurinational State of), Colombia, Ecuador, El Salvador, Jamaica, Panama and Peru. In Africa, trends have been mixed. For example, in Rwanda and the United Republic of Tanzania, the proportion of children living in single-parent households has increased, currently reaching about 15 per cent. On the other hand, the proportion has decreased but remained high in Kenya and Malawi, at 16 per cent and 9 per cent, respectively. In Asian countries, the proportion of children in single-parent households has changed the least, and remained the lowest.

[532] UNFPA, ICPD Secretariat (2013) *Analysis of Integrated Public Use of Microdata Series and UNDESA, Statistics Division, data*
[533] UNFPA, ICPD Secretariat (2013) *Analysis of Integrated Public Use of Microdata Series and UNDESA, Statistics Division, data*

Figure 48
Trends in proportion of children (0-14 years old) living in single-parent households by region



Source: Minnesota Population Center, Integrated Public Use Microdata Series (IPUMS), International: Version 6.2 [Machine-readable database], University of Minnesota, 2013, data retrieved on 23 September 2013.

Note: Data refer to census data and they are organized in time periods centred on census rounds (plus/minus 2 years around 1985, 1990, 1995, 2000, 2005, 2010).

As the world grows increasingly more urban, and the proportion of older persons in the global population increases, the proportionate increase in one-person households is likely to continue. Likewise, as trends in divorce are upward in several demographically large countries (India, China), and the social acceptance of unmarried childbearing appears to be increasing, it is difficult to anticipate a forthcoming decline in the proportion of single-parent families.

States, including through local municipalities, should take into consideration the growing diversity of household structures and living arrangements, the corresponding needs for housing and communal social spaces for one-person households among both young and older people, in order to reduce social isolation.

The ICPD Beyond 2014 Global Survey showed that three aspects of social protection systems relevant to the well-being of families and households were addressed in the past five years by close to 80 per cent of countries: increasing efforts to ensure health, education and welfare services (85 per cent); supporting and assisting vulnerable families (84 per cent); and providing effective assistance to families and individuals (82 per cent), although such proportions vary if examined by region, or income. Likewise, assisting families caring for family members with disabilities, and family members living with HIV, was reportedly addressed by 79 per cent of governments in the past 5 years, although to a lesser extent in the Oceanic (33 per cent) region.

However, the Global Survey indicated that providing financial and social protection schemes to single-parent families was less likely to have been addressed by governments in the past five years (61 per cent), despite the rise in the proportion of such households.

B. Internal migration and urbanization

1. Internal migration

Whether people move within or between international borders, be it permanently, temporarily or cyclically, their underlying motivations remain the same: to improve their well-being and life circumstances; to seek employment; to form, or maintain, a family. Mobility, and safety and security

during internal migration, are central to the opportunity for people to secure new and better capabilities, work and livelihoods.

While estimates of internal migration are very challenging to obtain, analysis suggests that 740 million people worldwide live in their home country but outside their region of birth[534], a scale that vastly outnumbers international migration (232 million[535]), even as the great majority of global attention to mobility has been drawn to the international dimension.

Increasingly, women are migrating on their own or as heads of households and principal wage earners.[536] Moreover, because migration requires a range of resources, migrants do not generally come from the poorer strata of rural society[537], except in movements forced by severe push factors such as famine, war or natural disasters.

Mobility occurs on a continuum from voluntary migration to forced displacement. The history of severe environmental crises shows that any associated mobility is often short-term and local[538], while displacement due to political crises or conflict may be sustained, transnational and even permanent[539]. Short or long-term movements, whether voluntary or not, demand resources, leaving the poor more likely to be caught without resources for re-location,[540] in conditions of forced displacement or trapped in refugee sites without resources to return home. **States should support people's right to move internally as a means of improving their lives, adapting to changing social, economic, political and environmental conditions, and avoiding forced displacement, and should promote, protect and provide all internal migrants with equal opportunities and access to social protection.**

The most pressing trend in internal migration is urbanization, including both circular and permanent movements from rural areas into urban settings large and small. In fact, urban areas are expected to absorb all population growth over the next 40 years (see Table 3), making this the most important spatial population trend for the coming decades. Along with migration from rural to urban areas, natural increase (the difference between births and deaths) in urban areas themselves is the other main source of urban growth.[541] The relative contribution of each factor varies considerably with time and place due to varying levels of fertility and urbanization rates. The one trend that unites them is that increasing urbanization levels are associated with an elevation of the contribution of natural increase to urban growth, since urbanization reduces the number of potential rural-urban migrants while also increasing the proportion of children born in cities – despite universal lower fertility in urban areas.

2. The scale and pace of urbanization

In 2008, for the first time, more than half of the world's population became urban. Between 1990 and 2010, 90 per cent of the growth in urban population occurred in developing countries, where the urban-dwelling population increased from 35 per cent to 46 per cent. During this period, the size of the urban population in the least developed countries more than doubled, from 107 million to 234 million. Though developed countries experienced this transition earliest, Latin America also underwent a surprisingly

[534] Bell and Muhidin (2009) *Cross-National Comparison of Internal Migration*. UNDP Human Development Reports. Research Paper 2009/30
[535] United Nations Department of Economic and Social Affairs, Population Division, The number of international migrants worldwide reaches 232 million (Population Facts No. 2013/2)
[536] UNFPA. (2007). *Unleashing the Potential of Urban Growth. State of the World Population 2007.* New York, UNFPA; Camlin CS, Snow RC, Hosegood V. (2013). Gendered patterns of migration in rural South Africa. *Population, Space and Place*, DOI: 10.1002/psp.1794
[537] Foresight: Migration and Global Environmental Change (2011). Final Project Report. The Government Office for Science, London.
[538] Tacoli, Cecilia. 2009. Chapter in *Population Dynamics and Climate Change*. New York and London: UNFPA and IIED.
[539] ICRC 2009 Internal Displacement in Armed Conflict: Facing up to the Challenges. ICRC, http://www.icrc.org/eng/assets/files/other/icrc_002_4014.pdf
[540] Foresight: Migration and Global Environmental Change (2011) Final Project Report The Government Office for Science, London
[541] Reclassification of rural areas as urban and changes in the definition of "urban" can also account for a variably small proportion of urban growth.

rapid and early urban transition.[542]

The world's urban areas (towns and cities) are projected to gain 2.6 billion people by mid-century, passing from 3.63 billion in 2011 to 6.25 billion 2050 (Table 3). However, while the scale of this growth is enormous, the rate is actually declining. Between 1950 and 2011, the world urban population grew at an average rate of 2.6 per cent per year and increased nearly fivefold. In contrast, during 2011-2030, the world urban population is projected to grow at an average annual rate of 1.7 per cent.[543]

Meanwhile, the world rural population is projected to start decreasing in about a decade, with an expected 300 million fewer rural inhabitants in 2050 than today. Most of the population growth anticipated in urban areas will be concentrated in the cities and towns of the less developed regions, with Asia projected to see its urban population increase by 1.4 billion, Africa by 900 million, and Latin America and the Caribbean by 200 million. The sheer scale of new urban residents in the coming decades is without parallel in human history, ushering unprecedented opportunities and challenges, and requiring new and visionary responses.[544]

Table 3
Trends and projections in urban-rural population by development group, 1950-2050

	Population (billion)					Average annual rate of change (percentage)			
Development group	**1950**	**1970**	**2011**	**2030**	**2050**	**1950-1970**	**1970-2011**	**2011-2030**	**2030-2050**
Total population									
World	2.53	3.7	6.97	8.32	9.31	1.89	1.55	0.93	0.56
More developed regions	0.81	1.01	1.24	1.3	1.31	1.08	0.51	0.23	0.06
Less developed regions	1.72	2.69	5.73	7.03	7.99	2.23	1.85	1.07	0.65
Urban population									
World	0.75	1.35	3.63	4.98	6.25	2.98	2.41	1.66	1.13
More developed regions	0.44	0.67	0.96	1.06	1.13	2.09	0.89	0.52	0.29
Less developed regions	0.3	0.68	2.67	3.92	5.12	4.04	3.33	2.02	1.34
Rural population									
World	1.79	2.34	3.34	3.34	3.05	1.36	0.87	-0.01	-0.44
More developed regions	0.37	0.34	0.28	0.23	0.18	-0.48	-0.48	-0.92	-1.14
Less developed regions	1.42	2.01	3.07	3.11	2.87	1.74	1.03	0.07	-0.4

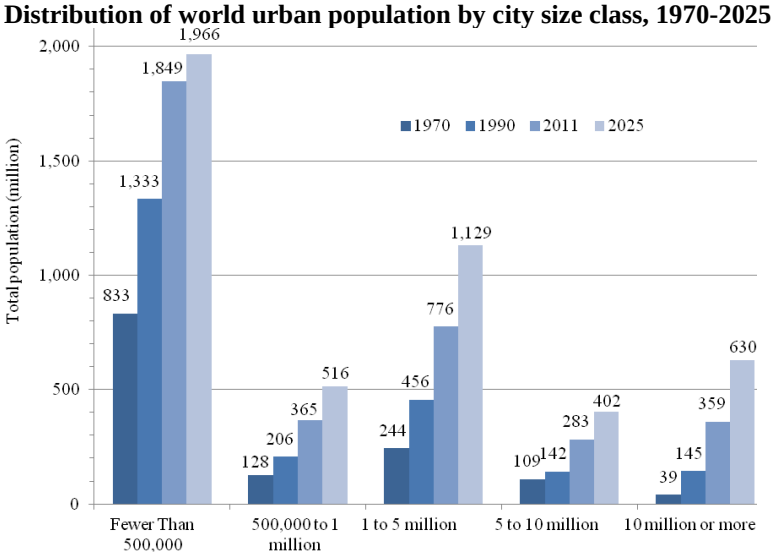
Source: UN Population Division (2012) *World Urbanization Prospects, 2011 Revision*, table 1, page 4, retrieved at http://esa.un.org/unup/pdf/FINAL-FINAL_REPORT%20WUP2011_Annextables_01Aug2012_Final.pdf

Today's 3.6 billion urban dwellers are distributed unevenly among urban settlements of varying size. As seen in Figure 49**,** over half of the world's 3.6 billion urban dwellers (51 per cent) still live in cities or

[542] United Nations, Department of Economic and Social Affairs, Population Division (2012) *World Urbanization Prospects, 2011 Revision*
[543] United Nations, Department of Economic and Social Affairs, Population Division (2012) *World Urbanization Prospects, 2011 Revision*
[544] United Nations, Department of Economic and Social Affairs, Population Division (2012) *World Urbanization Prospects, 2011 Revision*

towns with fewer than half a million inhabitants. To date, the absolute growth of these smaller cities has been considerably greater than cities of larger size.

Figure 49
Distribution of world urban population by city size class, 1970-2025



Source: UN Population Division (2012) *World Urbanization Prospects, 2011 Revision* , Figure II, page 5, retrieved at http://esa.un.org/unup/pdf/FINAL-FINAL_REPORT%20WUP2011_Annextables_01Aug2012_Final.pdf

In 2011, 23 urban agglomerations qualified as megacities, being home to at least 10 million inhabitants. Despite their visibility and dynamism, megacities account for a small, though increasing, proportion of the world urban population: just 9.9 per cent in 2011, and an expected 13.6 per cent in 2025. Furthermore, megacities are experiencing varying rates of growth, growing at higher rates in Africa and South Asia (e.g. Lagos, Dhaka and Karachi), and more slowly in Latin America.

3. Urbanization and opportunity for all

The Programme of Action recognized the role of cities in economic and social development, as do many of the people who are moving to urban areas in search of opportunity. Young adults account for a large proportion of urban growth. Research on urbanization in China and Bangladesh[545] highlights the appeal that urban contexts hold for young people, especially young women, who regard the move to urban areas as an opportunity to escape traditional patriarchy and experience new freedoms.[546] Even when urban housing and employment may fall short of expectations and they eventually return to village life for marriage, many of these young women speak of their urban working experiences as a vital period of freedom and autonomy.[547]

There is a strongly observed correlation between the level of urbanization and economic growth.[548] While in some countries urban poverty is growing, particularly with the arrival of migrants from rural areas, rural poverty remains universally higher[549]. Towns and cities are responsible for over 80 per cent of GNP worldwide, a function of advantages of proximity, concentration, economies of scale and increased access to services and information technology, which create opportunities for work and

[545] Gaetano AM, Jacka T, eds. (2004) *On the Move: Women in Rural-toUrban Migration in Contemporary China.* New York: Columbia University Press., Kabeer, Naila. (2002) Women, wages and intra-household power relations in urban Bangladesh. *Development and Change.* 28(2):261-302
[546] Kabeer, Naila. (2002) Women, wages and intra-household power relations in urban Bangladesh. Development and Change. 28(2):261-302
[547] Beynon, L (2004). Dilemmas of the heart: rural working women and their hopes for the future. Chapter 4 in Gaetano AM, Jacka T, eds. (2004) *On the Move: Women in Rural-to Urban Migration in Contemporary China.* New York: Columbia University Press , pp131-150.
[548] UN-Habitat (2010) *State of the World's Cities 2010/2011: Bridging the Urban Divide*
[549] Ravallion, M., Chen S., and P. Sangraula, 2007, "New Evidence on the Urbanization of Global Poverty," Policy Research Working Paper No. 4199 (Washington: World Bank); http://econ.worldbank.org/docsearch

entrepreneurship. They also provide the essential transport, trade and information linkages between rural, regional and global markets. In addition, demographic concentration helps reduce energy demand per capita, and makes it easier and cheaper for the state to provide basic health, welfare and education.[550]

Cities also offer increased autonomy in urban areas, with greater opportunities for social and political participation and new paths to empowerment, as evidenced by the rise of women's movements, youth groups, political and community associations and organizations of the urban poor in developing world cities[551].

Conditions in urban areas—including greater access to education, higher aspirations for children, reduced living space, and other factors favouring smaller families—contribute to lower desired fertility. In conjunction with greater access to sexual and reproductive health services, the result has been significantly reduced fertility, which has changed the trajectory of overall population growth in all countries experiencing the urban transition.[552]

Yet the shape of urban growth impacts sustainability across all its dimensions. The rise of urban inequality has increased social exclusion and marginalization in cities and exacerbated urban sprawl, or expansion in land that outpaces urban population growth. Along with poor public transportation infrastructure, sprawl has undermined the resource efficiencies of urban living as well as furthered the marginalization of the poor in remote or peripheral parts of cities, often in extremely dense informal settlements with little or no open and public space.[553] The poorest urban women are often unable to access services, and may live within urban cultural enclaves in which their marital and reproductive lives, and fertility rates, are closer to those of rural women.[554] How urbanization meets the needs and aspirations of urbanizing populations, particularly the poor, is therefore greatly dependent on the choices governments make regarding urban population growth, land, housing and infrastructure.

Though governments in 1994 recognized the importance of urbanization and cities, half of them considered the spatial distribution in their countries to be dissatisfactory and in need of modification, particularly associated with rapid urbanization and excessive concentration of populations in large cities. Many governments continue to have these concerns today.[555]

In the Global Survey, when governments were asked about urbanization issues that they have addressed that is, committed policies, budgets and implementation, in the preceding 5 years, the highest proportion of countries mentioned addressing decentralization (74 per cent). This issue is of particular relevance to African countries, where 85 per cent have committed to its implementation, as well as to countries in Asia (9 per cent) and the Americas (73 per cent). Decentralization can take place along spatial, fiduciary and/or administrative dimensions. Each can be appropriate in the right context, though the latter two usually comprise two of the universal aspects of good governance. For many cities the decentralization

[550] UNEP (2011): Towards a Green Economy: Pathways to Sustainable Development, UNEP, Nairobi; Sustainable Service Delivery in an Increasingly Urbanized World. USAID Policy. October 2013. http://www.usaid.gov/sites/default/files/documents/1870/USAIDSustainableUrbanServicesPolicy.pdf

[551] Mora, Luis. "Women's Empowerment and Gender Equality in Urban Settings: New Vulnerabilities and Opportunities", chapter 13 in Martine et al, eds, The New Global Frontier. London: Earthscan. 2008.

[552] White, M., Muhidin, S., Andrzejewski C., Tagoe E., Knight R., and Reed, H. (2008) Urbanization and Fertility: An Event-History Analysis of Coastal Ghana *Demography* 45(4): 803-816.; Goldstein S, Goldstein A. 1983. "Migration and Fertility in Peninsular Malaysia: An Analysis Using Life History Data" Rand Corporation Report No. N-1860-AID. Rand; Santa Monica, CA.; Brockerhoff M. "Migration and the Fertility Transition in African Cities." In: Bilsborrow RE, editor. Migration, Urbanization, and Development: New Directions and Issues. Norwell, MA: Kluwer Academic Publishers; 1998. pp. 357–90.; Shapiro D, Tambashe BO. "Fertility Transition in Urban and Rural Sub-Saharan Africa: Preliminary Evidence of a Three-Stage Process" Journal of Africa Policy Studies. 2002;8:103–27.

[553] UN-Habitat (2013), "The relevance of street patterns and public space in urban areas". Working Paper

[554] UNFPA. (2007). *Unleashing the Potential of Urban Growth. State of the World Population 2007*. New York, UNFPA; Tacoli, C. (2012) "Urbanization, gender and urban poverty: paid work and unpaid carework in the city." UNFPA and IIED Working Paper..

[555] United Nations, Department of Economic and Social Affairs, Population Division (2013), *World Population Policies 2011* Table VII-3, p. 98-99.

of decision-making and budgeting can go a long way toward resolving urban dysfunction and providing urban residents with a stronger voice in local governance. Yet decentralization can also place significant added governance responsibilities in the hands of secondary and tertiary cities, which are home to the large majority of urban residents globally yet often lack the capacity, resources and local tax bases of primary cities or megacities. Governments identified this in their responses to the Global Survey, with 71 per cent reporting having addressed the growth of small or medium-sized urban centres.

Among the most highly urbanized countries, governments were far more likely to address "land, housing, services and livelihoods for the urban poor" (71 per cent) and to report that they have been addressing "environmental management of urban agglomerations" (67 per cent) in the past five years. These issues had been addressed by only 40 per cent of less urbanized countries, despite the fact that many are now urbanizing very quickly (2 per cent or more annually).

"Proactive planning for urban population growth" is an issue that is addressed by well over half (57.8 per cent) of countries, with higher levels prevailing in fast-growing and less-urbanized countries. This information contrasts with other data showing a steady increase in the number of developing countries that are attempting to reduce urban growth. It also contrasts with addressing the "integration of rural-urban migrants," which only 23 per cent of countries reported. Commitment to this issue is critical, since the lack of integration of migrants into the city has been cited as one of the major factors underlying the rapid growth of slums.

4. The challenge of slums

Amidst widespread urban growth, many governments are presented with significant urban management concerns, including gaps in service provision, traffic congestion, poor land management and sprawl, and environmental degradation. While these challenges may affect all residents of a given city, they cause the greatest burden to the urban poor, who face enormous challenges in locating and maintaining secure housing, accessing work or public resources and achieving quality of life, as recognized in the 46th session of the Commission on Population and Development of 2013.[556]

The total estimated number of global slum dwellers has risen from over 650 million in 1990 to about 820 million in 2010.[557] Almost 62 per cent of the urban population in sub-Saharan Africa lived in housing designated as slums in 2010, the highest of any region in the world by a large margin.

But slum growth should not be conflated with urbanization, as urban population growth and urban slum growth are two distinct phenomena. The majority of evidence suggests that global urbanization is an inevitable trend, though at different rates in distinct places. Slum populations, on the other hand, have declined as a proportion of total urban population, even in sub-Saharan Africa, where 70 per cent of the population in urban areas in 1990 were in housing designated as slums. Slum growth is in a significant way an outcome of governance decisions to *limit access* to the city for the poor, through limited service provision to informal settlements, or by forced evictions and resettlement of the urban poor to peripheral or under-serviced areas.

The vulnerability of people, especially women, in many urban areas today reflects the absence of proactive, innovative planning for the provision of safe housing, adequate health services, reliable

[556] United Nations, Department of Economic and Social Affairs, 46th Session of the Commission on Population and Development, Resolution 2013/1, "New Trends in Migration: Demographic aspects"
http://www.un.org/en/development/desa/population/pdf/commission/2013/documents/CPD46_Resolution_2013_1.pdf

[557] UN-Habitat Global Slum Estimates, 2012. Captures population living in household that lack either improved water, improved sanitation, sufficient living area (more than three persons per room), or durable housing.

transport to the economic centre, and protections from violence, both through adequate lighting and sanitation, as well as community systems of social protection. **States, including through local municipalities, should fulfil the need for public housing; provide for affordable housing and the development of infrastructure that prioritizes the upgrading of slums and regeneration of urban areas; and commit to improving the quality of human settlements so that all people have access to basic services, housing, water and sanitation and transportation, with particular attention to security and safety, especially to prevent gender based violence.**

Yet despite the numerous stresses within urban slums, including evidence of heightened violence and risk within informal urban settlements,[558] urban centres continue to attract rural populations – especially young adults – in developing countries, as they seek greater economic opportunities and social freedom. This is why, despite anti-urban policies and widespread attention to lowering urban growth rates around the world, urbanization persists.

Human rights elaborations since the ICPD: Water and sanitation

Intergovernmental human rights outcomes: The General Assembly adopted *Resolution 64/292 The Human Right to Water and Sanitation* (2010) which "recognized the right to safe and clean drinking water and sanitation as a human right that is essential for the full enjoyment of life and all human rights." Subsequently, Human Rights Council *Resolution 15/9 Human Rights and Access to Safe Drinking Water and Sanitation* (2010) affirmed the right to water and sanitation as enshrined within the right to an adequate standard of living.

Other soft law*: General Comment No. 15: The Right to Water* (2002) adopted by the Committee on Economic, Social and Cultural Rights explains that the right to water is implicit in articles 11 and 12 of the *International Covenant on Economic, Social and Cultural Rights*, which protects the right to an adequate standard of living, and the right to health. The *Guidelines for the Realization of the Right To Drinking Water and Sanitation* (2005) are "intended to assist government policymakers, international agencies and members of civil society working in the water and sanitation sector to implement the right to drinking water and sanitation."

5. The importance of urban rural links: strengthening the health system

At the lowest income levels, health indicators for poor urban residents are often equivalent or worse than those of their rural counterparts – and far below those of the urban well-to-do. A review of rural and urban maternal health care across 23 African countries in the 1990s found that, while on average the urban poor received better antenatal and delivery care than rural residents, the disadvantage of the urban poor was more notable in countries where maternal health care was somewhat better.[559] In short, where health sectors are least effective, rural and urban care suffers more equally. But where resources have strengthened care, the urban middle and upper class have gained disproportionately.

For the urban poor, health services are routinely over-crowded and often manned by over-stretched health workers. With the rise of unregulated, private providers in urban areas, poor urban residents may have to pay for services that are delivered free of charge in rural areas at public health posts. For those living in slums, health-seeking can require long travel to facilities located on the outskirts of slums, and transport and cost can both act as barriers to care. The urban poor often receive poorer quality of services in both public and private sector facilities compared to wealthier urban residents. The urban

[558] Muggah, R. (2012). Researching the Urban Dilemma: Urbanization, Poverty and Violence. Ottawa: International Development Research Centre.
[559] Magadi, M., Zulu, E. and M. Brockerhoff (2003) *The inequality of maternal health care in urban sub-Saharan Africa in the 1990s*, Population Studies vol. 57, issue 3, 347-366

poor also face unhealthy and often risky living conditions that can contribute to poor health outcomes. Ultimately, the "urban health advantage" masks disparities between poorer and wealthier urban areas.[560] In most countries health workers are already disproportionately concentrated in urban areas,[561] although not necessarily serving the urban poor.[562] To avoid neglect of rural areas, innovations are needed to ensure that urban investments also benefit rural areas, for instance through health worker rotations, new uses of mobile technologies and other rural-urban health system linkages.[563] These innovations need also to move outside the traditional boundaries of the health system, to develop transport, resource and financial linkages between rural and urban areas that facilitate connections and reduce inequality across the spatial divide. A major challenge for the coming decades is the creation and evaluation of such innovative health system structures, responding to urban growth in a way that also yields investments in rural care.

States should promote development that will foster and facilitate linkages between urban and rural areas in recognition of their economic, social and environmental interdependence, including the development and equitable distribution of satellite and nodal centres of excellence in health, education, business, transportation and communications, to promote mobility, opportunity and economic growth for those residing in urban centres, small and medium towns and rural areas alike.

Given the urban growth expected in coming decades, coupled with the enormous reliance on urban areas for poverty reduction, economic growth and environmental sustainability, multi-sector leadership in urban planning is a growing need nationally, and globally.

Securing available and affordable land and housing is crucial to ensure housing security for the urban poor in contexts of rapid urban growth – as more people come to urban areas, space constraints and inequality in the distribution of land tend to produce rapidly increasing costs of living, with the elite capturing the most accessible and desirable land.[564]

The most significant policy challenge in the context of urbanization is not to change its trajectory, but to identify ways to extend the full set of potential benefits of urban life to all current and future urban

[560] Matthews Z, Channon A, Neal S, Osrin D, Madise N, et al. (2010) Examining the "Urban Advantage" in Maternal Health Care in Developing Countries. PLoS Med 7(9): e1000327. doi:10.1371/journal.pmed.1000327; Fotso JC, Ezeh A, Oronje R (2008) Provision and use of maternal health services among urban poor women in Kenya: what do we know and what can we do? *Journal of Urban Health* 85: 428–442. doi: 10.1007/s11524-008-9263-1; Mark R. Montgomery, "Urban Poverty and Health in Developing Countries," *Population Bulletin* 64, no. 2 (2009). Retrieved from: http://www.prb.org/pdf09/64.2urbanization.pdf.; Fasto JC, Ezeh A, Madise N, Ziraba A, Ohollah R. (2009). What does Access to Maternal Care Mean Among the Urban Poor? Factors Associated with Use of Appropriate Maternal Health Services in the Slum Settlements of Nairobi, Kenya. *Maternal and Child Health Journal*, 13(1):130-137; Salgado de Snyder NV, Friel S, Fotso JC, Khadr Z, Meresman S, Monge P, Patil-Deshmukh P. (2011). Social conditions and urban health inequalities: Realities, challenges and opportunities to transform the urban landscape through research and action *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 88(6); Ghei K, Siddharth A, Subramanyam MA, Subramanian SV. (2010). Association between child immunization and availability of health infrastructure in slums in India. *JAMA Pediatrics*, 164(3). : 243-249.; Hulton L, Matthews Z, Stones RW (2007) Applying a framework for assessing the quality of maternal health services in urban India. *Social Science &* Medicine, 64: 2083–2095. doi: 10.1016/j.socscimed.2007.01.019.; Das J, Hammer J (2007) Money for nothing: the dire straits of medical practice in Delhi, India. *Journal of Development Economics* 83: 1–36. doi: 10.1016/j.jdeveco.2006.05.004.; Das J, Hammer J. (2007). Location, location, location: residence, wealth and the quality of medical care in Delhi, India. *Health Affairs*, 26: 338–351. doi: 10.1377/hlthaff.26.3.w338.; Fotso JC. (2006) Child health inequities in developing countries: differences across urban and rural area, *International Journal of Health* Equity, 5:9.

[561] Lincoln Chen et al, Human resources for health: overcoming the crisis. Lancet 2004; 364: 1984-90; WHO Health workforce "Achieving the health related MDGs. Its takes a workforce" http://www.who.int/hrh/workforce_mdgs/en/index.html; Dussault G, Franceschini MC. (2006). Not enough there, too many here: Understanding geographical imbalances in the distribution of the health workforce. *Human Resources for Health*, 4:12. doi: 10.1186/1478-4491-4-12

[562] Matthews Z, Channon A, Neal S, Osrin D, Madise N, et al. (2010) Examining the "Urban Advantage" in Maternal Health Care in Developing Countries. PLoS Med 7(9): e1000327. doi:10.1371/journal.pmed.1000327; Mark R. Montgomery, "Urban Poverty and Health in Developing Countries," *Population Bulletin* 64, no. 2 (2009). Retrieved from: http://www.prb.org/pdf09/64.2urbanization.pdf.;

[563] Govindarajan, Vijay and Ramamurti, Ravi (2013). Delivering World-Class Health Care, Affordably. Harvard Business Review; Syed et al. (2012). Developed-developing country partnerships: Benefits to developed countries? *Globalization and Health* 8:17. http://www.globalizationandhealth.com/content/8/1/17; Judith A. Effken and Patricia Abbott (2009). IT-enabled Care for Underserved Rural Populations: The Role of Nursing. J Am Med Inform Assoc. Jul-Aug; 16(4): 439–445.

[564] UN-Habitat (2010). Land in Support of Sustainable Urbanization. Report from the Third Ministerial Conference on Housing and Urban Development.

residents, and to do so in ways that can also link urban-rural development. The following case studies in urban planning and management offer innovative examples of ways that governments and their partners are building sustainable urbanization.

Case study: Sustainable urbanization

Ecuador: *Preparing for urban expansion: access to residential land for the urban poor*[565]

Ecuadorian cities are no exception to urban expansion, and while currently there is undeveloped land available for residential development, there are serious shortages of serviced urban land for low-income housing in the formal sector. This has led to a great share of land subdivision and sale taking place in the informal sector – either through land invasions or through informal land subdivisions which do not conform to zoning and subdivision regulations. Compared to other countries, a very high percentage of urban households in Ecuador live in unauthorized housing communities without legal title documents.

In order to guarantee that residential land for the urban poor will remain affordable, municipalities must ensure that accessible urban land remains in ample supply in the coming years, so that land prices will not be subject to speculative increases.

To this end, seven intermediate municipalities in Ecuador which are presently experiencing rapid urban growth have started delimiting new expansion areas based on preliminary population and built-up area projections, planning the arterial road networks in the new expansion areas, refining legal tools for acquiring the rights of way for the arterial road networks and estimating the budgets needed for implementation. If carried out early enough, this strategy involves a relatively low amount of investment and has a potentially high rate of return in economic, social, demographic and environmental terms.

(For additional case study see Annex I, Box 2)

Capitalizing on urbanization[566]

First step: **Accept urbanization as a part of the development process**

- Political opposition to urban growth has little impact on slowing it, but infringes on individual rights, and can make both urban and rural poverty worse. When migrants make a choice to move to the city, they are making a rational choice to improve their lives and reduce vulnerability.
- Once policymakers accept the inevitability of urban growth, they are in a position to improve their cities and the lives of its present and future residents.

Second step: **Plan for growing cities in the context of rural urban links**

- The major issues that affect cities throughout the world – housing, transportation, environment, water, sanitation, energy, among others – all require a coordinated regional approach that cuts through fragmented boundaries and includes both peri-urban and rural areas. Rural development and urban development are not contradictory, but instead reinforce each other, particularly given that many people have dual residence.

Third step: **Promote the sustainable use of space**

- Work openly and transparently with communities and the private sector to develop a participatory vision of where and how the city should grow.

[565] Based on: Angel, S. "Preparing for Urban Expansion: A Proposed Strategy for Intermediate Cities in Ecuador", chapter 6 in Martine et al, eds, The New Global Frontier. London: Earthscan. 2008.
[566] Based on: UNFPA. (2007). *Unleashing the Potential of Urban Growth. State of the World Population 2007.* New York, UNFPA

- Promote urban growth within a systematic concern for environmental values.
- Minimize the size and impact of the urban blot through policies to limit sprawl.
- Set aside land for public space.
- Favour energy-saving and well-integrated mass transportation.
- Favour density, compactness and effective links between agglomerations.

Fourth step: **Promote the social use of space**

- Improve slum areas *in situ*, focusing on mixed use construction and housing solutions that can expand over time as households grow.
- Improve functioning of land markets and re-invest taxes charged on capital gains from urban land speculation in land banks for the future.
- Develop supports for land, housing and services for the urban poor; their integration and prospects for dignity and livelihoods are vital to the ongoing success of cities.

6. Government priorities: Internal migration and urbanization[567]

Improving the quality of urban life	**51 per cent of governments**
Develop urban planning programmes, policies, laws and institutions	**48 per cent**
Develop and promote small and medium urban centres	**32 per cent**
Social protection	**32 per cent**
Environmental management	**23 per cent**

National priorities particular to spatial distribution, internal mobility and urbanization can be understood across two critical dimensions aligned with the nature of urban growth and its intersection with both urban and rural development. The first focuses on whether the government places greater emphasis on improving urban centres, small and medium urban areas, or rural areas. Among these, governments were far more likely to give priority to "quality of urban life" (51 per cent of governments mentioned this among their top five priorities), while fewer mentioned "development and promotion of small and medium urban centres" (32 per cent), or "rural development[568]" (16 per cent). Among the governments mentioning "rural development" as a priority, almost 30 per cent of countries in Asia made this a priority, but just two of 30 governments in the Americas (where the urban transition is essentially complete).

The second dimension is whether governments prioritized recognition of "population dynamics related to urbanization" – urban population growth, sprawl or concentration, internal migration out of rural areas or into urban areas (14 per cent of governments) – or whether they prioritized "efforts to influence the spatial distribution of the population or prevent urbanization" (21 per cent of governments). A greater relative proportion of governments in Africa (27 per cent) and Asia (29 per cent), where rapid urbanization is currently unfolding, prioritized the latter.

Governments consistently prioritized the "development of urban planning policies, programmes and strategies and the creation of laws and institutions" associated with urbanization (48 per cent), as well as "social protection" (32 per cent) and "environmental management" (23 per cent). Asian governments were more likely to be concerned about environmental management linked to urban areas, with 34 per

[567] See Annex II for full table of government priorities by region including definitions of each priority.
[568] Refers to all priorities related to rural development, including addressing disparities between rural and urban areas, but excluding those with the stated intention of keeping people in rural areas.

cent identifying it as a priority. Social protection was the third most frequent priority in the Americas, with 40 per cent of governments identifying it.

States should capitalize on the opportunities that urbanization provides for sustainable development, and undertake proactive participatory planning to harness the benefits of higher population density in urban areas, recognizing the significant impact that greater internal migratory flows have on the distribution and concentration of populations in cities, notably higher energy efficiency in transport and housing, as well as cheaper provision of health, communications and other basic services per capita.

C. International migration

The total estimated number of international migrants[569] in the world has increased from 154 million in 1990 to 232 million in 2013, and its continued rise is expected into the foreseeable future. Although this represents an increase in the number of migrants, the percentage of international migrants compared to the global population has changed only slightly in the 23-year period, from 2.9 per cent in 1990 to 3.2 per cent in 2013. The percentage of all international migrants living in developed countries increased from 53 per cent in 1990 to 59 per cent in 2013, when international migrants represented 10.8 per cent of the total population in developed countries, compared with 1.6 per cent of the total population in developing countries.[570]

Contemporary patterns of international movement are significantly more complex than those of the past, not only because of the sheer numbers of international migrants, but also because the flows are now truly global. The growth and diversification of migration patterns have meant that an increasing number of countries are affected by migration, and that most countries are now concurrently countries of origin, destination and transit. In 2010, of the 43 countries hosting at least 1 million immigrants, 24 were the place of origin for more than 1 million emigrants. Countries that experienced large gains in numbers of migrants between 1990 and 2010, such as Malaysia, Nigeria and Thailand, also experienced a large increase in the number of their citizens living abroad.[571]

Additionally, the composition of migration flows is changing in a number of ways. Today's migrants come from a broader spectrum of economic, social and cultural backgrounds than ever before. Among international migrants worldwide today, approximately half are women (48 per cent) – 52 per cent in developed countries and 43 per cent in developing countries.[572] Since women often live longer than men, they tend to be overrepresented among older migrants. The large guest worker programmes in Europe in the 1950s, 1960s and the early 1970s were male dominated.[573] Changes in the migratory behaviour of women became apparent in the 1980s and 1990s with the development of service sector employment and, in particular, the growing need for nurses, teachers and domestic workers.[574] Women

[569] The data presented here refer to the international migrant stock defined as a mid-year estimate of the number of people living in a country or area other than the one in which they were born or, in the absence of such data, the number of people of foreign citizenship. Most statistics used to estimate the international migrant stock were obtained from population censuses, population registers and nationally representative household surveys. The estimates of the migrant stock were prepared by the Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat.

[570] United Nations Department of Economic and Social Affairs, Population Division, The number of international migrants worldwide reaches 232 million (Population Facts No. 2013/2)

[571] United Nations, Department of Economic and Social Affairs, 46th Session of the Commission on Population and Development, "New Trends in Migration: Demographic aspects", Report of the Secretary-General E/CN.9/2013/3

[572] United Nations Department of Economic and Social Affairs, Population Division, The number of international migrants worldwide reaches 232 million (Population Facts No. 2013/2)

[573] Martin P. (2006). Managing labor migration: Temporary worker programmes for the 21st century. International Symposium on International migration and Development, Population Division, Department of Economic and Social Affairs, UN Secretariat, Turin, Italy, 28-30 June 2006. UN/POP/MIG/SYMP/2006/07. Retrieved from: http://www.un.org/esa/population/migration/turin/Symposium_Turin_files/P07_Martin.pdf

[574] International Labour Organization. (2008). Women and men migrant workers: Moving towards equal rights and opportunities. Retrieved from:

are now likely to migrate on their own or as heads of households.[575]

The median age of international migrants is estimated to be 38.4 years, compared with 29.2 years in the total population. International migrants tend to be older than their non-migrating counterparts, especially because children born to persons born abroad are included in native-born population.[576] However, immigration flows to selected European countries (Denmark, Germany, Italy, the Netherlands, Norway, Slovenia and Sweden) for the years 2008 and 2009 suggest that a high proportion of the foreigners entering a country as migrants in any given year are concentrated in the younger adult ages.[577] In these countries, on average, 2 out of every 5 newly arriving migrants are aged 18 to 29.

1. Regional differentials in international migration

In 2013, there was as much international migration between developing countries as there was from developing to developed countries. About one-third (82.3 million or 36 per cent) of global migrants both originated in and was living in developing countries in 2013. Another one-third (81.9 million or 35 per cent) of the total number of global migrants were born in developing countries, but resided in developed countries. Further, about one-quarter (53.7 million or 23 per cent) of all international migrants in the world were born and living in developed countries. The percentage of international migrants who were born in developed countries and now living in developing countries stood at only 6 per cent (13.7 million).[578]

While migration from developing to developed countries has been the main driver of global migration trends, doubling from 40 million in 1990 to 81.9 million in 2013 and growing more than twice as fast as the global total, migration between developing countries remains the largest category (82.3 million).[579]

Major regions of the world account for different shares of migrants (Figure 50). For example, in 2013, Europe hosted 31 per cent of the total number of migrants, whereas it was the origin of 25 per cent of all emigrants (of whom 65 per cent were also living within Europe). In comparison, Asia and Northern America hosted 31 per cent and 23 per cent of the total number of migrants respectively, while they were the origin of 40 and 2 per cent of all emigrants. Furthermore, the majority of international migrants from Europe (65 per cent), Asia (58 per cent) and Oceania (58 percent) were living in a country within their region of birth (58 per cent in both cases), whereas, the majority of international migrants born in Latin America and the Caribbean (85 per cent), Northern America (72 per cent) and Africa (51 per cent) were residing in a country outside their major area of birth.[580]

International migration flows have become increasingly diversified over the past 20 years, with countries such as Mexico, China, India and the Russian Federation emerging as important places of origin and destination. In 2013, 3.2 million Bangladeshis were residing in India, whereas some 2.9 million international migrants from India were residing in the United Arab Emirates and 1.8 million in Saudi Arabia. Likewise, the United States of America hosted some 13 million persons born in Mexico, 2.2 million foreign-born from China, 2.1 million from India and 2 million from the Philippines. Finally,

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http://www.ilo.org/wcmsp5/groups/public/---dgreports/---gender/documents/publication/wcms_101118.pdf/

[575] UNFPA. (2007). *Unleashing the Potential of Urban Growth. State of the World Population 2007*. New York, UNFPA

[576] United Nations Department of Economic and Social Affairs, Population Division, International Migration 2013: Age and Sex Distribution (Population Facts No. 2013/4)

[577] United Nations Department of Economic and Social Affairs, Population Division. International Migration in a Globalizing World: The Role of Youth. Technical paper No. 2011/1

[578] United Nations Department of Economic and Social Affairs, Population Division, International Migration 2013: Migrants by origin and destination (Population Facts No. 2013/3)

[579] United Nations Department of Economic and Social Affairs, Population Division, International Migration 2013: Migrants by origin and destination (Population Facts No. 2013/3)

[580] United Nations Department of Economic and Social Affairs, Population Division, International Migration 2013: Migrants by origin and destination (Population Facts No. 2013/3)

bilateral flows of international migrants are especially large for Kazakhstan, the Russian Federation and Ukraine.[581]

One result of low fertility rates and ageing populations is labour shortages at all skill levels, and the need for skilled care for older persons in ageing societies will increase in coming decades.[582] These are already easily identifiable in many developed countries and can be foreseen in many developing countries, especially those that have seen unprecedented rates of economic growth in recent decades.[583] At the same time, many developing countries still experience a mismatch between the number of young, working-age people and the absorptive capacities of their labour markets.[584] As a consequence, while migration flows (particularly labour migration) are primarily due to economic conditions and inequalities, they can also be explained by demographic imbalances reflected in labour force surpluses and deficits. Migration already contributes to population growth in many countries, but the long-term demographic outcome of migration will vary depending on the composition of the migrant population and on whether movement is temporary, long-term, or permanent; whether it coincides with childbearing or childrearing in the country of destination; and whether migrant children are granted citizenship and adopt the new country as their own.[585]

Figure 50
International migrants by major area of origin and destination, 2013
(millions)

		Origin								
		Africa	Asia	Europe	LAC	Northern America	Oceania	Various	Total	per cent destination
Destination	Africa	15.3	1.1	0.8	0.0	0.1	0.0	1.4	18.6	82
	Asia	4.6	53.8	7.6	0.7	0.6	0.1	3.4	70.8	76
	Europe	8.9	18.6	37.8	4.5	0.9	0.3	1.3	72.4	52
	LAC	0.0	0.3	1.2	5.4	1.3	0.0	0.2	8.5	64
	Northern America	2.0	15.7	7.9	25.9	1.2	0.3	0.0	53.1	2
	Oceania	0.5	2.9	3.1	0.1	0.2	1.1	0.1	7.9	14
	Total	31.3	92.5	58.4	36.7	4.3	1.9	6.4	**231.5**	
	per cent origin	49	58	65	15	28	58			

Source: United Nations Department of Economic and Social Affairs, Population Division, International Migration 2013: Migrants by origin and destination (Population Facts No. 2013/3). [http://www.un.org/en/development/desa/population/theme/international-migration/index.shtml]

Note: Latin America and Caribbean refers to Latin America and the Caribbean

Migration is a key enabler for social and economic development in countries of origin and destination[586].

[581] United Nations Department of Economic and Social Affairs, Population Division, International Migration 2013: Migrants by origin and destination (Population Facts No. 2013/3)

[582] Mullan F, Frehywot S, Jolley LJ. (2008) Aging, Primary care, and self-sufficiency: health care workforce challenges ahead. *The Journal of Law, Medicine & Ethics: A journal of the American Society of Law, Medicine & Ethics*, Winter; 36(4): 703-708. doi: 10.1111/j.1748-720X.2008.00325.x.; Rechel B, Doyle Y, Grundy E, McKee M. How can health systems respond to population ageing? *Policy Brief 10*. World Health Organization Europe. Retrieved from: http://www.euro.who.int/__data/assets/pdf_file/0004/64966/E92560.pdf.; Center for Health Workforce Studies, School of Public Health, University at Albany. The impact of the aging population on the health workforce in the United States: Summary of key findings. Retrieved from: http://www.albany.edu/news/pdf_files/impact_of_aging_excerpt.pdf.

[583] Bloom DE, Canning D, Fink G. (2011). Implications for Population Aging for Economic Growth. Harvard School of Public Health. Program on the Global Demography of Aging, Working Paper Series, Working Paper No. 64. Retrieved from: http://diseaseriskindex.harvard.edu/pgda/WorkingPapers/2011/PGDA_WP_64.pdf.

[584] International Labour Organization. (2013). Global Employment Trends for Youth 2013: A Generation at Risk. Retrieved from: http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/publication/wcms_212423.pdf.

[585] International Organization for Migration. (2011). Economic Cycles, Demographic Change and Migration, Background Paper. International Dialogue on Migration 2011, the Future of Migration: Building Capacities for Change, Intersessional Workshop 12 and 13 September 2011. Retrieved from: http://www.iom.int/jahia/webdav/shared/shared/mainsite/microsites/IDM/workshops/economic-cycles-demographic-change/Background-Paper-EN.pdf.

[586] United Nations, Department of Economic and Social Affairs, 46th Session of the Commission on Population and Development, "New Trends in Migration:

It is also an important vehicle for the human development of migrants and their families, enlarging their capabilities, opportunities and choices that can improve their lives and those of their families. **States, should embrace the contributions migration makes to the political, economic, social and cultural fabric of countries of origin and destination alike, as well as to the global community, and should build better systems for monitoring the development benefits of migration.**

Financial transfers in the form of remittances, sent by migrants to their homes countries and networks, exceed official development assistance (ODA) and constitute the largest single source of financial flows to some developing countries, exceeding at times foreign direct investment (FDI) flows. These transfers, which reached US$ 401 billion in 2012 (not counting flows through informal channels)[587], can have positive development impacts on countries of origin. They supplement the family income, directly improving the quality of life, lifting families out of poverty, increasing access to education and health services, and, through their multiplier effects, may generate income and employment in the wider economy.

Migrants are also important for transmitting "social remittances" to their countries of origin[588], including new ideas, products, information and technology, and diasporas play an important role in establishing academic and business networks between countries of origin and destination.

There are also social costs of migration, including for children and the elderly who remain in the country of origin, as well the challenge of the emigration of skilled professionals from developing countries ("brain drain"). Migration of highly educated and highly skilled segments of the population can be a loss of much-needed talent to sending countries, and may hinder the implementation of national development strategies. In 2006, the global shortage of health workers was estimated at 4.3 million, including 2.4 million doctors, nurses and midwives. Among the 57 countries facing a critical shortage of doctors and nurses, 36 were situated in sub-Saharan Africa. Several countries have implemented voluntary codes to limit the recruitment of health workers from countries experiencing severe shortages of doctors and nurses. In 2010, the World Health Assembly adopted a global code of practice guiding Member States in the recruitment of health workers. While affirming the right of health professionals to seek employment in other countries, the code discourages Member States from actively recruiting health personnel from developing countries that face critical health worker shortages and promotes international cooperation regarding the development of the national health workforce.[589]

The ICPD Programme of Action was a landmark for international migration, recommending increased policy coherence, and calling on governments of countries of origin and destination to seek to make the option of remaining in one's country a viable one for all people. At the Millennium Summit, world leaders agreed, inter alia, to ensure respect for, and protection of, the human rights of migrants, migrant workers and their families.

In the Global Survey, the issue of international migration that governments most frequently reported addressing over the past 5 years is that regarding "the trafficking and/or smuggling of migrants" (65 per cent). Regionally, this topic was addressed by a consistently large proportion of countries in Europe (71.4 per cent), the Americas (70 per cent), Asia (69.7 per cent), and Africa (65.1 per cent), but few in

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Demographic aspects", Report of the Secretary-General E/CN.9/2013/3

[587] World Bank (2013) *Migration and Development Brief 20*, April 19, 2013 http://siteresources.worldbank.org/INTPROSPECTS/Resources/334934111031501516 5/MigrationandDevelopmentBrief20.pdf

[588] Peggy Levitt, Deepak Lamba Nieves, "Social Remittances Reconsidered," Journal of Ethnic and Migration Studies, 37 (1), pp. 1-22.

[589] United Nations Department of Economic and Social Affairs, Population Division. Health Workers, International Migration and Development. Population Facts No. No. 2010/2/E/Rev.

Oceania (11 per cent). Some sixty per cent of countries reported "protecting migrants against human rights abuses, racism, ethnocentrism and xenophobia" (60.4 per cent). This issue is addressed by a higher proportion of countries in the Americas (70 per cent) and Asia (70.6 per cent), compared with those in Africa (56.5 per cent), Europe (58.6 per cent) or Oceania (20 per cent).

As the number of international migrants continues to rise, destination countries are confronted with the challenge of promoting social, political and economic integration. Integration is often best achieved at a young age, underscoring the importance of education, services and full participation for young migrants[590]. Racism and xenophobia, fueled by the global economic crisis, have strained relations between immigrant and non-immigrant communities in a number of countries.

Greater efforts should be made to promote and protect the human rights and fundamental freedoms of international migrants, regardless of their migration status, especially those of women, young people and children, and provide social protection to all migrants, including from illegal or violent acts, including acts of discrimination and crimes perpetrated on any basis, and to protect their physical integrity, dignity, religious beliefs and cultural values.

Human rights elaborations since the ICPD: International migration

Binding instruments: The *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families* (1990), which entered into force in 2003, ensures fundamental human rights protections and principles among migrant workers and their families. *The Protocol against the Smuggling of Migrants by Land, Sea and Air to the Convention against Transnational Organized Crime* (2000; e.i.f. 2004) "prevent[s] and combat[s] the smuggling of migrants…while protecting the rights of smuggled migrants."

Other soft law: *General Comment No. 1 Migrant and Domestic Workers* (2011) of the Committee on the Protection of the Rights of all Migrant Workers and Members of Their Families highlights the multifaceted vulnerabilities of domestic migrant workers and their risks throughout the migration cycle. Further, *General Comment No. 2 Rights of Migrant Workers in an Irregular Situation and Members of their Families* (2013) focuses on the unique vulnerabilities of international migrants in an irregular situation and their families, and clarifies the normative framework for the protection their rights under the *Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families*.

Over 69 per cent of countries reported that they have addressed "international migration and development" by creating institutions and programmes, policies and/or strategies. Nonetheless, this percentage is as low as 39 per cent in Oceania and 61 per cent in Europe, but it exceeds 81 per cent in Asia. In the case of the Americas, 75 per cent of countries have addressed international migration, while in Africa 70 per cent of countries have done so.

A smaller proportion of countries have addressed the issue of "strengthening dialogue and cooperation between countries of origin, transit and destination" (54 per cent). Although no remarkable differences are observed by region or population growth, this issue was addressed by a higher proportion of wealthier countries. A similar proportion of countries have focused their efforts on "strengthening support for international activities to protect and assist refugees and displaced persons" (56 per cent). Although this issue also grows in relevance as countries develop, there are large differences between high-income OECD countries (91 per cent) and high-income non-OECD countries (11 per cent). Around

[590] Commission on Population and Development Report on the forty-sixth session (27 April 2012 and 22-26 April 2013), Economic and Social Council Official Records, 2013, Supplement No. 5, http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N13/329/81/PDF/N1332981.pdf?OpenElement

one third of countries in Europe have not addressed this issue, while in the case of Africa, the Americas and Asia this percentage increases to between 42 per cent and 50 per cent. In Oceania, 8 out of 13 countries, or 67 per cent, have not addressed it. **States should address international migration through increased international, regional or bilateral cooperation and dialogue and shared responsibility with a comprehensive and balanced approach to ensure orderly, regular and safe processes of migration, recognizing the roles and responsibilities of countries of origin, transit and destination, promoting policies that foster the integration and re-integration of migrants and ensure the portability of acquired benefits from work abroad and migration.**

Fewer than half of the responding countries have addressed "the root causes of migration so that migration is by choice" (35 per cent), or to "facilitate the flow and use of remittances to support development" (42 per cent). In relation to facilitating the flow and use of remittances to support development, Africa is the only region where half of its countries address it (52 per cent), as this proportion decreases in the case of the Americas (45 per cent), Asia (43 per cent), Europe (27 per cent) or Oceania (25 per cent). A detailed sub-regional analysis illustrates differences among the American sub-regions (Caribbean: 33 per cent; Central America: 57 per cent; South America: 50 per cent) as well as in the European ones (Western Europe: 100 per cent; Southern Europe: 10 per cent; Northern Europe: 20 per cent, Eastern Europe: 14 per cent). Income and population growth analysis show that this issue addressed by a higher proportion of poor and fast-growing countries.

Finally, only 23 per cent of countries have addressed "the factors that contribute to forced internal displacement," but global and regional frequencies might have been distorted as countries where the issue is not applicable might have responded "no" (there was no "not applicable" option available in the questionnaire). Most countries that have addressed this issue are located in Africa (12), Asia (10) and Europe (6).

2. Government priorities: International migration[591]

Development of migration programmes, policies, laws and institutions	**46 per cent of governments**
Capacity strengthening of research and data systems	**35 per cent**
Maximizing social inclusions and rights of migrants	**32 per cent**
International cooperation	**28 per cent**
Trafficking	**23 per cent**

When governments were asked to identify policy priorities related to international migration for the next 5 years, the most frequently listed issues were closely aligned with the most critical aspects of migration policy for development and for migrant supports, including the "development of migration programmes, policies, laws and institutions"; "strengthening capacity of research and data systems"; "maximizing social inclusion and rights of migrants"; "international cooperation" between governments of origin, destination and transit; and "trafficking."

A significant portion of international migration happens beyond the ability of governments to track or shape it, whether irregular migration (together with border control, a priority of 23 per cent of the world's governments) or regular migration that slips through spotty and insufficient observation systems. Lack of sufficient migration data is a recognized challenge around the world, and was a priority

[591] See Annex II for full table of government priorities by region including definitions of each priority.

among one-third (35 per cent) of all governments.

Perhaps as a result of these complexities, creating national governance functions associated with international migration was a priority for almost half of all governments (46 per cent), across all regions and among four of five income groups (except for high-income non-OECD countries). As regards international cooperation, formal mechanisms of international governance around migration are still relatively new, yet 28 per cent of countries considered such international interactions an important priority for preparing for, and managing, flows of migrants.

"Social inclusion and rights" incorporate the integration, equal treatment, empowerment and rights of international migrants in society. This issue was a priority among countries in the Americas (40 per cent) and Europe (43 per cent), as well as among high-income OECD governments, where 11 of 19 listed it. "Trafficking," a topic that garnered high response as an issue that countries have been addressing over the past 5 years, was listed as a future priority for only 23 per cent of governments, and this was relatively balanced across regions.

Despite the common focus on international migration as a labour market issue, "remittances" were only the 11th most mentioned priority globally,[592] although they were mentioned by more African governments (27 per cent). African governments also frequently prioritized both "promotion of investment among diaspora communities" (41 per cent) and "reducing emigration by creating favourable conditions and preventing brain drain" (25 per cent) – issues that received significantly less attention in other regions.

One issue of critical important for international migration, though only for very specific countries that may be existentially threatened, is the link with climate change impacts. Kiribati listed as its first priority its efforts to gain support from the international community to take on Kiribati workers as part of their strategy for climate change adaptation, asking whether other governments would take in Kiribati workers if they are trained and equipped to international standards. Kiribati highlighted that international law does not recognize climate displaced people as refugees, and it is are searching for options should climate change in the country reach the point where nationals are required to look for alternate homes.

D. Insecurity of place

One of the most basic of needs – a foundational aspect of human security – is land and housing security. Vast numbers of people around the world go to sleep every night without a roof or without assurance that they will have one the next day. Land and housing insecurity exacerbates multiple other insecurities, whether income, food, legal status, safety and/or health, posing a critical threat to dignity, to personhood in the eyes of the state, and to community connectedness.

The focus on insecurity of place within the Programme of Action recognized causes of displacement ranging from environmental degradation to natural disasters and internal conflicts that destroy human settlements and force people to flee from one area of the country to another. It focused on women's increasing vulnerability to violence in displacement situations, as well as the heightened risk of displacement for indigenous peoples. Right of voluntary and safe return was a key focus, as were basic services, including SRH services, during displacement.

[592] Remittances are vitally important for some countries, and not very important for others, meaning that this particularly priority may not lend itself to a global or regional analysis.

Across the spectrum of land and housing insecurity, invisibility in the eyes of the state is a common challenge, due to a severe lack of data that hinders both estimates of the scale of those impacted and effective measures to assist them. One of the ensuing challenges for the next 5 to 10 years is to understand the scale and characteristics of populations facing such vulnerabilities, and craft more humane programmes of support.

Human rights elaborations since the ICPD: Housing

Other soft law: The right to housing is enshrined in Article 11 of the *International Covenant on Economic, Social and Cultural Rights* (1966; e.i.f. 1967) and further elaborated in *General Comment No. 4 The Right to Adequate Housing* (1991) of the Committee on Economic, Social and Cultural Rights. Following the ICPD, the first *Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and on the right to non-discrimination in this context,* appointed in 2000, defined that "the human right to adequate housing is the right of every woman, man, youth and child to gain and sustain a safe and secure home and community in which to live in peace and dignity."[593] Numerous post-ICPD international human rights instruments, as well as general comments and recommendations of the treaty monitoring bodies, have emphasized the right to housing, and the interrelationship of housing with other basic human rights.[594]

1. Women's access to land

One of the most widespread forms of land insecurity is lack of ownership rights. While most countries allow widespread property ownership, and many do not legally differentiate between men and women as property owners, in practice enormous numbers of women are denied their rights to land ownership. Whether in rural areas of developing countries where they produce the large majority of food but hold title to almost no land[595], or in urban areas where women-headed households are common and formal land ownership is particularly scarce for the poor,[596] enormous numbers of women lack the security of home and livelihood for which land tenure and property rights are so critical.

Governments committed in the Programme of Action at all levels to ensure that women can buy, hold and sell property and land equally with men, obtain credit and negotiate contracts in their own name and on their own behalf and exercise their legal rights to inheritance.

Results of the Global Survey indicate that 76 per cent of governments have enforced laws to guarantee women's property rights, including right to own, buy, and sell properties or other assets equally with men, and this proportion increases to 86 per cent in Asia. While 65 per cent of governments report enforcing laws to guarantee equal rights for women to inheritance, 72 per cent reported enforcing laws to protect women's property through harmonized laws on marriage, divorce, succession and inheritance. In both cases, regional proportions remain close to the world average with the exception of Oceania, where the proportions fall to 50 per cent and 43 per cent respectively.

Despite these advances, many countries continue to have discriminatory property and inheritance laws or practices. Even where civil laws have been introduced to provide equal rights to inheritance and

[593] United Nations Office of the High Commissioner for Human Rights. Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and on the right to non-discrimination in this context. Retrieved from: http://www.ohchr.org/EN/Issues/Housing/Pages/HousingIndex.aspx

[594] See, for example, Article 28 of the Convention on the Rights of Persons with Disabilities, and General Comments No. 7 (1997), 14 (2000), and 15 (2003) of the Committee on Economic, Social and Cultural Rights.

[595] FAO (2007) Gender, Property Rights and Livelihoods in the Era of AIDS, Proceedings Report, FAO Technical Consultation, Rome 28-30 November 2007 [ftp://ftp.fao.org/docrep/fao/010/ai521e/ai521e00.pdf]

[596] Rabenhort, C. S. and Bean, A. (2011), *Gender and Property Rights, A Critical Issue in Urban Economic Development*. The Urban Institute.

ownership, these are not necessarily implemented or respected at a local level due to persistent discriminatory social norms, and the application of customary or religious laws.

Analysis of data from the OECD Social Institutions and Gender Index shows that, for countries where data is available, women hold only 15 per cent of all land titles.[597] Where they are unable to exercise their rights to land, women are particularly at risk of eviction following widowhood. Furthermore, as access to formal credit relies heavily on asset-based lending, land-poor borrowers are at a disadvantage and data confirms women's reduced access limits their access to credit, thereby limiting women's economic opportunities.[598]

Moreover, women's poverty, coupled with a lack of alternative housing options, makes it difficult for women to leave violent family situations. Forced relocation and forced eviction from home and land have a disproportionately severe impact on women. Lack of property rights often prevent return following displacement, or may push women to stay with land even in the face of significant dangers. The impact of gender based discrimination and violence against women on women's equal ownership of, access to and control over land and the equal rights to own property and to adequate housing is acute, particularly during complex emergency situations, reconstruction and rehabilitation.[599]

States should reform laws and address customs and traditions that discriminate against women and deny women security of tenure and equal ownership of, access to and control over land and equal rights to own property and to adequate housing. States should ensure the right of women to equal treatment in land and agrarian reform as well as in land resettlement schemes and in ownership of property including through the right to inheritance, and should undertake administrative reforms and other necessary measures to give women the same access as men to credit, capital, markets and information.

Human rights elaborations since the ICPD: Women's access to land

Intergovernmental human rights outcomes: The Commission on Human Rights issued a series of resolutions on women, housing, and land, including *Resolution 2005/25 Women's Equal Ownership, Access To and Control Over Land and the Equal Rights to Own Property and to Adequate Housing* (2005), which reaffirms, "women's right to an adequate standard of living, including adequate housing, as enshrined in the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights," and "affirms that discrimination in law and practice against women with respect to having access to, acquiring and securing land, property and housing, as well as financing for land, property and housing, constitutes a violation of women's human right to protection against discrimination and may affect the realization of other human rights."

2. Homelessness

An unknown but large number of people worldwide are homeless, that is, sleeping on the streets, in abandoned buildings, in make-shift structures, in parks, or where available, in shelters for the

[597] OECD (2012). *OECD Social Institutions and Gender Index: Understanding the drivers of gender inequality*

[598] World Bank. (2012). *Mapping the Legal Gender Gap in Using Property and Building Credit*, World Bank Group, Women, Business and the Law. http://wbl.worldbank.org/Reports/~/media/FPDKM/WBL/Documents/Notes/Legal-Gender-Gap-in-Using-Property-and-Building-Credit.pdf -last accessed 17 September 2012

[599] UN Special Rapporteur on violence against women, its causes and consequences (2000), *Integration of Human Rights of Women and the Gender Perspective; Violence Against Women*, Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, submitted in accordance with Commission on Human Rights resolution 1997/44 (E/CN.4/2000/68/Add.5)

homeless.[600]

Homelessness is often considered an urban issue, but impacts people in rural areas as well. At the time of the ICPD, estimates of rural homelessness in one country were between 7 and 15 per cent, upwards of 20 per cent in river-eroded areas,[601] and natural disasters and internal displacement continue to cause rural homelessness in developing countries.[602] Homelessness is not only a problem of the poor in poor countries, but a wide range of factors including lack of social protection systems, limited public housing, income screening and vulnerable unemployment combine into homeless in developed societies.[603]

The size of the homeless population worldwide is extremely difficult to determine because many countries lack any system to count them, because homeless people, especially youth and families, cycle in and out of housing, and because of the complexities of defining homelessness. There are many persons who are precariously or inadequately housed or at imminent risk of becoming homeless, but they are not routinely included in estimates of the homeless. Determining estimates of homeless persons is most difficult in the poorest societies, and there is limited research from developing countries, despite growing recognition of the reality of highly vulnerable homeless populations, including street children.[604]

The homeless population is gaining growing attention in Europe (especially France, Germany, UK and the Czech Republic), the USA, Japan, and Australia, and findings in these countries identify common population features, such as more men than women among the adult homeless, high rates of substance use and depression, and an over-representation of population groups who have traditionally experienced discrimination (e.g., African-Americans in the United States; Aborigines in Australia; recent immigrants from Africa, Asia, South America, the Middle East, and eastern Europe in western Europe).[605]

When defining homelessness, it is important to distinguish between homeless single adults, homeless families, and homeless youth, as these subgroups are often distinct in many dimensions.[606] *Homeless families* include intact (and even extended) families displaced by conflict or environmental crisis, or when homelessness is due to extreme poverty or eviction such families are more likely to include a single young mother with young children, who may also be escaping domestic violence. [607]

[600] Haber MG, & Toro PA (2004). Homelessness among families, children and adolescents: An ecological-development perspectives. Clinical Child and Family Psychology Review, 7(3); Toro PA. (2007). Towards an international understanding of homelessness. *Journal of Social Issues*, 63(3): 461-481

[601] Rahman, T. (1993), The rural homeless in Bangladesh, Unicef: Dhaka.

[602] CARDO (Centre for Architectural Research and Development Overseas) (2003) The nature and extent of homelessness in developing countries. DFID Project No. 7905. Retrieved from: http://r4d.dfid.gov.uk/PDF/Outputs/HumanSecurity/R7905.pdf.

[603] FEANTSA European Report. The role of housing in pathways into and out of homelessness: Annual Theme 2008 Housing and Homelessness. Retrieved from: http://www.feantsa.org/spip.php?article156&lang=en. Raphnael, Stephen. 2008. "Homelessness and Housing Regulation." Presentation.

[604] CARDO (Centre for Architectural Research and Development Overseas) (2003) The nature and extent of homelessness in developing countries. DFID Project No. 7905. Retrieved from: http://r4d.dfid.gov.uk/PDF/Outputs/HumanSecurity/R7905.pdf.; Carr-Hill R. (2013). Missing millions and measuring development progress. *World Development*, 46:30-44.; The United Nations Children's Fund. (2005). The state of the world's children 2006: Excluded and invisible. Retrieved from: http://www.unicef.org/sowc06/pdfs/sowc06_fullreport.pdf.; T. Peressini, L. Mcdonald, D.J. Hulchanski. *Towards a strategy for counting the homeless*. In D.J. Hulchanski, P. Campsie, S.B.I. Chau, Hwang, E. Paradids (Eds.), Finding home: Policy options for addressing homelessness in Canada, Cities Centre, University of Toronto, Toronto (2010).; Tipple G and Speak S. (2009). The hidden millions: homelessness in developing countries. Routledge.

[605] Toro PA. (2007). Towards an international understanding of homelessness. *Journal of Social Issues*, 63(3): 461-481.; European Federation of National Organisations Working with the Homeless (FEANTSA). (2002). Immigration and homelessness in the European Union: Analysis and overview of the impact of immigration on homeless services in the European Union.; Australian Government, Australian Institute of Health and Welfare. (2011). A profile of homelessness for Aboriginal and Torres Strait Islander people. Retrieved from: http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737418954.; European Federation of National Organisations Working with the Homeless (FEANTSA). (2010). Homlessnes, Poverty and Social Exclusion. *European Journal of Homelessness.* Volume 4, December 2020.

[606] Haber MG, & Toro PA (2004). Homelessness among families, children and adolescents: An ecological-development perspectives. Clinical Child and Family Psychology Review, 7(3).

[607] Haber MG, & Toro PA (2004). Homelessness among families, children and adolescents: An ecological-development perspectives. Clinical Child and Family Psychology Review, 7(3); Shinn, Marybeth and Beth Weitzman. "Homeless Families Are Different," in Homelessness in America, 1996; Masten, A., Miliotis, D., Graham-Bermann, S., Ramirez, M., & Neemann, J. (1993). Children in homeless families: Risks to mental health and development. Journal of Consulting and Clinical Psychology, 61, 335-343; Rog DJ & Buckner JC. (2007). Homeless Families and Children. 2007 National Symposium on Homelessness Research. Retrieved from http://www.huduser.org/publications/pdf/p5.pdf; Buckner, J. C., Bassuk, E. L., Weinreb, L. E., & Brooks, M.

Homelessness among families is on the rise in the European Union[608], and in countries near areas coping with conflict or extreme poverty. [609]

Homeless youth differ from homeless adults due to their age (typically under 21 years of age) and from homeless children (in families) because they are homeless on their own. A variety of terms have been used to describe homeless youth, including *runaways*, *throwaways*, and *street youth*, who may have raised themselves on the streets. These are not mutually exclusive groups. Most research has found roughly equal numbers of girls and boys among homeless adolescents, while boys are more common among studies of older street youth.[610]

Homeless single adults are more likely male and between 18 and 50, with persons over 60 years quite rare (less than 5 per cent; note that some homeless people look much older than their years and there is some evidence that the homeless population is older now than it was a decade ago)[611]. In countries where some, albeit incomplete, social data are available, adult homelessness has recognized social determinants, including a disproportionate number of persons who grew up as orphans, in foster care or unstable childhood housing; a childhood or recent exposure to violence; a history of substance use; racial or ethnic discrimination; veterans of war; and persons suffering from emotional and mental health disabilities, or other disabilities that preclude employment.[612]

States are called upon to promote new research on the demography and vulnerability of homeless populations and to design programmes to address the determinants of homelessness and to increase security of housing for all people.

3. Forced evictions

Forced eviction involves state action, direct or indirect, to remove people from their land or homes involuntarily, and does not apply to evictions carried out both in accordance with the law and in conformity with the provisions of international human rights treaties.[613] Forced evictions eliminate the possibility of return for those who have been removed and are defined as such, regardless of whether assistance has been provided in resettlement to other areas.[614]

Causes of forced evictions commonly include urban development, large-scale development (such as dams) in rural areas, the threat of natural disasters and climate change, mega events (for example, the

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(1999). Homelessness and its relation to the mental health and behavior of low-income school-age children. *Developmental Psychology, 35*, 246-257.

[608] European Federation of National Organisations Working with the Homeless (FEANTSA). (2010). Changing faces: Homelessness among children, families and young people.

[609] European Federation of National Organisations Working with the Homeless (FEANTSA). (2002). Immigration and homelessness in the European Union: Analysis and overview of the impact of immigration on homeless services in the European Union

[610] Haber MG, & Toro PA (2004). Homelessness among families, children and adolescents: An ecological-development perspectives. Clinical Child and Family Psychology Review, 7(3); Toro PA, Dworsky A, Fowler PJ. (2007). Homeless youth in the United States: Recent research findings and intervention approaches. 2007 National Symposium on Homelessness Research, http://aspe.hhs.gov/hsp/homelessness/symposium07/toro/; Robertson, M. J., & Toro, P. A. (1999). Homeless youth: Research, intervention, and policy. In L. B. Fosburg & D. L. Dennis (Eds.), *Practical lessons: The 1998 National Symposium on Homelessness Research* (pp. 3-1-3-32). Washington DC: U.S. Department of Housing and Urban Development and U.S. Department of Health and Human Services; Feitel, Margetson, Chamas, Lipman, 1992; Robertson, Koegel, & Ferguson, 1989; Feitel, B., Margetson, N., Chamas, J., & Lipman, C. (1992). Psychosocial background and behavioral and emotional disorders of homeless and runaway youth. Hospital and Community Psychiatry, 43, 155-159; Robertson, M. J., Koegel, P., & Ferguson, L. (1989). Alcohol Use and Abuse Among Homeless Adolescents in Hollywood. Contemporary Drug Problems, Fall: 415-452.

[611] Meschede T, Sokol B, Raymond J. (2004). Hard numbers, hard times: Homeless individuals in Massachusetts Emergency Shelters, 1999-2003. Center for Social Policy Publication. Retrieved from: http://scholarworks.umb.edu/csp_pubs/29/

[612] Caton CL, Wilkins C, Anderson J. (2007). People who experience long-term homelessness: Characteristics and interventions. *Towards Understanding Homelessness: The 2007 National Symposium on Homelessness Research.* Retrieved from: http://aspe.hhs.gov/hsp/homelessness/symposium07/caton/index.htm

[613] UNOHCHR (2007) "Basic Principles and Guidelines on Development-Based Evictions and Displacement. Annex 1 of the report of the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living "A/HRC/4/18 [http://www.ohchr.org/Documents/Issues/Housing/Guidelines_en.pdf

[614] OHCHR, Fact Sheet No.25, " Forced Evictions and Human Rights", http://www.ohchr.org/Documents/Publications/FactSheet25en.pdf

Olympics; World Cup), economic evictions and the global financial crisis, and discrimination or targeted punishment.[615]

Various efforts have been made to establish monitoring systems for forced evictions, but the data are very limited, given the interest of its practitioners in hiding its occurrence. As such, estimates vary widely. In 1994, the World Bank estimated that about 10 million people per year were evicted due to public sector projects alone. Currently, estimates across the six key drivers of forced evictions range from about 2.5 million per year based on reported cases to upwards of 15 million per year.[616]

UN-Habitat is developing approaches to measuring tenure security, which it defines as a combination of "the degree of confidence that land users will not be arbitrarily deprived of the rights they enjoy over land and the economic benefits that flow from it; the certainty that an individual's rights to land will be recognized by others and protected in cases of specific challenges; or, more specifically, the right of all individuals and groups to effective government protection against forced evictions".[617] **States should end forced evictions that violate national and human rights law and establish mechanisms to monitor their occurrence and impact on affected populations.**

Human rights elaborations since the ICPD: Forced evictions

Intergovernmental human rights outcomes: The Commission on Human Rights has addressed forced eviction as a gross violation of human rights through a series of resolutions, including *Resolution 2004/28 Prohibition of Forced Evictions* (2004), which reaffirmed that "the practice of forced eviction that is contrary to laws that are in conformity with international human rights standards constitutes a gross violation of a broad range of human rights, in particular the right to adequate housing."

Other soft law: The Committee on Economic, Social and Cultural Rights has addressed forced evictions in *General Comment No. 7: The Right to Adequate Housing: Forced Evictions* (1997). The *Basic Principles and Guidelines on Development-Based Evictions and Displacement* (2007) "address the human rights implications of development-linked evictions and related displacement in urban and/or rural areas."

4. Internally displaced persons

Internal displacement implies a double vulnerability to both the cause of displacement and to the tenuousness of well-being and security in points of destination. There are two main causes of internal displacement: armed conflict, generalized violence or human rights violations; and natural disasters.

Accurate statistics on IDPs are particularly hard to obtain, since IDPs often live in urban and other local communities, not refugee camps, or are dispersed geographically, making underestimations of the number of IDPs most likely. At the same time, it is difficult to update statistics to reflect that some IDPs may have returned home, which may lead to overestimation in some instances. Furthermore, data are seldom disaggregated: only 11 countries collect IDP data disaggregated by sex, age and location.[618]

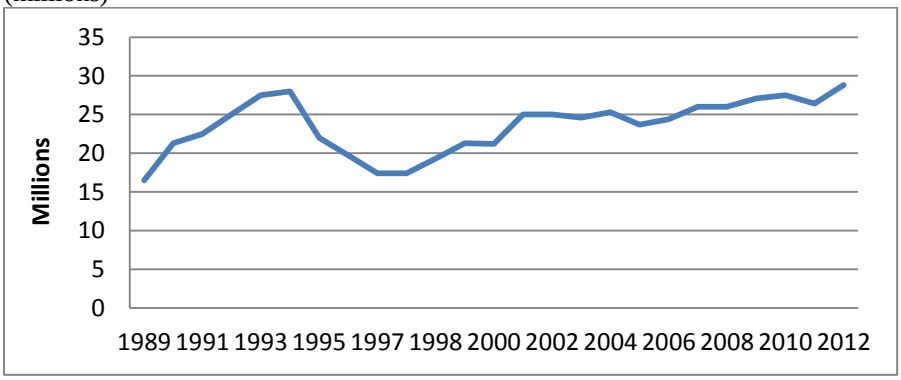
Worldwide, by the end of 2012, 28.8 million people were internally displaced due to armed conflict, generalized violence or human rights violations.[619] At the time of the ICPD, there was a peak in the

[615] UN-Habitat (2011), "Forced Evictions: Global Challenges, Global Solutions"
[616] Cernea and Mathur, in United Nations Housing Rights Programme, Jean Duplessis, 2011, p. 9; COHRE, 2009.
[617] UN-Habitat (2008) *Secure Land Rights for All* [https://www.responsibleagroinvestment.org/sites/responsibleagroinvestment.org/files/Secure%20land%20rights%20for%20all-UN%20HABITAT.pdf]
[618] Norwegian Refugee Council, Internal Displacement Monitoring Centre (NRC/IDMC) (2012), "Internal Displacement Global Overview: People internally displaced by conflict and violence"
[619] Norwegian Refugee Council, Internal Displacement Monitoring Centre (NRC/IDMC), (2013) "Internal Displacement Global Overview 2012: People

global number of persons displaced by war or conflict (see Figure 51). Following a decline through the late 1990s, there has been a steady increase in IDPs due to conflict, with recent estimates for 2013 surpassing the previously noted record numbers for 1994. In contrast to refugees, conflict-driven IDPs do not cross international borders, and therefore remain under their governments' protection, even when those governments cause the displacement. The largest number of IDPs was in sub-Saharan Africa, at 10.4 million (an increase from 9.7 million in 2011).[620] During 2012, about than 2.1 million IDPs had reportedly returned to their areas of origin, including in Libya and DRC. In DRC, 450,000 people were reported to have returned to their places of origin, but monitoring systems are so limited that accuracy is impossible to determine.

The International Displacement Monitoring Centre's (IDMC) Global Estimates Report estimates that 32.4 million people were forced to flee their homes in 2012 due to natural disasters such as floods, storms and earthquakes. For that year, nearly all of the displacement related to natural disasters was associated with climate and weather events. Floods in India and Nigeria, displacing 6.9 million and 6.1 million respectively, accounted for 41 per cent of the global total.[621]

Figure 51
IDPs due to armed conflict, violence or human rights violations, 1989-2011
(millions)



Source: Internal Displacement Monitoring Centre, Global IDP Estimates, retrieved from http://www.internal-displacement.org/8025708F004CE90B/(httpPages)/10C43F54DA2C34A7C12573A1004EF9FF?OpenDocument

In the more developed countries, an additional 1.3 million were displaced, especially within the USA. Tracking displacement over time needs to be done carefully, as displacement from natural disasters depends in part on whether disasters occur in any given year; year to year variations are likely to be caused by fluctuations in the occurrence of natural hazards, rather than due to a particular trend of displacement. Nonetheless, social factors matter just as much as the occurrence of the hazard itself: whether as a result of the earthquake in Haiti (2010) or Hurricane Katrina in the United States of America (2005), the poor, marginalized and disadvantaged were the least well-equipped to manage the consequences of displacement. In addition, climate change is projected to change the frequency, intensity, spatial extent, duration and timing of extreme weather and climate events,[622] possibly increasing displacement in the near future.

People displaced by either conflict or natural disasters share significant vulnerabilities. Secondary

Displaced by Disaster"
[620] Norwegian Refugee Council, Internal Displacement Monitoring Centre (NRC/IDMC), (2013) "Internal Displacement Global Overview 2012: People Displaced by Disaster"
[621] Norwegian Refugee Council, Internal Displacement Monitoring Centre (NRC/IDMC), (2013) "Internal Displacement Global Overview 2012: People Displaced by Disaster"
[622] IPCC 2009. Managing the Risks of Extreme Events and Disasters to Advance Climate Change Adaptation. http://ipcc-wg2.gov/SREX/images/uploads/SREX-SPMbrochure_FINAL.pdf

displacement is common, in which current IDPs are forcibly evicted due to discrimination or precarious housing situations. In 2011, this was the case in 18 of the countries monitored by IDMC. Unemployment is also generally higher among IDPs.[623] By virtue of their displacement, IDPs often lack documentation and authorization to work, and all too often, women IDPs have fewer options for income generation and, along with their children, turn overwhelmingly to precarious, low-paid, informal work and other strategies.[624] While females and males are generally displaced in equal numbers, social ruptures, temporary housing, scarcity of resources and lack of security can make conditions particularly unsafe for displaced women and girls, resulting in gender based violence.[625]

5. Refugees

According to UNHCR, the number of refugees worldwide peaked in 1992 at 17.8 million but was around 15.4 million people in 2012. In 2012, the largest group of refugees was Afghans (2.7 million), resulting in Pakistan and Iran being the two countries with the largest refugee populations within their borders. The four other countries with the highest refugee populations were Somalia, Iraq, the Syrian Arab Republic, and Sudan. Jordan has been particularly affected by the recent influx of Syrians, after also having absorbed waves of Iraqi and Palestinian refugees previously. The overwhelming majority of global refugee populations are located in the Arab region. Aside from looking at absolute numbers, the UN has devised assessments of refugee impact by considering refugees in relation to economic capacity. Using that measure, Pakistan, followed by Ethiopia and Kenya, have been the most affected by refugee influxes in 2012.[626]

Refugees experience many of the same vulnerabilities as IDPs, including the double vulnerability of displacement and livelihoods and well-being in points of settlement. As refugees face persecution and lack protection from their own state, countries of destination represent a viable solution to protect, promote and guarantee their human rights and dignity. **States should strengthen the protections and assistance to IDPs and refugees, through the provision of food, shelter, health, education and social services in the short-term, and facilitating their local integration, voluntary return, or in the case of refugees settlement in a third country in the long-term.**

Human rights elaborations since the ICPD: Internally displaced persons and refugees

Binding instruments: In 2009, the African Union adopted the *Convention on the Protection and Assistance of Internally Displaced Persons in Africa* to "establish a legal framework for preventing internal displacement, and protecting and assisting internally displaced persons in Africa."

Intergovernmental human rights outcomes: The Human Rights Council has adopted annual resolutions on the human rights of internally displaced persons, including *Resolution 20/9 Human Rights of Internally Displaced Persons* (2012) and resolutions on "human rights and mass exodus" concerning both internally displaced persons and refugees. The General Assembly has also passed resolutions on internally displaced persons and mass exodus.

Other soft law: The *Guiding Principles on Internal Displacement* (1998) provide the most

[623] IDMC, "Employment rate of IDPs", http://www.internal-displacement.org/idmc/website/countries.nsf/%28httpEnvelopes%29/C3D334B77955EA84C12579C70059E6CA?OpenDocument "Barriers to Employment of IDPs", http://www.internal-displacement.org/idmc/website/countries.nsf/%28httpEnvelopes%29/7D4A873BE935B1BBC12577ED005DDE12?OpenDocument

[624] UNHCR, New Issues in Refugee Research Paper No. 161, "Ignored Displaced Persons: the Plight of IDPs in Urban Areas", July 2008, pp. 9, 12, http://www.unhcr.org/487b4c6c2.pdf ; UNHCR monitoring and NGO reports, February – April 2008, in UNHCR IDP Working Group, "Internally Displaced Persons in Iraq – Update", June 2008, pp. 1, 17, http://www.unhcr.org/491956e32.pdf

[625] IDMC (2013), website: Internally displaced women. Gender-based violence" Retrieved on December 3 [http://www.internal-displacement.org/thematic/women#anchor0]

[626] UNHCR (2013) "*Global Trends 2012: Displacement, the new 21st Century Challenge"* [http://unhcr.org/globaltrendsjune2013/UNHCR%20GLOBAL%20TRENDS%202012_V05.pdf]

comprehensive set of human rights protections afforded to internally displaced persons to date. The Principles address the needs of internally displaced persons, and identify rights relevant to protecting persons from forced displacement and assuring "their protection and assistance during displacement as well as during return or resettlement and reintegration." The *UN Principles on Housing and Property Restitution for Refugees and Displaced Persons* (The Pinheiro Principles) (2005) contains standards on housing, land and property restitution rights for refugees and displaced persons. Regionally *OAS Resolution 2229* (2006) calls on states to address causes of internal displacement, and to provide internally displaced persons with assistance in line with the *Guiding Principles*. Similarly, *Recommendation Rec(2006)6 of the Council of Europe Committee of Ministers* recognizes the application of the *Guiding Principles* and other instruments relevant to internally displaced persons.

E. Place and mobility: Key areas for future action

1. Development efforts must recognize and account for the increasing diversity of households and living arrangements.

Marriage patterns and the ways that people organize themselves into households have gone through enormous changes in the last 20 years, resulting in more diverse types of households, including a notable rise in the proportion of people living alone, marrying late or not at all, a greater risk of divorce, and children living with a single parent. These changes fundamentally alter how we achieve the objectives of ensuring adequate, secure housing, the well-being of households and children, family support, long term care for the elderly, social protection more broadly and sustainable consumption and energy use. Many societies and legal systems continue to be oriented to traditional male-headed family structures despite these underlying changes. Women around the world suffer from having limited rights to property including land ownership, leading to disproportionate poverty in households led by women, as well as being denied inheritance in many countries, and/or left to rely on relatives in the case of widowhood or divorce.

2. The world must plan and build sustainable cities.

The world's urban population is currently growing by more than 1.3 million each week, unprecedented growth that represents people's aspirations for better prospects, and a critical opportunity for achieving sustainable development, *if the right policies are put in place to plan for this growth*. The benefits of proximity, concentration and scale in urban areas makes it easier and cheaper for the state to provide basic health, welfare and education, while at the same time maximizing energy and resource use efficiency. Cities provide major economic advantages for work and entrepreneurship, and similar advantages for social and political participation and empowerment. Yet the rise of urban inequality has increased marginalization in cities, including through the growth of urban slums, exacerbated urban sprawl and limited the ability of government to ensure the safety of urban residents. Urban management, including traffic, service provision and housing are increasingly stressed as cities grow, and the poorest residents are inevitably impacted most. The most significant challenge for urbanization is not to slow its occurrence, which has consistently proven unsuccessful, but to extend the full set of potential benefits of urban life to all current and future urban residents.

3. The international community should make migration work for development and ensure rights and security for migrants.

The total estimated number of international migrants in the world has increased since 1990, but more impactful has been the diversification of migration patterns, which has meant that a growing number of countries are affected. Migrants' formal remittances are significantly greater than official development assistance and a vital part of the development process. Today's migrants come from a broader spectrum

of cultural, economic and social backgrounds than ever before, and approximately half are now women. While many are taking advantage of new opportunities, others, particularly women, are victims of trafficking, exploitation, discrimination and other abuses. The ICPD's call for increased international, regional or bilateral cooperation continues to be relevant, and requires accelerated efforts to protect, respect and fulfil the human rights and well-being of migrants, reduce the cost of migration, enhance the knowledge base on migrants and to address attitudes and values that stigmatize migrants and obstruct their contributions to countries of origin, transit and destination.

4. Insecurity of place is a threat to dignity.

Far greater demographic and policy attention must be given to those without security of place, including those displaced by conflict or natural disasters, in refugee circumstances, those living in areas of conflict, in temporary or insecure housing, and the homeless. Insecurity of place is a threat to dignity, and leads to a disproportionate risk of violence, poverty, and adverse health outcomes. Despite some existing estimates, people without security of place are often uncounted and thereby not recognized by the state, heightening the overall precariousness of their living conditions, including the risks of exploitative and dangerous employment. Measures of those without security of place have been gradually improving, but far better monitoring and demographic attention is required to enable governments to provide social protection, health services, security and ultimately full social integration.

IV. Governance and accountability

The world has seen important shifts in the diffusion of authority and leadership since 1994, with growing recognition of the importance and power of a multiplicity of regional, national, local, civil society, private sector and other non-state actors. Understanding of governance has shifted from a dominant focus on the state, to recognition of the critical importance of partnerships for governance, and how significantly partnerships between stakeholders undergird progress towards, or away from, the fundamental development aims of dignity, human rights, equality and sustainability.[627]

States have the responsibility of designing and implementing transparent laws, policies, and programmes with clear goals, benchmarks, and adequate budgetary allocations, as well as monitoring and evaluation systems. Monitoring and evaluation of the implementation of laws, policies and programmes need to be grounded in comprehensive, reliable, accessible, transparent, and periodic information and data. Much of the existing data remain underutilized, especially in the developing world, and are not adequately brought to bear on development planning, budgeting or evaluation, calling for new investments in capacity strengthening.

As a cornerstone of good governance, accountability requires national leadership, effective state institutions, and enabling laws, policies, institutions and procedures for free, active, informed and meaningful participation of people without discrimination. Accountability represents a shift from needs to rights, to which all individuals are entitled, which has the potential to transform power relations, between men and women, service providers and users, and governments and citizens. States are obligated to respect, protect and fulfil human rights. Furthermore, mechanisms need to be in place to provide redress and remedies when rights of individuals are violated or at risk of being violated.

The ICPD generated momentum in the creation and renewal of institutions to address population and sustainable development, the needs of adolescents and youth, and women's empowerment and gender equality. The past 20 years have seen a measureable increase in the formal participation of intended beneficiaries in the planning and evaluation of investments related to the ICPD, via recognition and integration of wide networks of civil society and non-governmental organizations.

Resources for development have undergone a seismic shift, influenced by the HIV crisis, donor commitments to the MDGs, the economic crisis of 2008, and the emergence of new donor governments as well as enormously influential individual donors and foundations. Resource flows for efforts related to the ICPD have been significantly impacted, and the agenda has been shaped by new sources of funds.

These changes – the growing integration of population dynamics in development planning, greater participation and cooperation in development policy, changing resource flows, and growing global accountability systems for human rights and development – offer the potential for more evidence-based, transparent, accountable and effective governance beyond 2014.

"Governments… should work to increase awareness of population and development issues and formulate, implement and evaluate national strategies, policies, plans, programmes and projects that address population and development issues, including migration, as integral parts of their sectoral, intersectoral and overall development planning and implementation process. They should also promote and work to ensure adequate human resources and institutions to coordinate and carry out the planning,

[627] United Nations (2013). A life of Dignity for All. Secretary General's Report A/68/202.; United Nations Task Team on the Post-2105 UN Development Agenda (2012). Realizing the Future We Want for All. Report to the Secretary General.

implementation, monitoring and evaluation of population and development activities." (ICPD Programme of Action, Para 13.5)

"Governments, civil society at the national level and the United Nations system should work towards enhancing and strengthening their collaboration and cooperation, with a view to fostering an enabling environment for partnerships for the implementation of the Programme of Action. Governments and civil society organizations should develop systems for greater transparency and information-sharing, so as to improve their accountability." (Key Actions for the Further Implementation of the Programme of Action of the ICPD, Para 78)

"Governments… should strengthen their national capacity to carry out sustained and comprehensive programmes on collection, analysis, dissemination and utilization of population and development data." (ICPD Programme of Action, Para 12.3)

Human rights elaborations since the ICPD: Good governance

Intergovernmental agreements: The Human Rights Council has adopted a series of resolutions on the relationship between governance and human rights, including *Resolution 2005/68 The Role of Good Governance in the Promotion and Protection of Human Rights* (2005) which, "Urges States to provide transparent, responsible, accountable and participatory government, responsive to the needs and aspirations of the people, including members of vulnerable and marginalized groups, and to respect and protect the independence of judges and lawyers in order to achieve the full realization of human rights" and recognizes, "The need for Governments to ensure that services are delivered to all members of the public in a transparent and accountable manner that is adapted to the particular needs of the population and promotes and protects human rights."

Other soft law: In *General Comment No. 12: The Right to Adequate Food (Art.11)* (1999), the Committee on Economic, Social and Cultural Rights (CESCR) stated that "Good governance is essential to the realization of all human rights, including the elimination of poverty and ensuring a satisfactory livelihood for all." *CESCR, General Comment No. 10* (1998) highlights the role of national human rights institutions in the protection of economic, social and cultural rights. *CESCR General Comment No. 9* (1998), on the domestic application of the Covenant, provides the more developed elaboration on the governance systems and accountability mechanisms required in ensuring the effective application of economic, social and cultural rights.

A. Establishment of ICPD-related government institutions

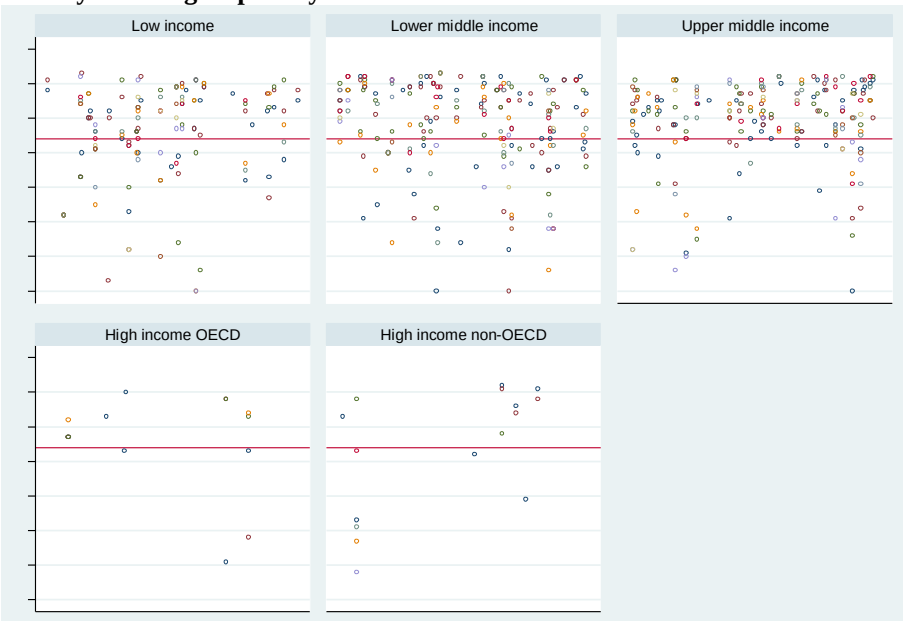
The ICPD Programme of Action called on governments to ensure adequate institutions to carry out the planning, implementation, monitoring and evaluation of population and development activities. The ICPD Beyond 2014 Global Survey (2012) asked governments whether they had "established institutional entities" to address issues related to any of the 11 major policy areas the Programme of Action: *population dynamics and sustainable development; gender equality and women's empowerment; older persons; adolescents and youth; persons with disabilities; indigenous peoples; urbanization and internal migration; international migration; family; sexual and reproductive health and rights; and education.*

Countries were asked to identify the year in which these institutions were established. For the majority of these, governments reported a wide range of institutions, established over the past 30-50 years, and some established as far back as the last century.

But for three of the 11 topics: *population dynamics and sustainable development; gender equality and women's empowerment, and adolescents and youth*, institutional expansion in the 1990s was notable, suggesting that 1994 and related conferences such as the 1992 UN Conference on Environment and Development, and the 1995 UN Conference on Women in Beijing – generated an expansion or reconfiguration of development-related institutions in countries. Figure 52, Figure 53 and Figure 54 illustrate these trends. Countries have been grouped according to World Bank income classification and for each income group one hollow circle represents one institution. The height of the circle represents the year of its establishment and institutions from the same country are aligned vertically in one line. The red horizontal line marks 1994, recognizing also that the ICPD was only one of several development-focused international conferences during the 1990s. Establishment or reconfiguration of institutions is to be interpreted at face value, as the data provide no indication of the budget, manpower, or mandate of the institution listed.

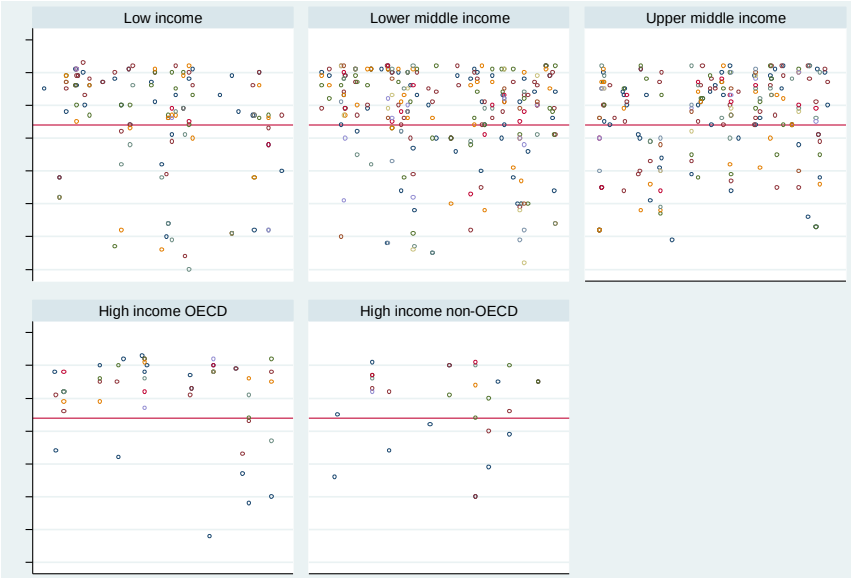
Figure 52

Establishment of institutions to address population, sustained economic growth and sustained development, by country income group and year of establishment



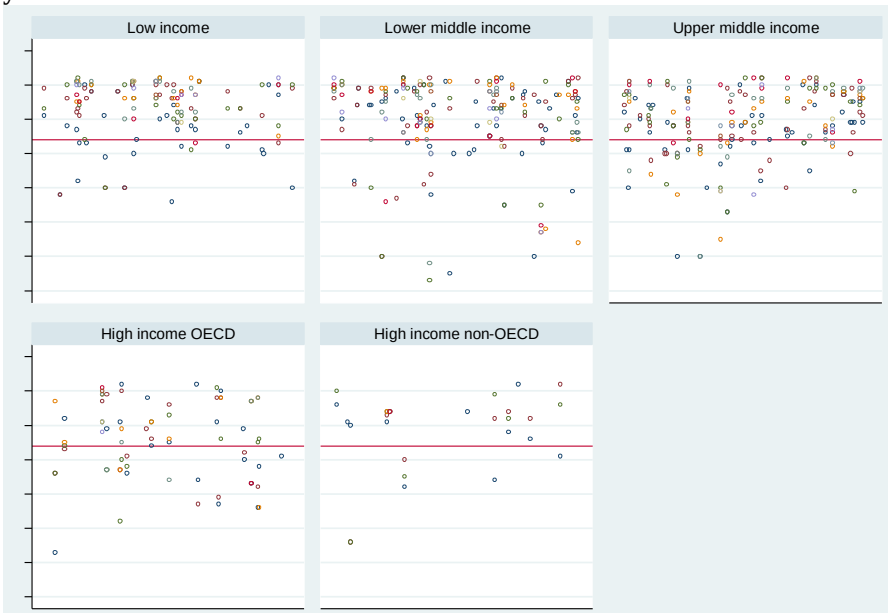
Source: The ICPD Beyond 2014 Global Survey (2012)

Figure 53
Establishment of institutions to address the needs of adolescents and youth, by country income group and year of establishment



Source: The ICPD Beyond 2014 Global Survey (2012)

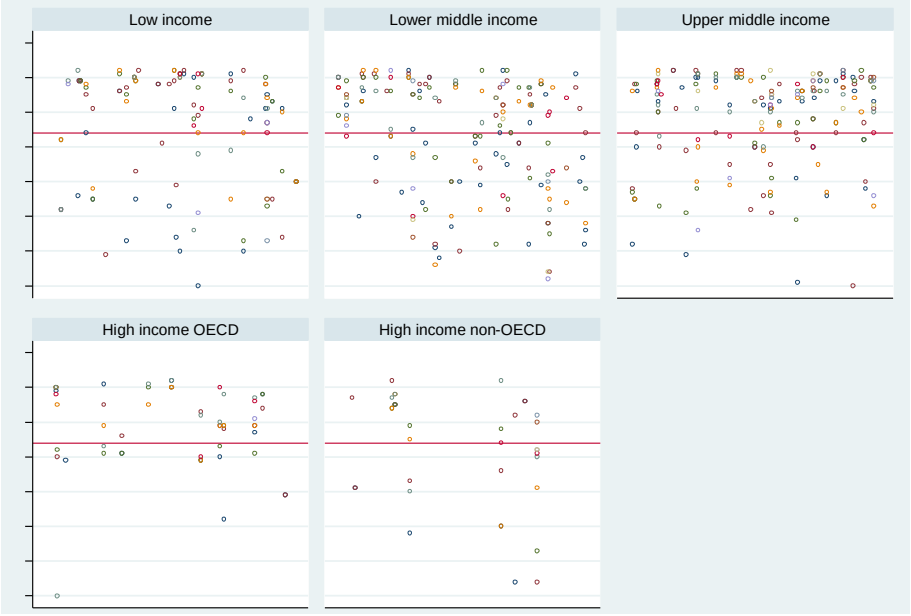
Figure 54
Establishment of institutions to address gender equality and women's empowerment, by country income group and year of establishment



Source: The ICPD Beyond 2014 Global Survey (2012)

Overall, the evidence suggests greater relative growth in government institutions to address gender equality, adolescents and youth, and population and sustainable development since the 1990s, and this clustering of newly-established institutions is not evident for the other eight themes. The theme of education serves as an example of themes for which governments reported many institutions that were established throughout the second half of the 20th century and the first decade of the 21st century (see Figure 55 below), with no explicit clustering since the 1990s.

Figure 55
Establishment of institutions to address education, by country income group and year of establishment



Source: ICPD Beyond 2014 Global Survey (2012)

The scatterplots suggest that greater institutionalization took place in developing countries, relative to richer countries, suggesting that developing countries may not have had institutions dedicated to youth or women's empowerment or use of population planning prior to the 1990s, while richer countries may have previously established (or mainstreamed) such institutions. Institutions are useful but not sufficient for development in new domains, and progress in integrating population dynamics, for example, into development planning at national and sub-national levels would require not only relevant institutions, but the necessary capacity for effective generation and use of population data within multiple sectors.

States should create and strengthen institutions to ensure the necessary capacity for effective integration of population dynamics into development planning, with a rights-based approach, as well as efficiency and accountability, including ensuring effective coordination of all relevant social and planning bodies.

B. Strengthening the ICPD-related knowledge sector

Sustainable development cannot be achieved without evidence-based governance. Effective governance demands good statistics to monitor progress, and to hold leaders accountable for their activities and achievements. Investing in statistical capacity in demography, public health, human rights, migration, economic growth, employment or climate change makes it possible to understand their linkages and impact on sustainable development, and to shape the policy process.

To address increasing inequality within countries, to better target vulnerable populations, and to ensure the benefits of development for all, sub-national and local data and projections are increasingly necessary. This responsibility falls largely on National Statistical Offices (NSOs), which are responsible for a wide array of data including census and surveys, vital registration, and administrative systems that enable the monitoring of development indicators. The dimension of the Programme of Action that focused on the integration of population data into development planning has not flourished in the last two decades, despite detailed elaboration within the Programme of Action and its importance for

ensuring development without discrimination. No clear social movement was pushing for this more technically-oriented and systems-level agenda, and the momentum to establish academic centres, think tanks, strong ministries or departments within government, has been sporadic at best. There is a need for stronger links between NSOs, academic researchers, and ministries (health, planning, finance, environment and others). While NSOs have made significant advances in the collection of disaggregated population data during the past 20 years, in many countries there are no established channels for the provision of population data directly to line ministries based on specific needs, nor is there necessarily an avenue for their analysis, nor strong partnerships between university researchers and government leaders.

Human rights elaborations since the ICPD: Building the knowledge sector

Binding instruments: International human rights instruments emphasize the importance of data collection and statistics for evidence-based program planning. For example, Article 31 of the *Convention on the Rights of Persons with Disabilities* (2006; e.i.f. 2008) states, "States Parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention. The process of collecting and maintaining this information shall…comply with internationally accepted norms to protect human rights and fundamental freedoms and ethical principles in the collection and use of statistics…The information collected in accordance with this article shall be disaggregated, as appropriate."

Intergovernmental human rights outcomes: The Human Rights Council has issued resolutions on freedom of expression, including freedom of information. *Resolution 12/116 Freedom of Opinion and Expression (2009)* stresses, "The importance of the full respect for the freedom to seek, receive and impart information, including the fundamental importance of access to information, democratic participation, accountability and combating corruption."

Other intergovernmental outcomes: The *Beijing Platform of Action* (1995) strategic objective H.3 calls for the generation and dissemination of "gender disaggregated data and information for planning and evaluation" and calls upon the UN to "promote the development of methods to find better ways to collect, collate and analyze data that may relate to the human rights of women, including violence against women, for use by all relevant United Nations bodies."

Other soft law: *The Guiding Principles on Extreme Poverty and Human Rights* (2012) highlight that "States should ensure that the design and implementation of public policies, including budgetary and fiscal measures, take into account disaggregated data and up-to-date information."

1. Civil registration

Civil registration and the resulting vital statistics are key public goods that benefit individuals and enable good governance. Civil registration is the compulsory, permanent, continuous and universal recording of the occurrence and characteristics of vital events. Through the official recording of births, deaths, marriages, divorces and adoptions, it provides individuals with the documentary recognition of their legal identity, their family relationships, their nationality and their ensuing rights. In most countries these records are also a source of vital statistics, serving the planning and monitoring needs of almost all development sectors, including health.

Recognition of the importance of legal identity by the international development and human rights communities has led to the increased profile of birth registration as a human rights issue. While the most developed countries have achieved universal coverage, in the least developed countries only about a third of the births are registered, despite an almost 30 percent gain since 2000.[628] Birth registration,[629] is

[628] UNICEF, 2013. Every Child's Birth Right: Inequities and Trends in Birth Registration. 2013. Statistical Table,pp.40-3.

the lowest in South Asia (39 per cent of births are registered) and sub-Saharan Africa (44 per cent), with birth registration rates less than 10 per cent in Ethiopia, Liberia and Somalia.[630] In countries with incomplete birth registration, rural areas and the poorest households have the greatest disadvantage.[631] For example, the difference in birth registration between urban and rural areas can be as high as over 40 percentage points in Guinea and Niger, while the difference between the richest and poorest wealth quintile can be as high as over 50 percentage points in Guinea, Mauritania, Nigeria, Sudan and United Republic of Tanzania.

The problems surrounding civil registration are often skewed against women. For example, women have difficulty in registering the births of their own children in the absence of a male relative and so are often unable to claim financial and social support for their children as well as nationality. Research commissioned by Plan International identified discriminatory laws that prevent a woman from registering her child alone and/or from conferring her nationality to her son or daughter. The Report also shows that discrimination happens in practice, even when legislation is gender-neutral.[632] For example, in Brazil, the Dominican Republic, Ecuador, India, Laos, Nepal, Pakistan, and Sudan, the law states that if a birth takes place at home, the primary responsibility for the registration of a child lies with the head of the household. In most cases this will be the husband or, for single women, their father or another male relative: rarely will a woman be head of household herself, and therefore may have difficulties in registering her own child.[633] Several studies have also identified the importance of civil registration in order to be able to access services in cases of conflict or disasters. Surviving women and children face particular challenges in proving their identity when identity is largely through male family members.[634]

Civil registration systems characterized by universal coverage and continuity are a source of vital statistics unmatched by other data-gathering methods. However, with regard to the *number* of countries in the world that provide quality statistics based on universal civil registration, there has been very little improvement over the past 30 years.[635] Currently, out of 193 UN member states, only 109 (56 per cent) have complete coverage[636] (90 per cent or more) of birth registration and 99 (51 per cent) have complete coverage of death registration.[637] Europe stands out as the only region with complete registration of births and deaths. By contrast, in Africa, only 10 countries have complete coverage of births (19 per cent of 54 countries in the region) and 5 countries have complete coverage of deaths (9 per cent). In the remaining regions, the proportion of countries with complete registration of births and deaths varies from less than half to less than two thirds.

Furthermore, quality data on *causes of death* based on civil registration system are provided by an even

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[629] Birth registration is calculated as the percentage of children less than 5 years old who were registered at the moment of the survey. The numerator of this indicator includes children whose birth certificate was seen by the interviewer or whose mother or caretaker says the birth has been registered.

[630] UNICEF, 2013. Every Child's Birth Right: Inequities and Trends in Birth Registration. 2013. Statistical Table,pp.40-3.

[631] UNICEF, 2013. Every Child's Birth Right: Inequities and Trends in Birth Registration. 2013. Statistical Table,pp.40-3.

[632] Wallace RMM, Audsley A, McCloy N, Wylie K (2009) Mother to Child: How Discrimination Prevents Women Registering the Birth of their Child. Plan & the UHI Centre for Rural Childhood http://www.perth.uhi.ac.uk/specialistcentres/ruralchild/Documents/Mother%20to%20Child%20Full%20Report.pdf (accessed 18 July 2013).

[633] Plan International (2009) Mother to child: How discrimination prevents women registering the birth of their child.

[634] Azarian AM, Pelling M, Social Resilience of Post-earthquake Bam.

[635] Philip W Setel, Sarah B Macfarlane, Simon Szreter, Lene Mikkelsen, Prabhat Jha, Susan Stout, Carla AbouZahr, on behalf of the Monitoring of Vital Events (MoVE) writing group, 2007. "Who counts? A scandal of invisibility: making everyone count by counting everyone". In *The Lancet*, Published online October 29, 2007 DOI:10.1016/S0140-6736(07)61307-5; Prasanta Mahapatra, Kenji Shibuya, Alan D Lopez, Francesca Coullare, Francis C Notzon, Chalapati Rao, Simon Szreter, on behalf of the Monitoring Vital Events (MoVE) writing group*, 2007. "Who Counts? Civil registration systems and vital statistics: successes and missed opportunities". In *The Lancet*, Published online October 29, 2007 DOI:10.1016/S0140-6736(07)61308-7;

[636] The assessment of coverage is based on self-reporting on quality and coverage of vital statistics obtained from civil registration of the National Statistical Offices to the United Nations Statistics Division, supplemented by self-reporting during workshops on civil registration and vital statistics conducted by United Nations Statistics Division. When self-reporting information is not available, additional sources are used, including from International Institute for Vital Registration and Statistics (IIVRS), UNICEF (the Multiple Indicators Cluster Survey), ICF Macro (Demographic and Health Survey) and/or the World Health Organisation.

[637] Analysis based on United Nations Statistics Division, 2012. Coverage of civil registration system. Available at http://unstats.un.org/unsd/demographic/CRVS/CR_coverage.htm. Downloaded December 2013.

smaller number of countries in the world. For example, an analysis of data availability between 1996 and 2005[638] shows that only 13 per cent of countries in the world are able to provide high quality cause-of-death data (defined by 90-100 per cent completeness, use of recent International Classification of Diseases, and less than 10 per cent ill-defined codes for cause of death). By comparison, 72 per cent of countries have not reported cause-of-death data to the WHO or the reported data was of low quality or limited use. The remaining 15 per cent of countries have cause-of death-data of medium quality.

In countries with inadequate civil registration systems, gaps in data on births, deaths and causes of death have been filled in the last 20 years by estimates or extrapolations from household surveys, population censuses, and demographic surveillance sites (DSS). Such alternative data collection systems have been viewed as reasonable interim substitutes for civil registration, with the exception of the assessment of causes of death. They are not, however, a long-term alternative to the development of complete national civil registration systems that are able to provide, on a current and continuous basis, data at the most disaggregated level for government functioning.[639]

2. Population censuses

Population census is the primary source of information on the size, distribution and characteristics of a country's population and the basis for calculation, estimation and projection of a variety of indicators needed for policymaking, planning and administration in all development sectors. Censuses have the potential to provide data at the lowest geographical levels and in countries with incomplete civil registration systems, population censuses, along with household surveys, provide needed statistics on vital events.[640]

Population censuses cover a variety of topics. In the 2010 census round, data on basic demographic characteristics of age, sex, marital status, labour force participation and occupation were collected in all or nearly all countries implementing a population census.[641] Migration was also covered by the majority of countries, with a higher proportion of countries inquiring about international, compared to internal migration. Education characteristics ranked high in coverage, with data on school attendance and educational attainment collected by a majority of countries in all regions, and literacy by a majority of countries in Africa, South America and Asia. With the exception of Europe, data on disability status was collected by a majority of countries in all regions.[642]

Census coverage of fertility and mortality was lowest in Europe and highest in Africa, reflecting the regional differences in availability of vital statistics from civil registration. For example, data on household deaths in the past 12 months, a topic related to maternal mortality, was covered better in Africa (74 per cent of countries) and Asia (48 per cent) and not covered at all in Europe.[643] Although some countries had already included questions on maternal mortality in their 2000 censuses, the number of countries that did so grew considerably in the 2010 census round.

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[638] Prasanta Mahapatra, Kenji Shibuya, Alan D Lopez, Francesca Coullare, Francis C Notzon, Chalapati Rao, Simon Szreter, on behalf of the Monitoring Vital Events (MoVE) writing group*, 2007. "Who Counts? Civil registration systems and vital statistics: successes and missed opportunities". In *The Lancet*, Published online October 29, 2007 DOI:10.1016/S0140-6736(07)61308-7;

[639] See for example, Kenneth Hill, Alan D Lopez, Kenji Shibuya, Prabhat Jha, on behalf of the Monitoring of Vital Events (MoVE) writing group, 2007. "Who Counts? Interim measures for meeting needs for health sector data:
births, deaths, and causes of death". In *The Lancet*, www.thelancet.com Published online October 29, 2007 DOI:10.1016/S0140-6736(07)61309-9; United Nations Statistics Division, (Forthcoming). *Principles and Recommendations for a Vital Statistics System*. Revision 3.

[640] United Nations, Department of Economic and Social Affairs, Statistics Division, 2008. Principles and Recommendations for Population and Housing Censuses. Revision 2. Statistical Papers Series M No.67/Rev.2. ST/ESA/STAT/SER.M/67/Rev.2 United Nations: New York 2008.

[641] Assessment based on analysis of 124 census questionnaires (mostly covering countries with traditional censuses) by the United Nations Statistics Division, as shown in United Nations, 2013. Implementation of United Nations Recommendations for Population Census Topics in the 2010 round. Paper prepared by the United Nations Statistics Division for the United Nations Expert Group Meeting on Revising the Principles and Recommendations for Population and Housing Censuses. New York, 29 October – 1 November 2013. ESA/STAT/AC.277/4.

[642] Ibid.

[643] Ibid.

For the 2010 World Census Programme, the Statistics Division reported that only 7 of the 193 States Members of the United Nations either would not conduct a census, or no information was available with regard to their census plans (as of 1 December 2013), compared with 25 countries in the 2000 census round. According to a survey carried out by the UN Statistics Division (June 2013),[644] there has been an increased use of alternative census methodologies and technological advances to reduce costs and improve the quality and timeliness of data. In terms of advanced technologies, Geographic Information System (GIS) was the most widely used, of great benefit to cartography. The fast growing capabilities of GIS and easier access to imagery, and Global Positioning System (GPS) coordinates, have considerably improved the quality of the maps produced for census purposes. The survey results show that 75 countries (64 per cent) are using GIS in their 2010 census round. This is the most used type of technology especially in Africa, North America and Asia. Use of technologies to enable faster release of census data has also been increasing, including computer-assisted coding (49 per cent of countries), internet (43 per cent), Optical Character Recognition (OCR) (42 per cent), Optimal Mark Recognition (OMR) (33 per cent) and other imaging and scanning methods (38 per cent).[645]

Dissemination was the weakest point of the censuses of the 2000 round – with important implications for public policy, and the integrated use of population dynamics in development planning. Census data have been disseminated by a wider variety of media, including CD-ROM/DVD, static web pages, online databases, and GIS web-based mapping tools, yet many developing countries could not fully disseminate their census results to the public. The main method for the dissemination of census results continues to be paper publications (52 per cent of countries), followed by static web pages (28 per cent), and interactive databases (14 per cent). In the African region paper publications are the method used by the majority of countries (89 per cent) followed by static web pages at 8 per cent. In Europe this is inverted, with static web pages (39 per cent) and interactive databases (36 per cent) the top two, followed by paper publications (22 per cent). South America has the highest percentage of countries using interactive databases (43 per cent) for census data dissemination, followed by static web pages (29 per cent), and paper publications and CD-ROMs/DVDs both with 14 per cent.[646]

Concerns have been raised that there are a declining number of census experts and demographers available to National Statistical Offices in developing countries to conduct and analyze their censuses, concerns that warrants further analysis.

States should strengthen national capacity to generate, disseminate and effectively use data on population dynamics, including data from birth and death registration, censuses and periodic representative surveys. Attention should be given to the need for training and career development of young demographers in developing countries, especially training in the newer technologies.

States and international institutions should strengthen efforts to improve data availability, quality and accessibility and place more population, health and development data in the public domain in order to facilitate sharing and use of knowledge.

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[644] US Bureau of Census, 2013. Mid-Decade Assessment of the United Nations 2010 World Population and Housing Census Program. Paper prepared for United Nations Expert Group Meeting on Revising the Principles and Recommendations for Population and Housing Censuses. New York, 29 October – 1 November 2013. ESA/STAT/AC.277/1.

[645] United Nations Statistics Division, 2013. Overview of National Experiences for Population and Housing Censuses of the 2010 Round. The 2010 World Population and Housing Census Programme. Available at: http://unstats.un.org/unsd/demographic/sources/census/2010_PHC/default.htm

[646] United Nations Statistics Division, 2013. Overview of National Experiences for Population and Housing Censuses of the 2010 Round. The 2010 World Population and Housing Census Programme. Available at: http://unstats.un.org/unsd/demographic/sources/census/2010_PHC/default.htm

3. Surveys

Household surveys focusing on demographic and health data have been a valuable resource for the development field since the 1970s, providing critical population data for countries lacking reliable vital registration.

The Demographic and Health Surveys (DHS) (initially begun as the World Fertility Survey), was already one of the world most valuable sources of nationally comparative data on fertility and maternal and child health by the 1980s, but was subsequently expanded to collect new data on sexual, reproductive and gender outcomes throughout the 1990s, including FGM/C, HIV behaviour and HIV knowledge, among others, and to include youth, men and unmarried women, and even health biomarkers, in select countries. Likewise, the Multiple Indicator Cluster Surveys (MICS) provide internationally comparable data on the situation of children and women – with DHS and MICS providing complementary coverage in many developing countries, if not fully comparable in implementation.

Despite the recent expansion of these household surveys on many health and population topics, other gaps remain, for example on the health of younger adolescents (10-14 years), on older persons, migration behaviour, and household behaviour relevant to environmental sustainability, among others. Likewise, while the data enable broad stratification across states within countries, and attention to rural-urban differences, further spatial disaggregation into extreme rural, peri-urban, small, medium or mega-cities, for example, are generally not possible.

Critical to goals of building accessible public knowledge, both DHS and MICS provide free access to their data, including compiler programmes to facilitate easy public use of the data. There are critical uncertainties in the representativeness of household surveys, as sampling frameworks are based the most recent census, which may be out of date. Nevertheless, these household surveys continue to be enormously helpful in generating estimates of key population, health and demographic data over time in countries where otherwise little to no such data are available.

Improvements in sexual and reproductive health data

One of the singular challenges after the ICPD was how to improve sexual and reproductive health, without reliable data on sexual and reproductive health epidemiology, especially in developing countries. While the Programme of Action broadly defined an essential package of sexual and reproductive health services, many countries lacked the necessary data on absolute or relative needs within their own country that would enable them to set priorities and target the problems causing the most severe burden of sexual or reproductive ill-health. Indeed, where the burden of illness was assumed to be highest, reliable data were least available.

Studies from rural India (Bang[647]) and Egypt (the Giza Study[648]) in the early 1990s had suggested a high prevalence of unreported reproductive and sexual morbidities in poor communities, but there was no ongoing surveillance of reproductive or sexual morbidity at the population level in 1994, beyond the important estimates of maternal mortality emanating from civil registration, DHS and RAMOS studies. The lack of reproductive morbidity data from Africa in the 1990s was especially striking, given that

[647] Bang RA, High prevalence of gynecologicial diseases in rural Indian women, Lancet 1989. i;85

[648] Zurayk H, Khattab H, Younis N, Kamal O, El-Helw M. Comparing Women's Reports with Medical Diagnoses of Reproductive Morbidity Conditions in Rural Egypt. *Studies in Family Planning*, Vol. 26, No. 1 (Jan. - Feb., 1995), pp. 14-21.
Younis N, Khattab H, Zurayk H, El-Mouelhy M, Fadle Amin M, and Abdel-Moneim Farag. 1993. A community study of gynecological and related morbidities in rural Egypt. *Studies in Family Planning* 24,3:175-186.

small studies suggested the continent had among the highest rates of both maternal morbidity and mortality worldwide, and it was well known that women had limited access to health care.[649]

One of the greatest achievements since the ICPD has been the improvement in the scope and quality of the available sexual and reproductive health epidemiologic and behavioural data from the developing countries, including the expansion and refinement of outcome measures in demographic and health surveys (Demographic and Health Surveys, Multiple Indicator Cluster Surveys, and National Family Health Surveys), the growth of demographic surveillance sites (DSS), and substantial new surveillance efforts undertaken to monitor HIV and AIDS-related burdens, including the increase in sexual behaviour research prompted by efforts to intervene and reduce sexual transmission.[650][651] Much of the latter has not been systematic at a global scale.

Gaps remain in both scope and quality, particularly for stigmatized events and outcomes such as abortion, interpersonal violence, sexually transmitted infections, obstetric fistula, morbidities such as incontinence, pain with intercourse, and sexual dysfunction, among others. The lack of adequate global surveillance for sexually transmitted diseases is especially egregious given evidence that incident cases of STIs appear to have increased since 1994. In addition, as urbanization progresses the conventional stratification of rural or urban may no longer offer adequate analytical insight to health differentials, requiring more spatial typologies including mega-cities, small and medium cities, and remote rural areas, among others.

While DHS and MICS offer core population health data for the widest number of developing countries, other multi-national household surveys have generated nationally representative data on complementary topics such as household income, expenditures, and well-being, allowing comparative analysis between countries, for example the World Bank's Living Standards Measurement Study (LSMS) surveys.

Monitoring of select SRH-related outcomes was made universal since 2000 (or 2005) after they were included among indicators for tracking progress towards the Millennium Development Goals (MDGs), but the choice of corresponding indicators has received a mixed response, at best, by evaluation experts.

Public opinion surveys offer a potentially powerful instrument monitoring public attitudes to many key dimensions of development, such as attitudes towards gender or racial equality, trust in the state or religious authorities, and belief in public participation and democracy. Many private public opinion polls demand high fees to collect such data, but the World Values Survey (WVS) conducts representative national surveys on peoples' values and beliefs regarding many population groups and values pertinent to human rights. For example, the latest round of surveys includes a module on attitudes towards older persons and their value to society. The WVS has been conducted in almost 100 countries, and includes repeating surveys in some countries. The findings on attitude surveys are especially valuable for policy

[649] Boerma T. The magnitude of the maternal mortality problem in sub-Saharan Africa. *Social Science & Medicine*. 1987, 24(6):551-558
Anosike JC, Onwuliri CO, Inyang RE, Akoh JI, Nwoke BE, Adeiyongo CM, Okoye SN, Akogun OB. 1993 Trichomoniasis amongst students of a higher institution in Nigeria. Applied parasitology 34(1):19-25.
Harrison K (1985) Childbearing, health and social priorities: A survey of 22,774 consecutive hospital births in Zaria, Northern Nigeria. British Journal of Obstetrics and Gynaecology 92(suppl 5):1-119.
Cronin WA, Quansah MG, Larson E (1993), Obstetric Infection Control in a Developing Country. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 22: 137–144.
Bimal Kanti Paul, Maternal mortality in Africa: 1980–87, *Social Science & Medicine*, Volume 37, Issue 6, September 1993, Pages 745-752.
P. Thonneau, B. Touré, P. Cantrelle, T.M. Barry, E. Papiernik, Risk factors for maternal mortality: Results of a case-control study conducted in Conakry (Guinea), *International Journal of Gynecology & Obstetrics*, Volume 39, Issue 2, October 1992, Pages 87-92.
[650] Hunter M (2005) Cultural politics of masculinities: Multiple partners in historical perspective in KwaZulu Natal. Chapter 6, pp 139-60. In: *Men Behaving Differently*, Reid G, Walker L, eds. Cape Town: Double Storey Books.
[651] Doherty ES, Padia NS, Marlow C, Aral S. (2005) Determinants and consequences of sexual networks as they affect the spread of sexually transmitted infections. *J Infectious Diseases*, 191:S42-S54.

makers in identifying where stigma and discrimination may be most entrenched, and therefore where individuals may be vulnerable.

States should integrate into the national statistics the measurement of public values and attitudes regarding gender inequality, ageism, racism, and other forms of discrimination. Such data can elaborate conditions and localities of extreme stigma, enabling social protection and efforts to redress discrimination.

4. Using data for development planning

The elaboration of surveys for development planning contributes potentially powerful material for public knowledge, but this depends on the capacity of governments, local academics and NGOs to analyze and use these data for decision-making, an area of continuing challenge in development countries.

Based on the Global Survey, a high percentage of countries (88 per cent) report having carried out research on population dynamics for planning purposes during the last five years (Americas 94 per cent, Africa 92 per cent, Europe 88 per cent, Asia 85 per cent, Oceania 71 per cent), yet only 49 per cent of countries have conducted a report covering the national and sub-national levels.

The periodic elaboration of situation assessments in key areas allows countries to determine the present and future needs across different sectors and population groups and represents the basis for improved targeting of public policy. While the proportion of countries that have conducted sectorial or population-based situation assessments during the last five years varies according to the theme and region explored, the issue of coverage remains a concern, since few countries have elaborated an assessment covering both the national and the sub-national levels (see Table 4).

Given the centrality of equality to the goals of the ICPD, a core recommendation from the Programme of Action was that, in principle, all relevant social and health data should be appropriately disaggregated by relevant factors such as age, sex, ethnicity, locality, and wealth, in order increase understanding of disparities in social development, and enable policy makers to redress inequalities. This was an issue of considerable focus in the ICPD Beyond 2014 regional reviews and outcomes. The household surveys described above all enable such disaggregation to varying degrees.

Table 4
Elaboration of situation assessments by theme, region and coverage

Theme/Region	*Proportion of countries that have conducted an assessment, either at the national level, sub-national level, or both (per cent)*						*Proportion of countries that have conducted an assessment covering both the national and sub-national levels (per cent)*
	World	*Africa*	*Americas*	*Asia*	*Europe*	*Oceania*	*World*
Needs of adolescents and youth	83	79	94	88	86	64	35
Needs of older persons	66	57	72	69	90	23	15
Needs of persons with disabilities	75	65	69	82	94	54	18
Needs of indigenous peoples	60	55	88	50	44	40	15
Internal migration and/or urbanization	73	54	84	80	95	62	28

International migration and development	63	59	77	72	59	23	15
Family, its needs and composition	75	64	80	80	93	54	26
Sexual and reproductive health and reproductive rights	83	87	78	77	85	93	35
Unmet need for family planning	67	83	63	74	39	64	27
Gender equality and empowerment of women	86	87	91	88	97	46	29
Education	93	92	94	98	93	86	36

Source: The ICPD Beyond 2014 Global Survey (2012)

Studies that disaggregate data down to district level, and that combine different data sources at this level for local planning purposes are particularly scarce in developing countries. There is also a scarcity of studies that analyze the effects of migration at the national, as well as the local level. Governments may also have difficulties making realistic assessments of emerging population trends. Particularly notable has been the inadequate capacity to project and plan for the pace of urban growth.

States should ensure adequate measures that allow monitoring of inequality in access to public services, accountability structures, and information, including sampling that will enable stratification and comparisons by race and ethnicity, age (including youth and older persons), household wealth, and with finer attention to spatial circumstances – especially those that reflect insecurity of place, such as slums or informal settlements, among recent migrants, and IDPs.

5. Capacity strengthening

The most crucial deficiency within the knowledge sectors of developing countries may be that information, even when available, does not make its way into planning decisions. Sustained efforts have been made in the last two decades to improve the capacity of countries to produce and use quality statistics in planning and decision making, partly driven by increased demands for improved statistics to monitor the MDGs and an emerging culture of results-based management of international aid[652]. A critical role in the improvement of data availability has been played by international survey programmes, including Demographic and Health Surveys, Multiple Indicator Cluster Surveys, and Living Standard Measurement Study surveys, and the international support in planning and carrying population censuses in the 2010 round. The main beneficiaries of these programmes were low-income countries with poor household survey programmes and inadequate coverage of civil registration. In some cases these investments did not necessarily reflect government commitments, raising concerns about the sustainability of data-related operations without international aid.[653]

Progress in statistical capacity has been noted, even in the poor countries.[654] Based on a World Bank index of statistical capacity, the quality of statistics in the world improved from 52 in 1999 to 68 in 2009 (out of 100 maximum).[655] The number of countries with a national strategy for the development of

[652] PARIS21, 2011. Statistics for Transparency, Accountability, and Results: A Busan Action Plan for Statistics. November 2011.
[653] Chen, Shuang, Francois Fonteneau, Johannes Jutting, Stephan Klasen, 2013. Towards a Post-2015 Framework that Counts: Developing National Statistical Capacity. Discussion Paper No.1., November 2013, PARIS21.
[654] United Nations, 2012. Report of the World Bank on efforts in developing a plan of action on statistical development. Note by the Secretary-General to the Forty-third session of the Statistical Commission, 28 February-2 march 2012. Economic and Social Council. E/CN.3/2012/16.
[655] United Nations, 2012. Report of the World Bank on efforts in developing a plan of action on statistical development. Note by the Secretary-General to the Forty-third session of the Statistical Commission, 28 February-2 march 2012. Economic and Social Council. E/CN.3/2012/16.

statistics increased[656] and statistical development has begun to receive a higher priority in national development programmes.[657] At the end of October 2011, 101 countries were participating in the General Data Dissemination System (GDDS) of the IMF.[658] The capacity to provide data for MDGs monitoring, for example, increased tremendously, although data for some of the indicators are based on estimates and modelling done by international agencies and not the countries themselves. In 2003, only 4 countries (2 per cent of 163 countries with information available) had two data points for 16 to 22 indicators; by 2006 this had improved to 104 countries (64 per cent) and by 2011, to 122 countries (75 per cent).[659]

Nevertheless, quality and coverage of baseline information, two issues highlighted in the ICPD Programme of Action, are still a concern. For example, gender statistics were assessed as insufficient and the measurement of migration as "least adequate". Two decades later, the availability of gender statistics has increased, but progress has been limited,[660] and data are still largely missing for topics such as gender based violence, time use, access to assets, finance and entrepreneurship[661]. Many countries still do not have the capacity to collect data or to integrate data from various sources in order to obtain reliable statistics on internal and international migration. Within the context of MDG indicators, data on health outcomes are among the most lacking,[662] mainly due to weak civil registration and administrative sources of data. Data on poverty are often unavailable,[663] with only 17 sub-Saharan African countries having collected data to measure changes in poverty in the past decade.[664] The Review shows that, in addition to the areas of concern mentioned here, other critical dimensions of sustainable development are either poorly measured or not measured at all in most countries, such as the extent of stigma or discrimination, the quality of education, access to health care among adolescents and youth, the quality of health care, and spatial inequalities other than crude dichotomies of urban versus rural.

A larger system-wide approach to capacity development, beyond responding to international data requests, is needed to ensure a sustainable national knowledge-based system relevant to national development priorities. In this regard, two objectives, highlighted in the Busan Action Plan for Statistics, stand out. First, better open access to statistics is essential for a transparent, accountable, and effective government – yet the call for greater accessibility at the ICPD is unfulfilled in many countries. Second, the integration of statistics in policy and decision-making, which remains weak across the developing world, needs to be addressed with an eye to long-term capacity, including better linkages between ministries and research universities within countries, career structures for retaining quality analysts in government service, and the development and investment in local independent centres of excellence that:

a. Coordinate efforts between data producers, users, and policy-makers
b. Advocate for improved production and use of high-quality and timely statistics
c. Design, implement and monitor National Strategies for the Development of Statistics (NSDS)

[656] PARIS21, 2011. Statistics for Transparency, Accountability, and Results: A Busan Action Plan for Statistics. November 2011.
[657] United Nations, 2012. Report of the World Bank on efforts in developing a plan of action on statistical development. Note by the Secretary-General to the Forty-third session of the Statistical Commission, 28 February-2 march 2012. Economic and Social Council. E/CN.3/2012/16.
[658] United Nations, 2012. Report of the World Bank on efforts in developing a plan of action on statistical development. Note by the Secretary-General to the Forty-third session of the Statistical Commission, 28 February-2 march 2012. Economic and Social Council. E/CN.3/2012/16.
[659] United Nations, 2012. Development indicators for monitoring the Millennium Development Goals. Report of the Secretary-General for the Forty-third session of the Statistical Commission, 28 February-2 march 2012. Un Economic and Social Council. E/CN.3/2012/29.
[660] United Nations, 2006. World's Women 2005. Progress in Statistics. Department of Economic and Social Affairs, Statistics Division. United Nations: New York
[661] PARIS21, 2011. Statistics for Transparency, Accountability, and Results: A Busan Action Plan for Statistics. November 2011.
[662] Chen, Shuang, Francois Fonteneau, Johannes Jutting, Stephan Klasen, 2013. Towards a Post-2015 Framework that Counts: Developing National Statistical Capacity. Discussion Paper No.1., November 2013, PARIS21.
[663] Chen, Shuang, Francois Fonteneau, Johannes Jutting, Stephan Klasen, 2013. Towards a Post-2015 Framework that Counts: Developing National Statistical Capacity. Discussion Paper No.1., November 2013, PARIS21
[664] PARIS21, 2011. Statistics for Transparency, Accountability, and Results: A Busan Action Plan for Statistics. November 2011

d. Provide knowledge through data archiving and documentation.

States should strengthen knowledge sectors within their planning ministries. States should integrate population dynamics into the planning and implementation of development initiatives within all sectors, and at national and sub-national levels. If development investments are to be based on evidence of need, and of impact, then governments need a social architecture that enables evidence to form the basis of public debate and policy and makes knowledge accessible to all persons, across and between all sectors of society, without exclusion.

C. Creating enabling legal and policy environments for participation and accountability

1. Laws and policies

States have the obligation to adopt laws and implement policies that contribute to the realization of human rights. Establishing a legal and policy framework which creates an enabling environment, respects all human rights and eliminates discrimination is a fundamental part of ensuring that rights-holders have a voice and are able to hold governments and other responsible parties to account. Laws protecting freedom of expression, freedom of association and access to public information play a critical role in ensuring that the right to participate is free, active and meaningful, as set forth in the international human rights framework.

As constitutionalism and democratic forms of governance have expanded, legislators have become central actors in the implementation and evolution of the ICPD agenda. Yet despite increased dialogue amongst parliamentarians through the establishment of national as well as regional, parliamentarian groups in support of the ICPD and the five international parliamentarians' conferences on the implementation of the Programme of Action held at the global level since 2002, the parliamentary process could be more effective in ensuring executive actions on related matters or in affecting public opinion in support of the Programme of Action. The potential to use tools of parliamentary oversight, questioning, investigation, resolution and control over budget allocations in order to ensure the implementation of the Programme of Action, has been insufficiently exploited over the past two decades.

2. Inclusive participation

Participation, that involves stakeholders and is underpinned by respect for the substantive freedoms of expression and assembly, is the basis for inclusive and thus more sustainable development. The involvement of beneficiaries in the planning, design, implementation, monitoring and evaluation of policies and actions is a hallmark of inclusive, responsive and good government in and of itself, but it can also improve government accountability and the delivery of public goods and services. The Programme of Action recognized that "population and development policies, plans, programmes and projects – to be sustainable – need to engage their intended beneficiaries" (13.2).

The broad consensus of the ICPD was the result of wide consultation in countries and regions, with the active participation of civil society. During the ICPD conference in Cairo, there was not only a separate NGO forum, but also NGO representation in many national delegations. Through their active presence, civil society, including women's groups and activists, were able to claim space and their voices were factored into the high-level policy discussions that dealt with their health and well-being.

The ICPD was ground-breaking in its recognition that peoples' agency is central to the exercise of

human rights, including sexual and reproductive health and rights. The Programme of Action emphasized the need to involve those directly affected, including especially those excluded as a result of discrimination, coercion or violence, in developing laws, policies and practices, with the aim of empowering individuals— especially women and girls—to more fully exercise their human rights. In this regard a major achievement since 1994 has been the increased mobilization of a broad and diverse range of diverse civil society organizations, other non-governmental stakeholders, and social movements around the ICPD agenda to shape global, regional and national legal, policy and accountability frameworks on ICPD-related issues. This development is essential to ensuring the ongoing realization of the ICPD and an inclusive Post-2015 development agenda.

Given the sensitive nature of some parts of the mandate of the ICPD, an appreciation of local cultures and a sustained engagement with cultural gatekeepers have enabled grassroots and community ownership of sexual and reproductive health and reproductive rights. In turn, this mobilization "from within" has shown it can be the tipping point towards successful processes which ultimately hold governments accountable to the realization of these rights. To that end, the engagement of civil society actors (NGOs, academia, eminent cultural personalities, faith-based organizations and religious and traditional leaders), as well as, parliamentarians and the media has proven to be critical for progress.

As far as the participation of adolescents and youth is concerned, a new paradigm, based on the goals and objectives of the ICPD, has emerged that recognizes adolescents and youth as rights-holders entitled to make informed and responsible decisions about issues that affect their lives, including their sexual and reproductive health and rights. This was widely acknowledged in the resolution on youth and adolescents adopted by the Commission on Population and Development (2012), and the Bali Global Youth Forum Declaration (2012).

The mobilization of the HIV community is a good illustration of effective collective action as well as a driving force for the implementation of the ICPD Programme of Action. Partnerships involving civil society have been recognized as fundamental to realizing the demand of people living with HIV and other key populations for the protection of their rights to treatment, non-discrimination and participation. This leadership from civil society organizations has revealed the powerful contributions that civil society can make to transformational change and should be applied to further enhance peoples' participation and empowerment in further fulfilment of the ICPD agenda.

Important strides have also been taken by indigenous peoples to ensure their inclusion and full participation affecting their human rights. The establishment of the UN Permanent Forum on Indigenous Issues in 2002 with participation of indigenous peoples' organizations was instrumental for the adoption of the Declaration on the Rights of Indigenous Peoples (2007), and since its inception, the Forum has issued numerous recommendations to advance the rights of indigenous peoples.

Special attention is needed to create and ensure an enabling and safe environment for human rights defenders working on human rights related to the ICPD agenda, including watchdog organizations and service providers, so that they can work and express their views freely without fear of reprisals. For instance, in regard to sexual and reproductive rights, denials of freedom of association, assembly and expression of people who speak out on violations of such rights occur in some countries. Frontline service providers are often also human rights defenders who can face considerable obstacles in assisting individuals to realize their rights – through restrictions in funding, harassment and violence by state and non-state actors, and in some cases criminal penalties for providing life-saving services.

States and the international donor community should provide financial and other necessary support for social accountability in order to sustain a diverse range of beneficiaries', citizens' and civil society organizations' capacity for, and involvement in, monitoring states' fulfilment of their human rights obligations through national policies, budgets, programming or other measures, and develop their capacity to engage with international and regional human rights mechanisms.

States should ensure that human rights defenders are protected in their work, including through creation of an enabling environment, consistent with the Declaration on the Protection of Human Rights Defenders.

Human rights elaborations since the ICPD: Participation

Other soft law: Clarifying rights related to participation, *General Comment No. 25: The Right to Participate in Public Affairs, Voting Rights and the Right of Equal Access to Public Service* (1996) of the Human Rights Committee clarifies the "rights of every citizen to take part in the conduct of public affairs" and "the right of individuals to participate in those processes which constitute the conduct of public affairs." *The Guiding Principles on Extreme Poverty and Human Rights* (2012) highlights the importance of developing policies and programmes consistent with human rights principles and that encourage the participation of key populations in the design of relevant policies and programmes, "States should devise and adopt a poverty reduction strategy based on human rights that actively engages individuals and groups, especially those living in poverty, in its design and implementation. It should include time-bound benchmarks and a clear implementation scheme that takes into account the necessary budgetary implications. It should clearly designate the authorities and agencies responsible for implementation and establish appropriate remedies and grievance mechanisms in the event of non-compliance."

Government support for the inclusion of key population groups in decision-making processes varies notably across regions, income groups and population groups themselves, as reported in the Global Survey. For instance, "instituting concrete procedures and mechanisms for the participation of adolescents and youth" is high, with more than three-quarters of countries (76 per cent) addressing this issue during the past five years. Although no major variations are observed across income groups, a higher proportion of countries in the Americas (88 per cent) address this issue (Table 5). On the contrary, the same objective is addressed by only 47 per cent of countries in relation to older populations, although in this latter case the Americas (63 per cent) and Europe (56 per cent) remain above the world average. This issue is addressed by a higher proportion of wealthier countries. The issue of "instituting concrete procedures and mechanisms for participation for persons with disabilities" has been addressed by around 6 in 10 countries globally (61 per cent), but this share always falls below the world average in the case of Oceanic and African countries. Generally, a higher proportion of richer countries have addressed this issue as opposed to poorer countries.

If a composite indicator is created for these three groups of beneficiaries, results show that out of the 129 countries with complete data, only 39, or 30 per cent, have addressed the participation of youth, older persons and persons with disabilities. In fact, 15 countries, or 12 per cent, have not addressed the participation of any of these populations in the planning, implementation and evaluation of development activities.

Table 5
Percentage of governments addressing political participation by population group

Indicator/Population group	*Adolescents*	*Older*	*Persons with*	*Indigenous*

	and youth	*persons*	*disabilities*	*peoples*
Addressing political participation, world	76.3%	47.2%	60.7%	57.5%

Source: The ICPD Beyond 2014 Global Survey (2012)

Approximately half of all reporting countries have addressed the issue of "instituting concrete procedures and mechanisms for the participation of indigenous peoples" (58 per cent) (Table 5). This may, in part, reflect that not all countries include a defined population of "indigenous persons" that is distinct from the majority population. Nonetheless, fewer than half of African countries (36 per cent) have addressed this issue during the past five years, while over or close to two-thirds of countries in the Americas (75 per cent), Asia (71 per cent) and Oceania (86 per cent) have done so.

Case study: Urban transformation via participation

Brazil[665]

The Programme of Action recognized the importance of increasing participation in governance, and in the subsequent decades, the combination of decentralization and the emergence of powerful mechanisms of direct participation in local governance have been instrumental in Brazil. One of the most prominent global examples is participatory budgeting in municipalities, which has also been applied to slum upgrading efforts in Brazil's *favelas*.

In 2001, Brazil adopted the Statute of the City ("Estatuto da Cidade"), a major advance in the democratization of urban planning and governance. It has two key components, prioritizing social versus commercial functions of urban land and buildings, and institutionalizing participatory and democratic city management. This statute extends participatory budgeting, which has emerged from the grassroots level in Porto Alegre in the late 1980s, and has since expanded to more than 200 cities in Brazil (as well as to cities around the world). Key elements include diverse community participation, institutionalization of the approach through scheduled meetings between local government and community groups, and effective assignment of a portion of the city's budget to the outcome of the process. Recent research[666] comparing matched pairs of municipalities in Brazil, one that did and one that did not institute participatory budgeting, suggests that it has had appreciable impact on enhancing equality.

These approaches have been extended to slum upgrading efforts. Favelas Bairro is an upgrading programme started in 1994 to reunite Brazil's divided cities. The objective was social and physical integration of all low-income neighborhoods into the formal urban fabric of Rio de Janeiro by 2020. The key difference in this effort relative to conventional poverty reduction policies was the use of unique legislative reforms. These encouraged community governance through the support of existing community programmes, which allowed the absence of land tenure legislation and its use of the concession of "right to use but not own" land. The use of design as a core project strategy for social and physical integration was a success on the whole, but the project has also shown that structural upgrades cannot reduce crime on their own; improving facilities leads to the threat of gentrification, and governance is critical, or corrupt representation can erode the participatory process.

[665] Martine, George and Gordon McGranahan (2010). "Brazil's early urban transition: what can it teach urbanizing countries?" UNFPA and IIED Working Paper, New York and London

[666] Baiocchi, Heller and Silva. (2011). Bootstrapping democracy: Transforming local governance and civil society in brazil. Stanford University Press.Stanford, California.

States should guarantee and facilitate the participation of non-state actors in policy and programme development, implementation, and evaluation, including the intended beneficiaries. In doing so, States should pay particular attention to adolescents and youth, representing all education and income sectors of society, and ensure and facilitate their participation in policy and programme development, implementation, and evaluation, in particularly in matters that affect them. This should intentionally extend to include representatives of those living in poverty, from groups who frequently experience discrimination, and other intended beneficiaries of development.

3. Remedies and redress

All victims of human rights violations have a right to an effective remedy and to reparations. Ensuring accountability not only requires responding to human rights violations that have occurred, but also identifying systemic failures and the necessary corrective actions. States must also be held responsible for acts committed by private actors if the state fails to prevent violations of rights or to investigate and punish actions and omissions committed by non-state actors.

National institutions, such as courts, administrative review bodies, and parliaments, among others, have direct obligations that emanate from human rights law, as part of the state which is party to human rights treaties. The judiciary, when adequately resourced and sensitized, can play a crucial role in ensuring justice for human rights violations. However, in many parts of the world these mechanisms are not accessible to many victims of human rights violations, due to geographic, economic, and social factors.

States should ensure access to remedies and redress to victims of human rights violations. To ensure the effective use of remedies, the State should systematically raise awareness about the applicability of claims relating to human rights, among lawyers, judges and the public, and provide adequate funding for accountability mechanisms. States should combat impunity by increasing access to justice, so that aggrieved individuals have access to remedies and reparations that encompass restitution, rehabilitation, measures of satisfaction and guarantees of non-repetition, where appropriate. Special mechanisms need to be put in place to ensure access for rural and underserved communities, as well as for people in conflict, post-conflict and humanitarian situations and fragile contexts.

At the international level, accountability mechanisms have been strengthened in the past 20 years as mechanisms for redress. States, the United Nations, and civil society, amongst other crucial actors, have established many positive examples of engagement with international human rights mechanisms such as treaty bodies and special procedures, and the expert opinions coming from those bodies have further enhanced the reinforcement of human rights obligations related to the ICPD Programme of Action. The Universal Periodic Review (UPR) of the Human Rights Council, established in 2006, is also an important accountability mechanism for States to realize the human rights commitments made at the ICPD. International accountability requires systematic integration of information on human rights related to the ICPD agenda into reports submitted to these international human rights mechanisms, together with implementation of recommendations from these bodies. The observations and interpretations made by different bodies have served the dual purpose of ensuring accountability on the one hand while also clarifying the nature and extent of states' obligations to guarantee human rights on the other.

States should ratify international and regional human rights treaties, and lift reservations to treaty provisions, relevant to all dimensions of dignity, including gender equality, non-

discrimination, sexual and reproductive health and rights, security of place, mobility, and political participation. States should harmonize national laws with international instruments and monitor the extent to which human rights are respected, protected, promoted, and fulfilled, and ensure that human rights protection mechanisms are in place. This should include the development of legislation and administrative practices to regulate, control, investigate and prosecute actions by non-state actors that violate human rights.

D. Collaboration, partnerships and coherence

International cooperation has proven essential for the implementation of the Programme of Action during the past two decades. Such cooperation takes place in various forms, including multilateral, bilateral, regional, inter-regional, South-South and triangular cooperation. Efforts to ensure effective donor coordination under national ownership at country level have drawn attention to the negative impact of conditionality, the need to improve development effectiveness and reduce transaction costs, including through coherence between donor assistance and national priorities, capacity development and aid exit strategies. Since 1994, the number of financial donors has steadily increased and the profile of the donor community has increasingly been shaped by the growing presence of non-governmental and private-sector organizations.[667] As mentioned above, partnerships with civil society actors have been instrumental in moving the implementation of the Programme of Action forward on the ground, and against the background of an increasingly complex aid environment, with new stakeholders and partnerships for development, and a number of mechanisms seeking to coordinate donor contributions in sectoral and national planning processes.

Human rights elaborations since the ICPD: Collaboration, partnerships and coherence

Intergovernmental human rights outcomes: General Assembly *Resolution 61/160* (2006) and Human Rights Council *Resolution 8/5 Promotion of a Democratic and Equitable International Order* affirms that "the enhancement of international cooperation for the promotion of all human rights should continue in full conformity with the purposes and principles of the Charter of the United Nations and international law." Building on the triennial comprehensive policy review, the General Assembly adopted by consensus on 21 December 2012 *Resolution 67/226 2012 Quadrennial Comprehensive Policy Review* promoting enhanced system-wide coherence that "recognizes the value of improving linkages between operational activities and norms and standards such as freedom, peace, security and human rights and the importance of mainstreaming sustainable development into the mandates, programmes, strategies and decision-making processes of UN entities."[668]

1. Multilateral response to the Programme of Action

The Programme of Action has been adopted as a framework by multilateral institutions since 1994; it influenced the conception of the MDGs. As the intergovernmental bodies of the UN have sought to integrate the agenda of the ICPD in the resolutions and outcomes on economic, social and environmental matters, the UN System, including the World Bank, has worked cooperatively to reflect this through thematic groups, country level thematic and UN programming frameworks as well as through the coordination under the United Nations Development Group and the United Nations Chief Executives Board for Coordination. Through the regular refinements of the General Assembly Triennial, now Quadriennial Comprehensive Policy Review, and the emerging Delivering As One (DAO) approaches,

[667] Jyoti Shankar Singh "Creating a New Consensus on Population: The Politics of Reproductive Health, Reproductive Rights and Women's Empowerment" 2nd edition 2009 Earthscan, London

[668] DCPB/OESC/DESA, 4 January 2013, 2012 QCPR Outcome. Retrieved from: http://www.un.org/esa/coordination/pdf/note_on_qcpr_outcome.pdf

as well as joint programming and multi-donor funding modalities, the population and development agenda has been further integrated into both analysis and programming for multilateral assistance. The European Commission as a funding and policy player in its own right has championed support for the implementation of the Programme of Action.

UNFPA has played a convening role in promoting the ICPD through the adoption of global, regional and country programmes focused on key aspects of the agenda of the ICPD resulting in policies, programmes and services in all regions. Since 1994, targeted funding has been provided to UNFPA Country Programmes in more than 130 countries in all regions to promote and implement human rights-based population policies and programmes.

WHO decreased their research emphasis on generating entirely new methods of contraception to include a broader research agenda on sexual and reproductive health conditions, and the technologies, norms and standards for a woman-centred and rights-based delivery of sexual and reproductive health services in response to the ICPD.[669]

OHCHR has continually worked to ensure that international human rights standards build upon and strengthen the ICPD agenda, through the work of treaty bodies and other expert mechanisms.

The UN Population Division has played an active role in the intergovernmental dialogue on population and development, producing updated demographic estimates and projections for all countries, including data essential for the monitoring of the progress on the implementation of the Programme of Action, developing and disseminating new methodologies, and alongside UNFPA preparing the reports for the annual sessions of the Commission on Population and Development.

At the regional level, the UN Economic Regional Commissions have promoted the agenda of the ICPD by revitalizing social divisions and centres of excellence like the case of CELADE/ECLAC in the Latin American region, to address emerging population issues and improve the capacity of governments to respond to them through national policies aimed at development and human rights.

Multilateral financial institutions like the World Bank, the Asian Development Bank and the Inter-American Development Bank have supported programmes such as the conditional cash transfer programmes, hotline services against gender based violence and youth friendly services, including health services for women, consistent with the goals and objectives of the ICPD. In many countries the UN has worked in collaboration with donors and financial institutions to enable governments to conduct censuses and to help countries to integrate population dynamics into development plans, affecting a wide range of policies and decision making in all regions.

2. Intergovernmental follow up

The Programme of Action, and its Keys Actions adopted five years later, has been reaffirmed by the international community in the major United Nations conferences and summits, including, among others, the Beijing Platform for Action in 1995, the Millennium Declaration in 2000 and thereafter, the World Summit Outcome in 2005, the MDGs review summit in 2010 and the United Nations Sustainable Development Conference (Rio + 20) in 2012.

The General Assembly, the Economic and Social Council and the Security Council and the subsidiary

[669] WHO, 1995 "Reproductive Health: WHO's Role in a Global Strategy" in Jyoti Shankar Singh "Creating a New Consensus on Population: The Politics of Reproductive Health, Reproductive Rights and Women's Empowerment" 2nd edition 2009 Earthscan, London

bodies such as the Commission on Population and Development, the Commission on the Status of Women, the Commission for Social Development and the Commission on Sustainable Development have since 1994 adopted resolutions and other outcomes on all aspects of population and development agenda. These outcomes have reinforced the links between human rights and development; women, peace and security; zero tolerance for gender based violence, including the human rights of all women to have control over and decide freely and responsibly on matters related to their sexuality, free of coercion, discrimination and violence; as well as the need to protect the human rights of adolescents and youth to have control over and to decide freely and responsibly on matters relating to their sexuality, including sexual and reproductive health, regardless of age and marital status, among others.

There have been significant developments at the Human Rights Council, which has adopted resolutions on maternal mortality and morbidity and human rights[670] (2009-2012) and on discrimination on the basis of gender identity and sexual orientation[671] (2011).

3. South-South cooperation and triangular cooperation

The Programme of Action refers to South-South Cooperation (SSC) as an important development instrument and resource mobilization objective. Subsequent summits and conferences have shaped the SSC framework, including the 2000 South Summit in Havana, the 2003 High-Level Conference on South-South Cooperation in Marrakech, the 2005 Second South Summit in Doha and the 2009 High-Level United Nations Conference on South-South Cooperation in Nairobi. The "Framework of operational guidelines on United Nations support to South-South and triangular cooperation" (SSC/17/3) highlights the key role that UN organizations can play in improving South-South knowledge sharing, networking, information and best practices exchanges, policy analysis and coordinated actions on major issues of concern.

Many middle-income countries have become active proponents of South-South partnerships.[672] Emerging economies have made significant investments in SSC. Traditional donors have recognized the value of SSC as well. This has reinforced SSC as a horizontal learning mechanism well placed to boost the development of national capacities as well as promote triangular mechanisms that fund South-South partnerships with contributions from donor governments.[673]

An example of South-South and triangular initiative enabling national institutions to promote horizontal cooperation in areas related to the ICPD is the intergovernmental organization Partners in Population and Development (PPD), established to promote SSC in the field of reproductive health, population, and development. Over the past two decades PPD's annual inter-ministerial conferences have provided a peer review mechanism for the member countries on all aspects of population and development issues.

4. Changes in the global burden of disease and corresponding aid

Since the adoption of the Programme of Action, the architecture for development cooperation has also been shaped by the response to the global crisis in HIV and AIDS, which has had a profound impact on

[670] The UN Human Rights Council has issued several resolutions on maternal mortality and human rights, including Resolution A/HRC/18/2 *Preventable maternal mortality and morbidity and human rights* (adopted 18 November 2011) which recognizes that, "a human rights-based approach to eliminate preventable maternal mortality and morbidity is an approach underpinned by the principles of, inter alia, accountability, participation, transparency, empowerment, sustainability, non-discrimination and international cooperation" and "encourages States and other relevant stakeholders, including national human rights institutions and non-governmental organizations, to take action at all levels to address the interlinked root causes of maternal mortality and morbidity, such as poverty, malnutrition, harmful practices, lack of accessible and appropriate health-care services, information and education, and gender inequality, and to pay particular attention to eliminating all forms of violence against women and girls."

[671] See General Assembly Resolution A/HRC/RES/17/19.

[672] UNFPA *South-South Cooperation Strategy*, 2010-2013

[673] United Nations General Assembly, Report of the Third United Nations Conference on the Least Developed Countries, Brussels, Belgium (14 to 20 May 2001), retrieved from: www.unohrlls.org/UserFiles/File/LDC%20Documents/Report%20of%20the%20LDC%20III_E.pdf.

the operational structure of new donor initiatives (for example, the Global Fund), the scale of donor support for a single (albeit complex) health condition (for example, the scale of PEPFAR eclipsed many national health budgets), and it led to an acute concentration of donor support to Africa due to the exceptionally high burden HIV and AIDS in that region.

The scale of the epidemic and corresponding HIV and AIDS-related resource flows heightened global political commitments to health[674] and dramatically increased recipient countries' capacity to roll out HIV prevention and HIV and AIDS treatment. In countries where Global Health Initiatives (GHIs) – the main funders of single-disease programmes – were well aligned with country priorities, HIV-related aid proved effective in strengthening the health system, promoting leadership and advocacy for HIV and AIDS, and led to unusual and sometimes innovative partnerships between health departments and other sectors of government for HIV prevention, e.g. the transport, defense and education sectors.[675]

Yet, in other countries, where GHIs have fostered an environment of fragmented and uncoordinated aid and donor competition, the scale of HIV-related aid exacerbated problems. Recipient countries were unable to predict their annual health budget from one year to the next, and were beholden to donor interests and priority projects that focused on HIV and AIDS rather than health sector-wide investments.[676] Countries were often held accountable to strict and focused HIV-related donor reporting frameworks, expending valuable resources to track aggregate coverage-based indicators that can mask gross disparities in quality of care.

High levels of vertical HIV funding also led to a rapid proliferation of nongovernmental organizations (NGOs) implementing HIV programmes in developing countries, some of which were highly effective agents of change, but some of which were not. Unregulated and unsupervised NGOs led, in some cases, to an exodus of health workers from the public sector to NGOs, improving employment opportunities, but also undermining the capacity of the local public primary health system.[677] In combination with a weak public sector, health services delivered by single-issue NGOs forced patients to navigate a complex network of uncoordinated services, often causing interruptions in the continuity of care and supply of essential medicines, and limiting the systematic or comprehensive care of patients' health needs.[678]

Since 2000, increased attention has been devoted to aid effectiveness, prompted in part by developing country frustrations over problems of unequal aid partnerships, and the loss of their ability to effectively plan, coordinate and lead the development process in their own country. In the 2001 Abuja Declaration, countries in the African Union committed to increasing health spending to at least 15 per cent of the national budget and called upon donor countries to scale up support accordingly.

The High-Level Fora on Aid Effectiveness and resulting outcomes (the Paris Declaration (2005), Accra

[674] Yu D, Souteyrand Y, Banda MA, Kaufman J and Perriëns JH. (2008). Investments in HIV/AIDS programs: Does it help strengthen health systems in developing countries? *Globalization and Health*, 4(8)

[675] Spicer N, Aleshkina J, Biesma R et al. (2010). National and subnational coordination: Are global health initiatives closing the gap between intent and practice? *Globalization and Health*, 6(3).; Biesma RG, Brugha R, Harmer A, Walsh A, Spicer N, Walt G. (2009). The effects of global health initiatives on country health systems: A review of the evidence from HIV/AIDS control. *Health Policy and Lanning*, 24:239-252.

[676] Martinez-Alvarez M, Acharya A. (2012). Aid effectiveness in the health sector. UNU-WIDER, Helsinki. Retrieved from: http://www.wider.unu.edu/stc/repec/pdfs/wp2012/wp2012-069.pdf

[677] Pfeiffer J, Johnson W, Fort M, Shakow A, Hagopian A, Gloyd S, & Gimbel-Sherr K. (2008). Strengthening health systems in poor countries: A code of conduct for nongovernmental organizations. *American Journal of Public Health*: 98(12): 2134-2140.
doi: 10.2105/AJPH.2007.125989

[678] Pfeiffer J, Johnson W, Fort M, Shakow A, Hagopian A, Gloyd S, Gimbel-Sherr, K. (2008). Strengthening Helath Systems in Poor Countires: A Code of COnduct for Nongovernmental Organizations. *American Journal of Public Health*, 98(12):2134-2140.
(http://www.aspeninstitute.org/sites/default/files/content/images/Section%206k%20-%20Pfeiffer,%20et%20al.pdf); Pfeiffer J. (2003). International NGOs and primary health care in Mozambique: The need for a new model of collaboration. *Social Science & Medicine*, 56(4): 725-738. (http://www.sciencedirect.com/science/article/pii/S0277953602000680)

Agenda for Action (2008) and Busan Partnership For Effective Development Cooperation (2011) have strengthened commitments to deliver aid more effectively, with an emphasis on capacity development and national ownership and execution. The increasing importance of the aid effectiveness agenda has been reflected in the development of structures for donor coordination, and greater acknowledgement of country leadership and mutual accountability in these collaborations. A WHO/UNFPA multi-country assessment study[679], looking into the implications of recent changes in the aid environment for SRH policy development and programming, found that organizational engagement at the country level was increasingly characterized by a focus on sector-wide approaches and poverty-reduction strategies, as well as on strategizing to achieve the MDGs, in particular MDG 4, 5A and 5B. The latter was found to have resulted in an increased awareness of issues around maternal and newborn health, while other aspects of SRH were found to have been marginalized, in terms of both country priorities and donor support.[680]

The study furthermore found that secure, predictable funding for sexual and reproductive health remains a problem, and much of the funding for activities are still donor dependent. Multi-sectoral approaches to sexual and reproductive health programmes were found to have remained largely underdeveloped in the countries that were part of the assessment study. Yet the shift towards health-systems strengthening and its support through the International Health Partnership (IHP+) and other related initiatives were reported to offer a framework within which sexual and reproductive health may be more broadly addressed.

5. New global partnerships

Recent years have seen a proliferation of a large number of new initiatives, partnerships and formal and informal cooperation and coordination mechanisms, involving UN agencies and others, established to accelerate concerted efforts in implementing certain parts of the Programme of Action.

These include, amongst others, the UN Action against Sexual Violence in Conflict, an interagency group consisting of 12 UN agencies, provides support to the Secretary General's campaign Unite to End Violence Against Women. The UNFPA-UNICEF joint programme on FGM/C supports 17 countries, as of 2014, with an aim of reducing and eliminating this harmful practice. The Interagency Task Force on Adolescents Girls has been established to coordinate the work among 7 agencies to address the needs of this particular population group, with special emphasis on marginalized girls, including those at risk of child marriage. The Global Campaign to End Fistula is active in countries to provide support for fistula prevention, as well as treatment and social reintegration for those who have suffered this severe condition.

The Action 2 programme was set up in response to a call by the UN Secretary General for joint UN action to strengthen human rights related actions at the country level and enhance support for the establishment and strengthening of national human rights promotion and protection systems consistent with international human rights norms and standards. The initiatives have worked to integrate human rights throughout the UN system in all its humanitarian, development and peacekeeping work, and promoted a human rights approach to programming. In 2009, in the framework of the implementation of the Secretary General's Policy Committee decision on human rights and development, the UNDG endorsed the establishment of the UNDG human rights mainstreaming mechanism (UNDG-HRM), to reinforce the accomplishments of the Action 2 programme.

[679] WHO/UNFPA (2011) *Strengthening country office capacity to support Sexual and reproductive health in the new aid environment Report of a technical consultation meeting: wrap-up assessment of the 2008–2011 UNFPA–WHO collaborative project*

[680] WHO/UNFPA (2011) *Strengthening country office capacity to support Sexual and reproductive health in the new aid environment Report of a technical consultation meeting: wrap-up assessment of the 2008–2011 UNFPA–WHO collaborative project*

In the area of health, the International Health Partnership is scaling up efforts to advance the health-related Millennium Development Goals. The Partnership is strengthening national processes in 21 countries in Africa and Asia with a focus on revitalizing health systems. The Health 4+ (H4+) is a joint effort by United Nations and related agencies and programmes UNAIDS, UNFPA, UNICEF, UN Women, WHO, and the World Bank. The global Partnership for Maternal, Newborn and Child Health, which was launched in 2005, provides a forum through which members can combine their strengths and implement solutions.

The Reproductive Health Supplies Coalition, a global partnership of multilateral and bilateral organizations, private foundations, Governments, civil society, and private-sector representatives has been established with the goal of ensuring that all people in low- and middle-income countries can access and use affordable, high-quality contraceptives and other reproductive health supplies. More recently, Family Planning 2020 (FP2020) has been building on the partnerships launched at the London Summit on Family Planning that was organized by The UK Government and the Bill & Melinda Gates Foundation, in partnership with UNFPA, and brought together national governments, donors, civil society, the private sector, the research and development community, and others from across the world to reach 120 million more women and girls in the world's poorest countries with access to voluntary family planning information, contraceptives, and services by 2020.

In the area of international migration, UN agencies and IOM collaborate and coordinate efforts in the Global Migration Group (GMG) with the objective of promoting the wider application of all relevant international and regional instruments and norms relating to migration, and to encourage the adoption of more coherent, comprehensive and better coordinated approaches to the issue of international migration.

The Partnership in Statistics for Development in the 21st Century (PARIS21) was founded in 1999 by the United Nations, the European Union, OECD-DAC, the IMF and the World Bank, in response to a UN Economic and Social Council resolution that addressed the reduction of poverty and the improvement of governance in developing countries by promoting the integration of statistics and reliable data in the decision-making process. In its most recent plan (Busan 2011) PARIS21 adopted a system-wide approach to capacity development to integrate national statistical activities with the requirements of planning, budgeting, monitoring, and results and recognized the important synergies between survey and census-based data, administrative data, and vital statistics. The plan also explicitly supports greater transparency and encourages the use of new methods and technologies to increase the reliability and accessibility of statistics. The action plan explicitly recognizes the statistical activities necessary to support key global commitments including on initiatives such as gender equity and the empowerment of women.

Coordination and partnerships are essential to address the complex challenges of sustainable development in an increasingly globalized world. Such partnerships also hold promise for broad public accountability, if initiatives and mechanisms are not “owned” by a particular group of governments, foundations, or international civil servants, and that scarce development funds are not wasted through fragmentation or duplication of efforts.

E. Financial resource flows

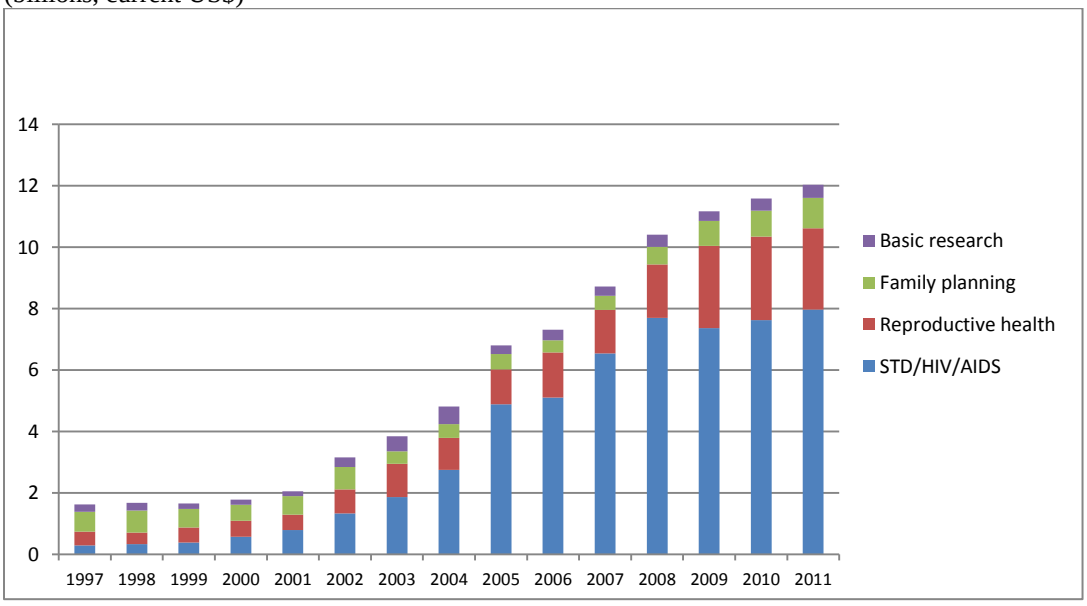
Based on results of the Global Survey, 88.8 per cent of countries report having "allocated resources to monitor population trends and prepare population projections and scenarios" during the last five years, and this reached 100 percent among European countries. Eighty-six (86.2 per cent) of countries reported having earmarked resources to "explore the linkages between population and poverty".

1. Donor aid for select components of the ICPD

At the ICPD in 1994, the international community agreed that US $17 billion would be needed in 2000, $18.5 billion in 2005, $20.5 billion in 2010 and $21.7 billion in 2015 to finance four core programmes in the area of population and development: family planning; basic reproductive health; prevention of sexually transmitted diseases, including HIV/AIDS; and programmes that address the collection, analysis and dissemination of population data. Two thirds of the required amount would be mobilized by developing countries themselves and one third, or $5.7 billion in 2000, $6.1 billion in 2005, $6.8 billion in 2010, and $7.2 billion in 2015 was to come from the international community.

Routine monitoring for ICPD funding for components related to sexual and reproductive health have been sustained over time, and show a steep increase in donor assistance since 2004 for HIV and AIDS related activities. The largest proportion of population assistance — 66 per cent in 2011 — went to activities related to prevention of sexually transmitted infections/HIV/AIDS, the majority of which was allocated to HIV/AIDS (Figure 56). A total of 8 per cent of population assistance was expended for family planning services, 22 per cent for basic reproductive health services and 4 per cent for basic research, data and population and development policy analysis.

Figure 56
Donor expenditures for population assistance by ICPD category, 1997-2011
(billions, current US$)



Source: UNFPA, 2013. *Financial Resource Flows for Population Activities in 201 and Resource Flows Project database.*

Funding for the four areas has increased in absolute dollar amounts, but HIV/AIDS activities received an increase of 27 times the funding allocated for this component in 1997. Financial flows to reproductive health activities have increased as well, although less dramatically. The amount of money allocated to reproductive health was 22 per cent of the total assistance for these in 2011. Sub-Saharan Africa, which

includes the majority of the least developed countries assisted, has been the largest recipient, receiving about two thirds of such assistance going to the five geographic regions,[681] reflecting the regional high need in all dimensions of SRH, but particularly in HIV and AIDS.

Although funding for population activities has been rising, it was not meeting growing needs in developing countries. To ensure adequate funding for the implementation of these components of the ICPD Programme of Action, in 2009 the United Nations Population Fund reviewed the existing estimates for the four categories of the ICPD costed population package (ICPD para. 13.14) and revised them to reflect current needs and costs. The revised estimate across the four categories totaled US $64.7 billion for 2010, which was expected to rise to US $69.8 billion by 2015.[682] These revised estimates are much higher than the original ICPD targets agreed upon in 1994 because they take into account both current needs and current costs and include interventions such as AIDS treatment and care, and reproductive cancer screening and treatment that were not part of the original costed package. The revised costs are considered minimum estimates required to finance interventions to meet growing needs in these four categories. Further revisions may now be warranted based on the findings of this Review.

Systematic monitoring of donor aid for the implementation of the ICPD agenda has not been carried out in a manner that embraced the full far-ranging objectives and actions of the ICPD (which might include, for example, human rights, violence, the social protection of migrants, research on climate change, among others), but such estimations would admittedly be challenging to execute because they would reach across multiple development sectors.

2. Bilateral support

OECD/DAC donor countries have played an essential role in supporting the implementation of the ICPD Programme of Action worldwide by supplementing domestic resources, in particular for SRH in developing countries, with family planning, safe motherhood and HIV/AIDS as the three main areas of funding. Nevertheless, the weight in terms of funding as per what was agreed in the ICPD Programme of Action is insufficient to address national and regional needs. In particular, family planning information and services have slid far down the public policy agenda, STI surveillance is grossly inadequate, and primary health care systems need substantial investment to name only a few of the gaps identified in this Review.

The nature of donor support and funding structures has not always been geared to support of integrated or holistic service delivery. Existing family planning and maternal and child health programmes and institutional structures continue to have strong donor commitment, as they have often been supported and built up by donors over many years. These programmes, however, still require vertical accountability, which tends to perpetuate programmme-specific flows of funding, management, commodities, logistics, reporting and so on. This siloed funding and vertical orientation has been contrary to stated donor and government policy goals to provide integrated service delivery and strengthen the long-term capacity and growth of the health sector, as agreed to in the Programme of Action. Despite all good intentions, such vertical approaches may have been exacerbated by the establishment of vertical funding mechanisms, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (2000).

[681] United Nations Population Fund (2013). Financial Resource Flows for Population Activities in 2011.

[682] United Nations (2009), Report of the Secretary-General on *The Flow of Financial Resources for the Implementation of the Programme of Action of the International Conference on Population and Development*, E/CN.9/2009/5. UNFPA (2009), *Revised Cost Estimates for the Implementation of the Programme of Action of the International Conference on Population and Development: A Methodological Report*.

3. Domestic expenditures

Domestically generated financial resources, which include government, national NGO and private out-of-pocket expenditures, account for the majority of funding the costed components of the ICPD. Although much harder to measure, it is estimated that developing countries and countries in transition mobilized $54.7 billion for population activities in 2011, the largest amount ever. The considerable increase from previous years is due in part to the large expenditures reported for family planning in China, but the latest numbers may not be entirely comparable to past estimates due to the inclusion of new data on out-of-pocket expenditures from the World Health Organization. (Table 6).[683]

Developing countries as a whole are currently funding over three fourths of the expenditures of the population package costed under the ICPD. However, most domestic resource flows originate in a few large developing countries. The majority of developing countries has limited financial resources to utilize for population and reproductive health programmes and cannot generate the required funds to implement these programmes, largely relying on donor assistance. Moreover, private consumers in developing countries account for over half of domestic resources through out-of-pocket expenditures. This has important implications with regard to access, reaching the most marginalized and slow progress in achieving targets. It also has important implications for policy initiatives aimed at reducing poverty and income inequality in the developing world.[684]

Table 6
Estimates of global domestic expenditures for four components of the ICPD, 2011
(thousands of US$)

	Source of Funds				
Region	*Government*	*NGO*	*Consumers**	*Total*	*Percentage spent on STD/HIV/AIDS*
Africa (sub-Saharan)	3,244,374	119,916	3,567,490	6,931,780	95%
Asia and the Pacific	11,249,700	157,910	27,944,254	39,351,864	10%
Latin America and the Caribbean	2,190,262	80,799	1,133,654	3,404,715	85%
Western Asia and North Africa	542,511	60,014	349,920	952,445	36%
Eastern and Southern Europe	2,669,365	16,025	1,374,723	4,060,113	96%
Total	19,896,212	434,664	34,370,040	54,700,916	32%

Source: United Nations Population Fund (2013). Financial Resource Flows for Population Activities in 2011. See also Erik Beekink, *Projections of Funds for Population and AIDS Activities, 2011-2013*, The Hague, 2013

Human rights elaborations since the ICPD: Resource flows

Other Intergovernmental Outcomes: The *Monterrey Consensus on Financing for Development* (2002), the outcome of the United Nations International Conference on Financing for Development, reflects a commitment to international development cooperation. The Consensus states, "Good governance is essential for sustainable development. Sound economic policies, solid democratic institutions responsive to the needs of the people and improved infrastructure are the basis for sustained economic growth, poverty eradication and employment creation. Freedom, peace and security, domestic stability, respect for human rights, including the right to development, and the rule of law, gender equality, market-oriented policies, and an overall commitment to just and democratic societies are also essential and mutually reinforcing."

[683] United Nations Population Fund (2013). Financial Resource Flows for Population Activities in 2011.
[684] United Nations Economic and Social Council, 2013.Flow of financial resources for assisting in the implementation of the Programme of Action of the International Conference on Population and Development. Report of the Secretary General. Commission on Population and Development. Forty-sixth session, 22-26 April 2013 E/CN.9/2013/5

F. The ICPD Beyond 2014 monitoring framework

In the two decades since 1994 there has been an elaboration of efforts to measure the evolution of human rights protection systems, develop new indicators of gender equality and empowerment, to appraise the quality within sexual and reproductive health services, and to define national and global indicators of human development, such as those elaborated for measuring progress towards the MDGs. Most of these efforts, the MDG framework project included, have garnered ample criticism, but by virtue of being tested and evaluated, they provide a foundation for monitoring agreed goals Beyond 2014.

The ICPD Beyond 2014 Monitoring Framework will provide a basis for national and global reporting on progress that can enhance the review and appraisal of implementation of the Programme of Action functions of the General Assembly, the Economic and Social Council and the Commission on Population and Development. Both the global score card and the global report will also provide readily available input for any monitoring under the Post 2015 development agenda. Reporting against commitments related to the ICPD in treaty bodies as well as in the intergovernmental bodies of the United Nations that take place separately or independently will be more easily integrated into the processes of the Commission on Population and Development (See Annex IV).

G. Governance and accountability: Key areas for action

1. Population dynamics data are critically important for development planning.

Population dynamics must not be regarded as numeric abstractions but as foundational data on the human experience, including how the characteristics of people affect the potential for development, how they interact with their environment, where they are living or moving, whether or not they are well or living with fear and insecurity, and what social protections and public services they may need. Population dynamics today underscore the world's dramatic demographic disparities and varied trends: rising numbers of older persons worldwide, most advanced in Europe and parts of Latin America and Asia; young populations and continued high fertility in Africa; and the changing nature of households in many regions, with increasing proportions of one-person and single-parent households. The capacity to monitor and project population dynamics must be a core investment for development – informing the response to where and how best to invest development resources and promote human rights and dignity.

2. Knowledge sectors need strengthening.

This Review highlights considerable weaknesses in the knowledge sector in population and development in countries, including inconsistent civil registration and censuses, limited use of innovations, but especially in the generalized low capacity for using data for development planning, implementation, monitoring and evaluation. There is a pressing need to strengthen capacity in demography, public health, human rights, economics and related social sciences, and to improve productive linkages between researchers, development planners and ministries, allowing nationally generated data to foster knowledge-driven governance.

Strengthened leadership is required in overall planning for the knowledge sector, including resource allocation and investments in human resources. Pressing needs include the number and quality of human resources; integrating new methods and technologies; strengthening civil registration and other administrative data sources, as well as migration statistics; disseminating data and democratizing data use; and making sure that population data inform policy decisions. A shift should be made from dependence on survey data to a balanced use of all relevant data sources, including civil registration and

other administrative data sources.

3. More systematic, inclusive participation.
While States continue to bear the primary obligation to ensure human rights, it is increasingly recognized that achieving good governance and development is the responsibility of a variety of non-state actors. Thus, the promotion of favourable conditions for free and inclusive participation of all members – governments, parliamentarians, civil society and other stakeholders, representing a diversity of opinions, interests and skills, as was recognized by the Programme of Action – remains a priority. Improvements and innovations have been introduced, but greater efforts must be made to redress inconsistencies and foster the inclusive, transparent participation of all key population groups in the decisions that affect them, including adolescents and youth, persons with disabilities, older persons and indigenous peoples.

4. Better accountability systems are needed for national and global programs, as well as for the emerging complexity of development partnerships.
As a cornerstone of good governance, systems of accountability build a foundation for realizing rights-based development objectives; ensure that quality data and knowledge is accessible to the public and to all decision-makers; and create enabling environments that allow the informed representative participation of civil society to hold governments and other key actors to account. National and international legislation, administrative practices, and protection systems are needed to ensure equal access to programmes and services, prevent abuses, address systemic gaps and failures, and provide opportunities for redress and remedy. Mechanisms of review and oversight, including national human rights protection systems, courts, administrative review bodies, parliaments, and forums for community participation are critical to this process. Equally important, effective international, multilateral, regional, South-South and triangular cooperation must be grounded in principles of national ownership, system-wide coherence, transparency and accountability to ensure that development aid and new global partnerships harness development potential, rather than increase fragmentation and duplicate efforts.

V. Sustainability

Scheduled only two years after the 1992 Rio Earth Summit, the ICPD was profoundly imprinted by the goal of "sustainable development". Attention to sustainable development has only increased in the intervening 20 years, especially now as the world constructs a new agenda for global development. The Review defines the unfinished agenda of the ICPD within the context of a new development environment that is shaped by, and must respond to, a need to reconcile rising levels of consumption, threats to the environment, and growing wealth and income inequality. The fact that the poor bear the brunt of environmental burdens, and that the accustomed model for improving living standards, expanding opportunities and guaranteeing dignity and human rights is inherently unequal and proving unsustainable, is one of the major ethical quandaries in human history. At this challenging threshold, the core message of the ICPD – *that a fundamental commitment to individual dignity and human rights is the basis of a resilient and sustainable future* – can define a set of pathways to addressing this quandary and achieving sustainable development for all.

"The right to development must be fulfilled so as to equitably meet the population, development and environment needs of present and future generations." (Principle 3, ICPD Programme of Action)

"The objective is to raise the quality of life for all people through appropriate population and development policies and programmes aimed at achieving poverty eradication, sustained economic growth in the context of sustainable development and sustainable patterns of consumption and production, human resource development and the guarantee of all human rights, including the right to development as a universal and inalienable right and integral part of fundamental human rights." (Para 3.16, ICPD Programme of Action)

"Modify unsustainable consumption and production patterns through economic, legislative and administrative measures, as appropriate, aimed at fostering sustainable resource use and preventing environmental degradation" (Para 3.29b, Key Actions for the Further Implementation of the Programme of Action of the ICPD)

A. The heterogeneity of population dynamics

Rapid population growth in the 20th century gave rise to widespread and heavily politicized concerns about overpopulation and the possibility that the world would not be able to generate enough food or other essential resources to sustain its people.[685] The urgent need for the ICPD's pro-rights platform reflected decades of resulting population and development policies that prioritized population control without heed to people's reproductive aspirations, their health, or the health of their children. The Programme of Action reflected a remarkable consensus among diverse countries that increasing access to health and education, and greater human rights for women, including their reproductive health and rights, would ultimately secure a better social and economic future – *and also lead to lower population growth* – than targeted efforts for birth control. The evidence of 2014 overwhelmingly supports the accuracy of that consensus.

There were an estimated 5.7 billion people in the world at the time of the ICPD in 1994. Global population has now reached 7.1 billion, and continues to grow by some 82 million people per year. Yet over this period, global annual population growth rates have been steadily declining, from 1.52 per cent in the period 1990-1995 to 1.15 per cent in the period 2010-2015. Annual rates of population growth have declined in developing countries as well, from an average of 1.8 per cent in 1990-1995 to 1.3 per cent in 2010-2015.

[685] Ehrlich, P. (1968) *The population bomb*, Sierra Club/Ballantine Books, New York

Africa's population is growing the fastest, at 2.3 per cent per year during 2010–2015, a rate more than double that of Asia at 1.0 per cent per year. Still, in 2011, 60 per cent of the global population lived in Asia and only 15 per cent in Africa. Asia's population is currently 4.2 billion, while the population of Africa surpassed a billion only in 2009. The populations of all other major regions combined (the Americas, Europe and Oceania) amounted to 1.7 billion in 2011.[686]

Global and regional population trends mask considerable and growing heterogeneity of demographic experiences around the world. The demographic transition associated with declining fertility and mortality levels, together with the urban transition that has shifted the locus of human activity from rural to urban areas, have caused unprecedented changes in population size, age structures and spatial distribution.

Comparison of the periods 1990-1995 and 2010-2015 show that global total fertility rates declined 16 per cent,[687] yet notable differences in fertility rates are observed across and within countries and regions.[688] Developed countries and some middle-income countries are now experiencing below-replacement fertility levels (that is, when women are not having enough children to ensure that, on average, each women is replaced by a daughter who survives to the age of procreation), declining population growth rates, and in some cases, declining population size. Low-fertility countries include all countries in Europe, 23 of the 51 countries in Asia, 18 of the 38 countries in the Americas, two in Africa and one in Oceania.[689]

In 2010–2015, total fertility rates remained high at four children per woman or greater in 45 developing countries, including 18 countries where total fertility was five children per woman or greater. High-fertility countries are mostly concentrated in Africa (38 out of the 57 countries in the continent have high fertility), but there are five in Asia and two in Oceania.[690]

As fertility declines, child dependency ratios decline, resulting in a population with relatively more working age adults (15-59) and fewer non-working age dependents. In developed countries, the proportion of the population of working age increased steadily from 61.8 per cent in 1990 to 62.9 per cent in 2005. Since then, that proportion has been declining, and in 2010 it was at the same level as in 1990. In developing countries, the proportion of the population of working age increased considerably from 56.8 per cent in 1990 to 62.4 per cent in 2010, and is projected to decline to 58.4 per cent in 2050. Among the least developed countries, the proportion of the population of working age is expected to rise from 53.8 per cent in 2010 to 59.8 per cent in 2050 and then decline thereafter.[691]

The diversity in fertility levels illustrates a broader diversity of demographic trajectories between countries. Low-fertility countries are increasingly being faced with the opportunities and challenges of ageing as their citizens live longer and healthier lives. Countries that are witnessing rising proportions of youth and working-age populations due to recent declines in fertility can take advantage of a short-term demographic dividend under the right social and economic conditions. And countries that have high fertility continue to experience rapid population growth, creating challenges in building capabilities in education and health and generating sufficient employment opportunities. While mortality has been declining and people are living longer in almost all countries of the world, a number of developing countries continue to have unacceptably high rates of morbidity and mortality and low life expectancy.

[686] United Nations, Department of Economic and Social Affairs, Population Division, 2013. World Population Prospects: The 2012 Revision
[687] Period estimates provided here differ from the point estimates in the introduction, accounting for the difference in the stated fertility decline.
[688] United Nations, Department of Economic and Social Affairs, Population Division, 2013. World Population Prospects: The 2012 Revision
[689] United Nations, Department of Economic and Social Affairs, Population Division, 2013. World Population Prospects: The 2012 Revision
[690] United Nations, Department of Economic and Social Affairs, Population Division, 2013. World Population Prospects: The 2012 Revision
[691] United Nations, Department of Economic and Social Affairs, Population Division, 2013. World Population Prospects: The 2012 Revision

International migration, while not necessarily increasing in scale, has diversified in an interconnected and interdependent world, with many countries at the same time sending, receiving and being points of transit for migrants. And countries all around the world are at widely different stages of urbanization, with steady urban populations in Europe and North America coinciding with rapid urban growth and eventual declines of rural populations in Asia and Africa.

The Review has shown that population dynamics matter for development and shape critical aspects of dignity, health, place and mobility. The rise in heterogeneity means that population dynamics is contextually specific and dependent on many other aspects of the different development paths that countries are experiencing. Too often, though, population dynamics, and particularly population size and growth, are treated as undifferentiated and global, frequently as part of discussions about other phenomena that are indeed global. Climate change, one of the most important challenges for sustainability, is fundamentally global; its trajectory is dependent on the intersection of population and models of economic growth, production and consumption and it will demand global responses. Understanding this intersection is therefore essential for generating pathways to sustainable development.

B. The drivers and threats of climate change

The current development paradigm is predicated on a social and economic model that favours production, accumulation and the consumption of goods and services in ever greater amounts.[692] Increasing consumption is vital to improving well-being for the poor, yet at high income levels the benefits of further consumption result in no discernable impact on well-being.[693] While global population growth is slowing, levels of production and consumption have increased, and are expected to accelerate as long as natural resources can sustain them. Global Gross Domestic Product (GDP) increased by a factor of 73 between 1820 and 2008, while world population increased only seven times.[694] Average consumption per capita almost tripled between 1960 and 2006.[695] Such economic gains have helped to bring relief from stark poverty to hundreds of millions of people, with particularly notable gains made in the last two decades. The number of people[696] living on less than US $1.25 per day fell from over 2 billion in 1990 to under 1.4 billion in 2008 while global population was increasing by almost 1.5 billion, underscoring both significant progress and the enormous number of people left behind.

Economic progress has taken place at the expense of the environment. The risks of ignoring our planet's global environmental limits in pursuit of ever rising production and consumption levels are growing exponentially. It is estimated that anthropogenic activities have already or will soon surpass ecological thresholds with respect to critical Earth systems and natural cycles. Most urgent are biodiversity, the nitrogen cycle and climate change, with other serious concerns including degradation of land and soils, excess production of phosphorus, stratospheric ozone depletion, ocean acidification, global consumption of freshwater, changes in land use for agriculture, and air and

[692] Veblen, Thorstein. 1902. The Theory of the Leisure Class: An Economic Study of Institutions. New York: Macmillan; Georgescu-Roegen. Nicholas 1993. "The entropy law and the economic problem". Chapter 3 in Daly, Herman and K.N. Townsend. Valuing the Earth: Economics, Ecology and Ethics. Pp. 75-88. Cambridge, MIT Press; Georgescu-Roegen. Nicholas. 1979. "Energy analysis and economic valuation." Southern Economic Journal. Vol 45, No. 4, Pp. 1023-1058; Daly, Herman. 1991. Steady-State Economics, 2nd edition. Island Press, Washington, DC; Stern, Nicholas. 2006. The Stern Review on the Economics of Climate Change. HM Treasury. U.K Government; Jackson, Tim. 2009. Prosperity Without Growth: The Transition to a Sustainable Economy. Sustainable Development Commission. [www.sd-commission.org.uk/.../prosperity_without_growth_report.pdf]; Worldwatch. 2010. State of the World 2010: Transforming Cultures from Consumerism to Sustainability. Washington, New York and London. W.W. Norton and Co.; Assadourian, Erik. 2010. "The rise and fall of consumer cultures." Chapter 1 in State of the World 2010: Transforming Cultures from Consumerism to Sustainability. W.W. Norton and Co.

[693] Diener, Ed and Martine E.P. Seligman (2004). Beyond Money: Towards and Economy of Well Being. *Psychological Science in the Public Interest* 5(1):1-31.

[694] Madisson, A. (2010), "Statistics on World Population, GDP and Per Capita GDP, 1-2008 AD", The University of Groningen [http://www.ggdc.net/maddison/oriindex.htm] and UN DESA (2013), Population Division, "World Population Prospects: the 2012 Revision".

[695] Worldwatch. 2010. State of the World 2010. Washington, Worldwatch. Change to this reference instead: The Worldwatch Institute (2010), "State of the World 2010: Transforming Cultures", Washington, Worldwatch Institute

[696] United Nations (2012), "The Millennium Development Goals Report"

chemical pollution.[697]

The consensus of scientific discussions today is that human activity is at the root of these various pressures. In the case of climate change, our carbon footprint is the critical factor. The concentration of CO_2 and other greenhouse gasses in the atmosphere continues to increase – 400 parts per million has been surpassed for the first time in three million years[698] – with the challenge of keeping global mean temperature rise below the critical threshold of 2 degrees Celsius above the pre-industrial level only increasing in difficulty.[699] Rising levels of atmospheric CO_2 and other greenhouse gases are causing increased global temperatures, climate change and ocean acidification.[700] Rises in temperatures will accelerate the melting of glaciers and permafrost and that could lead to the liberation of trapped methane gas (CH_4), which is 30 times more potent than CO_2, though with a much shorter half-life. The copious and expanding use of fossil fuels as energy sources, including in buildings and transport, represents the main source of greenhouse gas emissions.[701] The longer it takes to reduce greenhouse gas emissions, whether by shifting to renewable energy or through other means, the more severe the economic disruption will be of both climate change and efforts to mitigate it.[702]

Climate change, as well as broader environmental degradation, poses a threat to the livelihoods and well-being of all societies and individuals. Yet the impacts of climate change – both acute and long term – are likely to be worse for the poor and marginalized, who have contributed little to greenhouse gas emissions and at the same time lack the resources and societal supports to adapt effectively to current and future changes.[703] Climate change therefore presents humanity with extremely difficult decisions at the crossroads of development, equality and sustainability. The negotiations of the Conference of Parties of the UN Framework Convention on Climate Change have brought these issues to the forefront, and the lack of progress to date – the world's inability to curtail the growth of emissions, and the lack of funding to prepare for or alleviate climate impacts – underscore how far we are from the transformations so vitally needed to stop the warming of the climate.

Technology has historically been relied upon to relieve natural resource constraints and environmental impacts through, at least, partial delinking of consumption and production from resource use and pollution. Technological progress can, and should, contribute to efforts aimed at reconciling economic growth, consumption, and environmental resources. While certain technologies are proven and being widely deployed, innovation to develop new, as-yet unproven technologies will be critical to achieving the ambitious reductions in environmental impacts that will be required in coming decades. In this regard, the development of a variety of renewable energy sources and

[697] UNEP. 2012. Emerging Issues in our Global Environment. UNEP Yearbook 2012. *United Nations Environment Program.* St-Martin-Bellevue: UNEP.
[698] National Oceanic and Atmospheric Administration. Up-to-date weekly average CO_2 at Mauna Loa. http://www.esrl.noaa.gov/gmd/ccgg/trends/weekly.html
[699] World Bank (2012). Turn Down the Heat: A Report for the World Bank by the Potsdam Institute for Climate Impact Research and Climate Analytics.
[700] IPCC (2013). Assessment Report 5: Summary for Policy Makers.
[701] Estimates vary but fossil fuels still account for over 80% of the world' energy needs. As noted by Murphy (2013), fossil fuels represent a generous one-time gift from the Earth; no other energy source can provide all the same benefits but fossil fuel stocks are finite. See: T.W. Murphy. 2013. "Beyond fossil fuels: assessing energy alternatives." Chapter 15, State of the World 2013: Is Sustainability Still Possible? Washington, The Worldwatch Institute. Island Press. Kindle Edition; Thomas Princen, Jack P. Manno, and Pamela Martin. 2013. "Keep them in the ground." Chapter 14 of Worldwatch, 2013. State of the World 2013: Is Sustainability still Possible?. Washington, The Worldwatch Institute; Smil, Vaclav. 2010. Energy Transitions: History, Requirements, Prospects (Santa Barbara, CA: Praeger); T.W.Murphy. 2011. "The energy trap." *Do the Math* at physics.ucsd.edu/do-the-math/2011/10/the-energy-trap; T.W.Murphy. 2012. "The alternative energy matrix." *Do the Math* at physics.ucsd.edu/do-the-math/2012/02/the-alternative-energy-matrix;
[702] National Research Council. 2010. Hidden costs of energy: Unpriced consequences of energy production and use. Washington, D.C.;Eric Zencey. 2013. "Energy as master resource." Chapter 7 in State of the World 2013: Is Sustainability Still Possible? Washington, The Worldwatch Institute.; Shakuntala Makhijani and Alexander Ochs. "Renewable Energy's Natural Resource Impacts." Chapter 8 in State of the World 2013: Is Sustainability Still Possible? Island Press, The Worldwatch Institute; Hall, C. A. S, S. Balogh and D.J.R. Murphy. (2005). "What is the minimum EROI that a sustainable society must have?" Energies, 2(1): 25-47. Stern, Nicholas (2006). The Economics of Climate Change: The Stern Review. Cambridge: Cambridge University Press.
[703] IPCC (2009). "Managing the Risks of Extreme Events and Disasters to Advance Climate Change Adaptation." http://www.ipcc.ch/pdf/special-reports/srex/SREX_Full_Report.pdf

storage technologies to substitute for the use of fossil fuels is a priority.[704] There are also many challenging technical problems to be ironed out, for instance the intermittency and variability of wind and solar energy, the reliable integration of renewable energy generation into existing electric grids, the decreasing availability of rare earth elements used in wind turbines and electric cars, as well as the scarcity of other more common resources.[705]

Improvements in energy efficiency are critical to lessen the eventual scale of renewable energy deployment. Yet increased efficiency can reduce the price of energy, incentivizing yet greater use (a phenomenon known as the Jevons Paradox). Energy conservation, even should the world transition to renewable energy, is therefore necessary for a sustainable future.

States should remove all barriers to sustainability through increased use of clean technology and innovation, and promote and develop sustainable production and consumption patterns through research and technical cooperation between countries and regions, including mutually agreed sharing of all relevant technologies.

The error that is habitually made in discussing demographics and climate change is to identify a larger population with greater emissions – that is, to equate one person with one unit of consumption. Yet, as of now, only 2.5 billion people, a little more than a third of the world's population, could be minimally considered as having consumption profiles that contribute to emissions[706]. Of this total, less than a billion actually have a significant impact on emissions and a smaller minority is responsible for an overwhelming share of the damage. All people should be sharing the Earth's resources, but if they did so in the manner and at the rate of the developed countries, our ecological support system would have broken down long ago.

While the immediate stabilization of population size would clearly improve the situation in the long term, it would make little difference in our current global ecological predicament. With very few exceptions, countries displaying higher levels of consumption have fertility levels that are already low or below replacement level. Hence, their population growth is due to net in-migration or inertia (due to the fertility levels of previous generations and thus to the number of women currently in reproductive age groups) and is not amenable to significant changes via family planning programs. Indeed, many of these countries are actually trying to *increase* their fertility.

On the other hand, the higher fertility countries tend to be mired in poverty and have very low levels of consumption. Poor countries and their populations have the right to development and to improve their living standards, a feat that in today's world requires higher economic growth. Under this scenario, their consumption profiles will and should increase, and unless this increase happens in a radically different manner than has been the case for wealthier countries, it will further contribute to climate change.

Another important aspect of population and development that is generally ignored is the link between fertility changes and consumption. As a society develops, individuals and households are motivated to reduce their fertility for various complementary reasons, including the decline of infant mortality and increased consumption aspirations. Fertility declines, in turn, are associated with higher per capita income in the household unit and, thus, with greater capacity to consume. Consequently, emissions reduction to be achieved if family planning programmes are effective in reducing fertility is highly dependent on the extent and nature of consumption and economic growth.

[704] Costanza R., J. Farley, and I. Kubiszewski. (2010), "Adapting Institutions for Life in a Full World" inThe Worldwatch Institute (2010), "State of the World 2010: Transforming cultures", Washington, Worldwatch Institute
[705] \The Worldwatch Insitute (2013), "State of the World 2013: Is sustainability still possible?", Washington, Worldwatch Institute
[706] Mckinsey(2012), 'Consumers' are defined in that analysis as those with an income of at least ten dollars a day. Such a low bar obviously inflates the number of people who are making significant contributions to emissions. Nevertheless, it is useful in establishing the fact that a minority of the world's population are actually consumer/emitters.

C. The cost of inequality for achieving sustainable development

The global development model has brought many out of poverty. Yet prevailing inequalities in income, living standards, and, more generally, opportunity remain at the root of economic, social, environmental and political segmentation, with 8 per cent of the world population accumulating 82 per cent of global wealth as part of a trend of steeply rising wealth inequality for the past 20 years.

When growing inequality precludes human well-being for vast numbers of people, every part of society is impacted. Inequality is a threat to social cohesion, empathy and shared responsibility because it generates and exacerbates social segmentation. This is true politically, where economic resources significantly determine political access, influence and outcomes, and socially, because it diminishes the likelihood that people with varying degrees of wealth and income will share neighborhoods, meet within schools, and gain the chance for shared understanding and empathy. It also constrains class mobility and therefore people's ability to emerge out of poverty and achieve more secure livelihoods.[707]

A broadly educated, healthy, secure and empowered population is the goal of development, and also necessary for inclusive economic growth. Active states that promote the capabilities of their people, provide universal public services, govern effectively and efficiently, fight discrimination and are shaped by the political participation of their people are able to generate more equal development.[708] As inequality grows, the ability and will of governments to provide a strong common foundation of capabilities for all of their people is degraded. And when people experience discrimination, due to income, gender, ethnicity or race, disability status, sexual orientation and gender identity, or other factors, their health, dignity and ability to maximize their capabilities and contributions is deeply impacted, at great cost to all of society.[709]

The degradation of the environment only compounds the extent and impacts of inequality. The poorest bear most of the environmental costs of industrial waste and byproducts, and are extremely impacted by climate change. Rising inequality also further threatens the ability of the world to provide for all. The creation of wealth requires natural resources; diversion of the vast majority of the world's wealth – and therefore its finite resources – to a small part of the population limits the resource base for poverty reduction and the extension of rights-based development to present and future generations. These challenges underscore the need for equitable living conditions for all persons over their life course, and fair distribution of the risks and health consequences of industry.

Human rights elaborations since the ICPD: Right to development

Intergovernmental human rights outcomes: Reaffirming the *Declaration on the Right to Development* (1986), and "emphasizing the urgent need to make the right to development a reality for everyone," the Human Rights Council has adopted resolutions, including *Resolution 21 /32 The Right to Development* (2012), which takes note of the activities of the Intergovernmental Working Group on the Right to Development and the process of developing criteria and operational sub-criteria for the implementation of the right to development.

[707] Hellman, Joel S. and Daniel Kaufmann (2002). The Inequality of Influence. Social Science Research Network Working Paper; Corak, Miles. 2013. "Income Inequality, Equality of Opportunity, and Intergenerational Mobility."Journal of Economic Perspectives, 27(3): 79-102; Bjorvatn, K. and A.W. Cappelen (2003). Inequality, Segregation, and Redistribution. *Journal of Public Economics* 87(7-8): 1657-1679.
[708] Dreze, Jean and Amartya Sen (2013). *An Uncertain Glory: India and its Contradictions*. Princeton: Princeton University Press.
[709] Krieger, N. (1999). Embodying Inequality: A review of concepts, measures, and methods for studying health consequences of discrimination. *International Journal of Health Services*, 29(2): 295-352; Pascoe, E.A., Smart Richman, L. (2009). Perceived discrimination and health: A meta-analytic review. *Psychological* Bulletin, 135(4): 531-554.; Williams, D.R., Neighbors, H.W., Jackson, J.S. (2003). Racial/ethnic discrimination and health: findings from community studies. *American Journal of Public Health*, 93(2): 200-208.; Williams, D.R., Mohammed, S.A. (2009). Discrimination and racial disparities in health: Evidence and needed research. *Journal of Behavioral Medicine*, 32(1): 20-47.

Other soft law: In *Resolution 17/4* (2011), the Human Rights Council endorsed the *Guiding Principles for Business and Human Rights,* which provide a global standard for preventing and addressing adverse impacts of business activities on the enjoyment of human rights.

1. Government priorities: Interaction between population and sustainable development[710]

Social sustainability, poverty reduction and rights	**70 per cent of governments**
Environmental sustainability	**52 per cent**
Integration of population dynamics in sustainable development	**43 per cent**
Physical infrastructure development	**40 per cent**
Health and education	**35 per cent**

Government responses to the ICPD Beyond 2014 Global Survey (2012) suggest widespread acknowledgement that social and environmental sustainability must be at the core of inclusive development, and that economic growth is the means for, rather than the measure of, social well-being. When asked to identify the population and sustainable development issues anticipated to receive public policy priority for the next five to ten years, the most frequently listed issue was "social sustainability, poverty reduction and rights", the priority among 70 per cent of governments. This was followed by "environmental sustainability" for 52 per cent, and only 25 per cent listed "economic growth" as a priority.

D. Paths to sustainability: Population and development beyond 2014

Notable progress has been celebrated in the preceding chapters of this Review, highlighting the central success of the paradigm adopted by Member States at the ICPD 20 years ago – that protection of individual human rights and the advancement of gender equality would not only accelerate inclusive development, but contribute to a further deceleration of population growth. Accomplishments since 1994 have been substantial, opening the door for further opportunity to reflect on unfulfilled goals for sustainable development beyond 2014, and within the Post 2015 Agenda.

Recommendations in each of the preceding chapters have elaborated technical, institutional and political changes needed to fulfil human rights, achieve better health, public knowledge and participation, ensure more secure and accessible options for settlement, and generate more robust systems of accountability. While each recommendation in this framework can be addressed on its own, they echo and complement one another, and provide a foundation for achieving sustainable development, as summarized in the following seven paths to sustainability.

1. Strengthen equality, dignity and rights

For the past 20 years, the principles set forth by Member States at the ICPD, that all persons are "free and equal, in dignity and rights", have guided efforts to expand human rights protection systems and means of accountability, in particular to fulfil and protect the reproductive rights of women and young people. At the same moment that much progress can be celebrated, discrimination and lack of opportunity remain a daily reality for many women, girls, young persons, older persons, migrants, persons with disabilities, indigenous peoples, ethnic and racial minorities, persons of diverse sexual orientation and gender identity, people living with HIV, refugees, sex workers, and others.

[710] See Annex II for full table of government priorities by region including definitions of each priority.

Human rights violations against women and girls including gender based violence; harmful practices such as child, early and forced marriage and female genital mutilation/cutting; women's and girls' unequal access to education; and women's unequal access to employment, leadership and decision-making constitute major threats to their dignity and well-being, and that of their families and communities, as well as barriers to the achievement of inclusive sustainable development. Thus, the full realization of gender equality and women's empowerment is imperative.

Further, the evidence reviewed herein highlights a growing body of social research that stigma, discrimination and violence, and thereby the exclusion of persons from full participation in society, have costs that are manifest not only in the physical and mental health of those affected, but in undermining their productivity and achievements in measurable ways. In order to secure the tremendous benefits to development of human creativity, innovation, diligence and productivity, far greater investment, now and in the future, is required to create more just, non-discriminatory, non-violent societies.

The population and development agenda set out in 1994 remains strong, yet unfulfilled, and the agenda beyond 2014 should be based on the recognized universality of human rights and dignity for all persons, in present and future generations. Ensuring that the ICPD sectorial benefits reach all persons is necessary for ending the inter-generational transmission of poverty and building sustainable, adaptive and cohesive societies.

2. Invest in lifelong health and education, especially for young people

The principled need for good health and quality education, including comprehensive sexuality education must be re-affirmed and inform multiple sectors of government and private sector investments. Lack of education and ill-health are the most common risk factors and manifestations of poverty, curtailing economic growth and human well-being and limiting the capability of both individuals and societies to innovate and thrive in a changing world. Investments in the education and health of girls and women have been historically neglected, and provide especially high returns for societies, as evident in the accelerated progress that greater women's empowerment, education and the progressive realization of their reproductive rights have contributed to global development in the past 20 years.

The largest demographic cohort of young people in human history is about to enter the workforce, and their success will define the development trajectories for not only sub-Saharan Africa and Central Asia, where they represent such a high proportion of the population, but for the entire world, given our increasingly inter-connected and globalized economies. The window of opportunity is upon us for enriching and preparing young people with the capabilities they will need to expand their individual choices and shape the innovation and sustainable future of the planet going forward.

As societies age – a phenomenon occurring in many countries now and many more in the coming decades – the legacies of under-education persist, underscoring the need for a lifelong approach to education. Such an approach will enable older persons to contribute to changing economies, thereby providing a second demographic dividend via an engaged, experienced and well-trained older workforce.

While the review underscores the progress made by many countries in sexual and reproductive health and in improving access to and achieving gender parity in school enrolments, the achievements have not reached many who need them most, and who were most deprived in 1994. The capabilities of the world's poorest citizens, both urban and rural, remain untapped through poor quality schools, fragile and under-staffed health systems, public profits diverted through corruption, and the prioritization of short-term economic returns. The differences in development progress over the past 20 years in states re-investing in public capabilities versus states failing to prioritize such investments highlight

the essential nature of these investments for long-term economic growth, public health, and population well-being.[711]

3. Achieve universal access to sexual and reproductive health and rights

For most of the world's women, young women in particular, the struggle for individual human rights and the freedom to decide on their personal future has been an historic struggle, one that is far from won. The extent to which societies have tolerated the use of force and violence to sustain patriarchal control over women, across diverse countries, and all classes of society, is one of the great injustices of human history. If women are to contribute to the enrichment and growth of society, to innovation and development, then they must have the opportunity to decide on the number and timing of their children, and to do so free from violence or coercion, with full confidence that pregnancy and childbirth can be entered into without grave fear of illness, disability or death; and with confidence in the probable health and survival of children.

Early marriage is not a guarantee of social protection, and leads to many of the health risks of early childbearing and often an end to a young women's education. Averting early marriage and unwanted childbearing provides the time for young women to develop their capabilities, move outside the household or migrate to a new place, enter the labor market and gain income, and enter marriage and childbearing with greater autonomy and knowledge. Delayed marriage and childbirth also saves lives: complications from pregnancy and childbirth together are the main cause of death among adolescent girls 15-19 in developing countries.[712]

Gender equality cannot be achieved unless all girls and women can make free and informed choices about sex and reproduction, which demands renewed investment to ensure universal access to quality sexual and reproductive health and rights for all. The review has highlighted persistent inequalities in access to health services and resulting poor SRH outcomes for many, especially mortality and morbidity of poor women during pregnancy and childbirth, including from unsafe abortion.

The achievement of universal access to quality sexual and reproductive health and rights for all demands urgent renewed investments directed towards holistically strengthening health systems and thus bringing these critical services to where people live and are. This should be a core dimension of proposals for universal health coverage. Further, structural inequalities and other barriers to access, including those due to stigma and discrimination, must be addressed to fully ensure the necessary realization of sexual and reproductive health and rights for all.

4. Ensure security of place and mobility

Migration is an intrinsic feature of a globalizing world, in which people increasingly have information and access to different places, both within and beyond their national borders. In some places, poverty, lack of opportunities, or the lack of investment in capabilities lead people, in particular young people, to migrate internally or abroad to secure better wages, generate remittances, and expand their opportunities for a better life. For young women living under highly patriarchal conditions, such migration is increasingly recognized as a reach for freedom and autonomy that may seem impossible in their place of origin.

For some, then, migration is less a choice than a necessity for family or individual survival. Migration exists along a continuum from forced to voluntary, with very few migration decisions entirely one or the other.[713] Sustainability through security of place and mobility means ending forced migration and supporting people who do want to move. For those who want to remain where they are, it means building better livelihood options and creating social conditions of dignity,

[711] Dreze, Jean and Amartya Sen (2013). *An Uncertain Glory: India and its Contradictions*. Princeton: Princeton University Press.
[712] UNFPA (2010). Sexual and Reproductive Health for All.
[713] Hugo, G.(1996), "Environmental Concerns and International Migration." *International Migration Review* 30(1): 105-131.

equality and opportunity, in order to decrease what the Programme of Action referred to as push factors. Even absent push factors, though, many want to migrate to improve their social or economic condition. For those who do, freedom to move means removing the obstacles faced by migrants or potential migrants, embracing their contributions to societies of destination as well as origin, and protecting migrants and members of their families from discrimination or other forms of exclusion. Investments in communities of origin and destination have to be supported by the promotion and protection of human rights and the fundamental freedoms of all persons, irrespective of their migratory status, and by combating all forms of discrimination that migrants face, including the violence and exploitation faced by women and girls.

While some internal and international migrants may achieve their goals, others are not able to leave their places of origin or are trapped in new communities of destination, without the freedom or resources to move, in conditions of heightened insecurity, extreme poverty and vulnerability. Some have lost their homes and land altogether and are homeless, while others have been displaced within their country or to another country as a result of conflict. All persons, whether internal migrants, international migrants, homeless persons, internally displaced persons or refugees, should be provided with access to education, health care and social protection, their safety and security ensured, and their social integration fostered.

5. Build sustainable, inclusive cities

As the world's cities and towns are currently growing at rate of more than 1.3 million a week, planning for urbanization and building sustainable cities should be a priority focus for countries undergoing the urban transition. Cities that are accepting of population growth, are connected to rural areas around them, and deliver for the poor are a key part of sustainable development and also for the effective development of rural areas.

Future environmental outcomes depend to a great extent on the decisions that are made with respect to location and patterns of urban settlement and growth. Cities present significant potential advantages in terms of conciliating the economic and demographic realities of the 21st century with the demands of sustainability and of coping with the effects of climate change. It is widely recognized that, controlling for income, urban concentration is more resource efficient and, with its advantages of scale, allows for more sustainable land use. Moreover, the protection of biodiversity and of natural ecosystems, including the conservation of natural forests, depends on the absorption of population in densely-populated areas. Environmentally-oriented proactive urban planning, including improved energy efficiency, especially in the transport and housing sectors, could transform cities into a vital part of the solution to climate change and other environmental challenges.[714] The fact that the world is undergoing a dramatic urbanization process, particularly in Africa and Asia where much of the world's population growth will be, is therefore an enormous opportunity for sustainability, if the right policies are put in place.

These policies must combine the aims of resource efficiency and minimized environmental impact with ensuring that cities are designed for and deliver dignity, human rights and opportunity for the poor and marginalized, both in the city and beyond. Strong links between cities and rural areas that facilitate access to the city and the flow of people and resources can stimulate markets, improve access to services and create opportunity. As people move to cities, vital to their security of place is ensuring sufficient affordable housing, given that urban growth and densification tend to drive up prices and increase the risk of exclusion of the poor. "Development-based evictions"[715] are one of the

[714] UN DESA (2013). World Economic and Social Survey 2013.

[715] Evictions often planned or conducted under the pretext of serving the "public good", such as those linked to development and infrastructure projects (including large dams, large-scale industrial or energy projects, or mining and other extractive industries); land-acquisition measures associated with urban renewal, slum upgrades, housing renovation, city beautification, or other land-use programmes (including for agricultural purposes); property, real estate and land disputes; unbridled land speculation; major international business or sporting events; and, ostensibly, environmental purposes. For more information: OHCHR (2007), "Basic Principles and Guidelines on Development-based Evictions and Displacement"

most common causes of displacement of the urban poor, often framed as delivering for the public good yet in practice violating the human rights of the poor and undermining their dignity and opportunities. At the 2005 UN World Summit, world leaders committed to slum prevention and upgrading in order to eliminate widespread practices of slum clearance and evictions. Justice systems need the authority to enforce these commitments and to protect the security of land tenure, particularly for women who are often denied inheritance, and both women and indigenous groups who are often denied property ownership – if not in law, but in practice.

Widespread participation in urban governance can help ensure that urban policies address the needs of the most vulnerable. Such participation needs to be institutionalized, for instance via dedicated budgets and the formal inclusion of civil society organizations and marginalized communities, which can help to prevent elite capture of governance systems and deliver governance by all and for all.

6. Change patterns of consumption

A fundamental change to patterns of consumption is required to slow down the frenetic waste of natural resources, to refocus development aspirations on achieving dignity for all and to enrich prospects for human dignity for future generations. Without marked changes in consumption behaviour, material aspirations and shared incentives, particularly among those at the top end of the consumption curve who account for so much drain on resources, new technology and improvements in business and transport practices can only delay impending disasters.

Change in consumption begins at the societal level. The base contributions to consumption – our modes of transport, our housing options, our utilities – are significantly determined by the organization and the public infra-structure of the societies in which we live. In this light, one of the most established, effective and just means of change that governments can undertake to introduce efficiencies and ensure that physical, social and economic opportunities are equally accessible and beneficial to all is the generation and maintenance of universal, cost-efficient, public infrastructures and services. Vital public services include clean water; communication systems; a strong, functioning public health system; regulated utilities; and energy efficient public transport systems. These goods, which are primarily the responsibility of government to deliver, provide critical means of reducing individual, hence overall consumption, while at the same time realizing dignity and creating opportunity.

Investing in public services has an immediate and tangible impact on all individuals and societies as a whole. Additionally, the yields of such investments are in many cases transferred to future generations, whose capabilities are in turn expanded. The benefits of changing our consumption patterns on the environment are unlikely to be witnessed by our generation. However, this abstract perception must not distance us from the shared responsibility we have in improving opportunity for future generations.

Individuals also bear responsibility for sustainable consumption. While those at the bottom end of the income distribution have little or no choice regarding consumption, and indeed consume comparatively little, at higher incomes people have significant choices, and too often choose high consumption. As more and more people recognize the risks of climate change and other human impacts on the environment, incentives for reducing consumption, together with innovations to generate viable means of consuming less without declines in well-being, will help make different choices a reality.

While the ICPD offered a paradigm shift in 1994 regarding how the world weighed individual human rights against fears of over-population, a cultural paradigm shift is again required, one that recognizes that well-being is not and must not be solely based on increasing consumption. In order to

[http://www.ohchr.org/EN/Issues/Housing/Pages/ForcedEvictions.aspx]

sustain the rights-based individual and development principles of the ICPD Programme of Action, a collective shift should be made towards individual well-being derived from modes of living and livelihoods that are more equitable and have less impact on the environment, with a radical focus on innovation and more effective collective action on global challenges.

7. Strengthen global leadership and accountability

Global leadership and knowledge-based accountability are required to achieve progress in the six areas above, through political will, wide civil society participation and the generation and use of knowledge to monitor sustainable development commitments.

The nature and gravity of these intersecting problems make global leadership a critically important concern at a time when global governance is unfortunately low, particularly when it involves addressing the intersecting need for accountability regarding human rights, poverty reduction, highly variable economic and demographic trends in different countries, and the both urgent and long-term need to protect the environment.

Expectations for global consensus were raised in advance of the Copenhagen "Climate Summit" in 2009, the most prominent of the broad-based sustainable development negotiations since the early 1990s, and its failure to make significant progress created widespread disillusion with international summits. There were lower expectations of subsequent Conference of Parties (COPs), and of the Rio+20 United Nations Conference on Sustainable Development, and these expectations have not been exceeded.[716] Considering the history of past attempts to create the institutions of global governance, these difficulties are not surprising,[717] even when there is widespread agreement that the stated goals are laudable.

New systems of leadership and participation may be needed, ensuring democratic participation of all population groups in governance processes and public institutions for the ensured delivery of investments that promote social, economic and environmental sustainability. But participation and leadership also demand the need for sound and accessible information on population dynamics, human rights, present and emerging trends in social and economic equality, and the pending threats to the environment, as a basis for shared priority-setting, policymaking, budgeting and accountability. The revolution in information technology provides the potential to bring this information to people around the world, including young people and those who are marginalized and deprived, thereby creating a foundation for broader knowledge, transparency, and inclusion.

F. Beyond 2014

The past 20 years have garnered widespread support across diverse societies for the central agreements secured at the ICPD in 1994, namely, that investing in individual human rights, capabilities and dignity – across multiple sectors and through the life-course – is the foundation of sustainable development. The framework of actions based on the Review call for a holistic approach to sustainable development which recognizes the inter-linkages between human rights, non-discrimination, women's equality, sexual and reproductive health, population dynamics, development and sustainability, and between planning, implementation and accountability for results.

In light of current social and economic inequalities, threats to the planet, and the findings of the Review, present and future development choices must be shaped, and indeed innovated, by a greater sense of common humanity and unyielding respect for the principles and objectives set forth in the

[716] Goldin, I. (2013), "Divided nations: Why global governance is failing, and what we can do about it" Oxford University Press, Oxford.
[717] Mazower, M. (2012), "Governing the world: The history of an idea", Penguin Press, New York

Programme of Action of the ICPD. Young people are growing up with an increasing awareness that human actions are threatening the environment. This, combined with their growing access to collective knowledge and communication, gives hope for innovations towards a sustainable future.

Effective collective action on global challenges outlined in this framework, on the basis of the findings of the Review, would require the leadership of the General Assembly and the Secretary General, in cooperation with the governing bodies of the UN system, to undertake a review of the existing institutional and governance mechanisms for addressing global issues with a view to ensuring, effective, coordination, integration and coherence at national, regional and global levels consistent with the scale of comprehensive response required to ensure rights-based sustainable development.

The Special Session of the General Assembly on the Follow-up to the International Conference on Population and Development Beyond 2014 has the defining opportunity to act on the findings and recommendations of this Review for the further implementation of the Programme of Action beyond 2014, and the 68th session the General Assembly is invited to consider ways to integrate them into initial consideration of the Post-2015 Development Agenda, as well as in the preparation towards the Special Session, in order to fully extend principles of equality, dignity and rights to future generations and ensure sustainable development.