

Key Challenges for Achieving Accountability for Sexual and Reproductive Health and Rights (SRHR)

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*Accountability for the post-2015 development
framework: untapping civil society potential*

EuroNGOs Worksho,
Madrid, 29 October, 2014

2014 Operational Review of ICPD –

Substantial Achievements since 1994

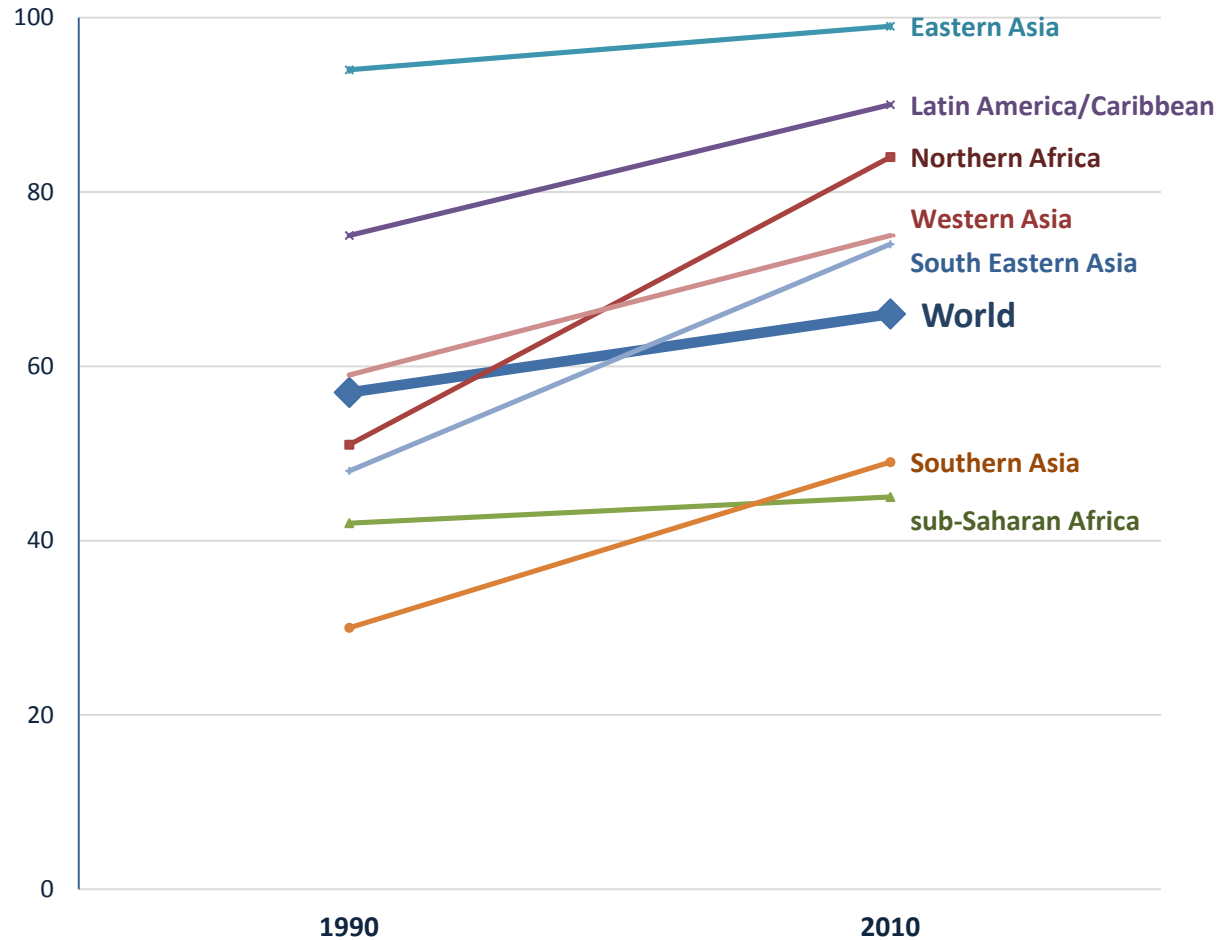
- Nearly 1 billion lifted from poverty
- Gender parity in primary school
- MMR reduced by almost half
- Decline in deaths from unsafe abortion
- Growing access to life-saving Tx for AIDS

YET – Unequal progress

- The world has grown more unequal in both earnings and wealth;
- Reproductive rights unfulfilled
- Demographic trends are far more diverse – youth bulge, rapid aging;
- Highest number of refugees ever recorded
- Rapid urbanization unfolding without capacity in health, transport, housing, etc.

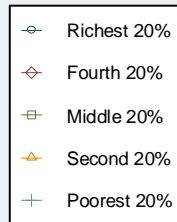
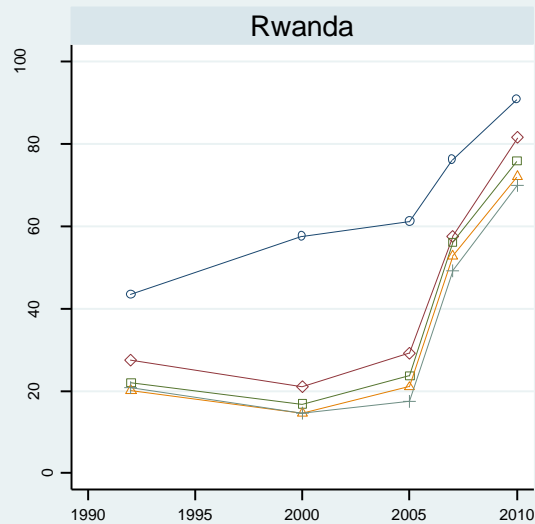
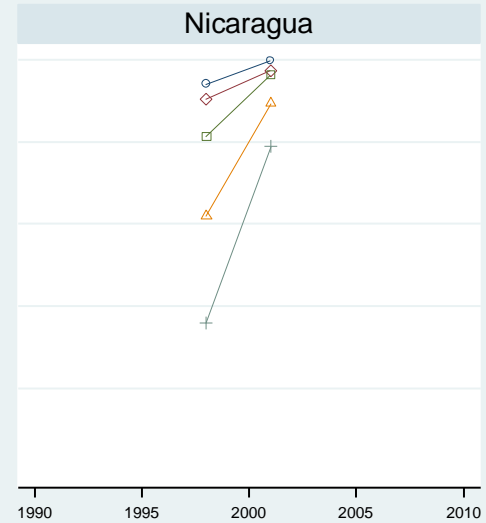
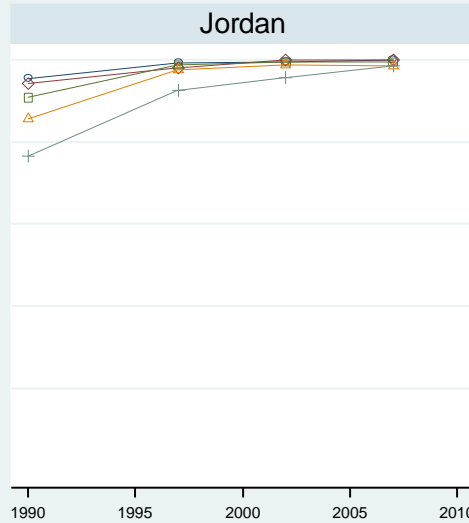
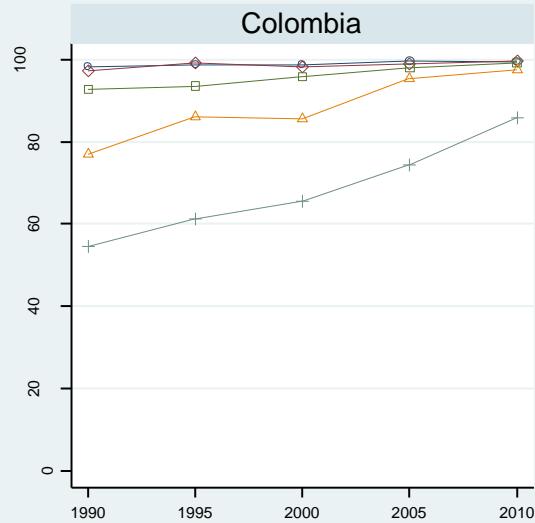
Global Skilled Birth Attendance increased from 56 to 67% (~ 19.6%), 1990-2010 (DHS, MICS)

Percentage of women who had a skilled attendant (doctor, nurse or mid-wife) at birth, 1990 and 2010

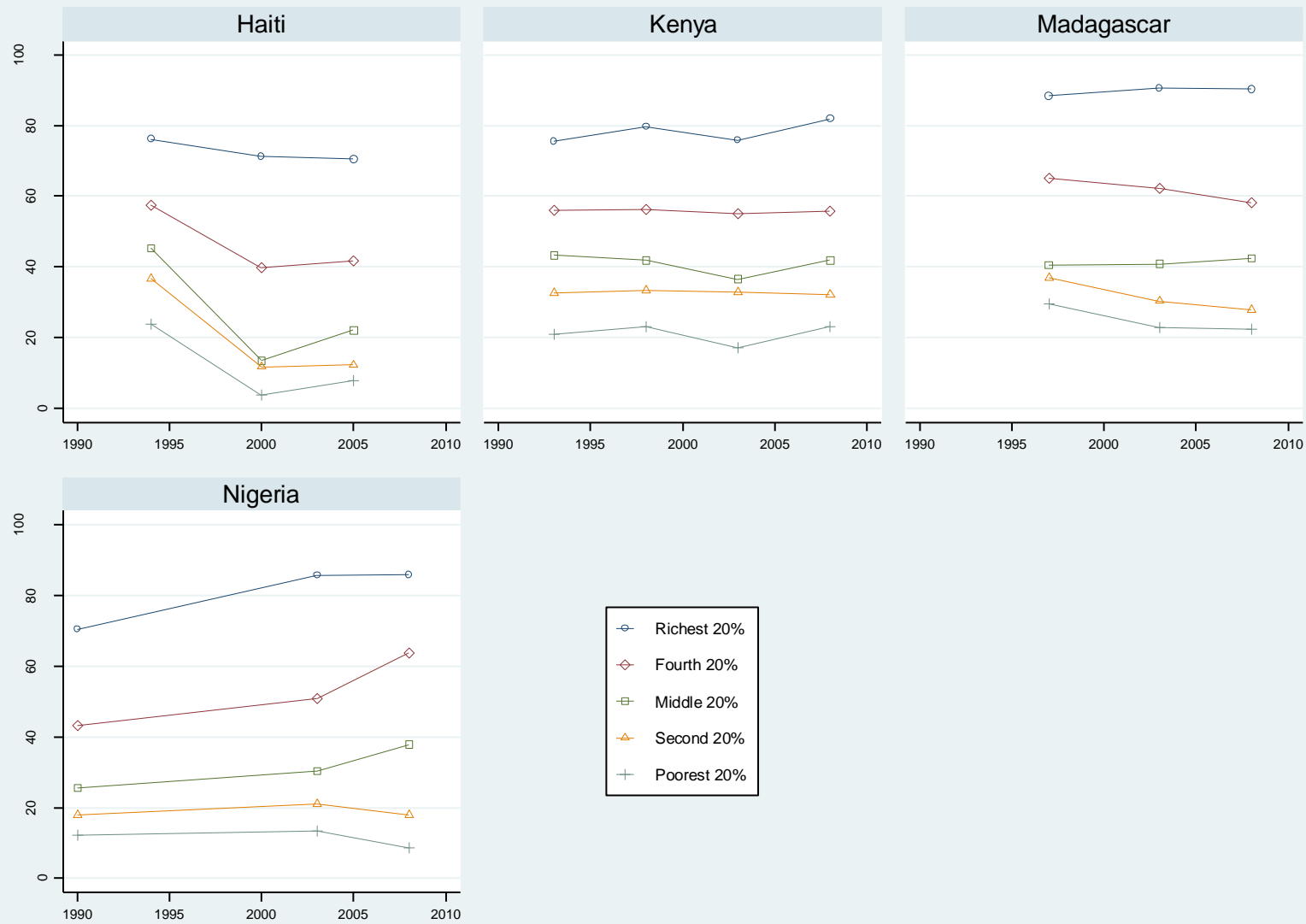


Source: UN Millennium Development Goals 2012 Report Statistical Annex

And in some countries, good progress: Absolute & relative gains in skilled attendance



Yet in others, stagnancy or increasing inequalities in skilled attendance



Accountability for unequal access to SRHR?

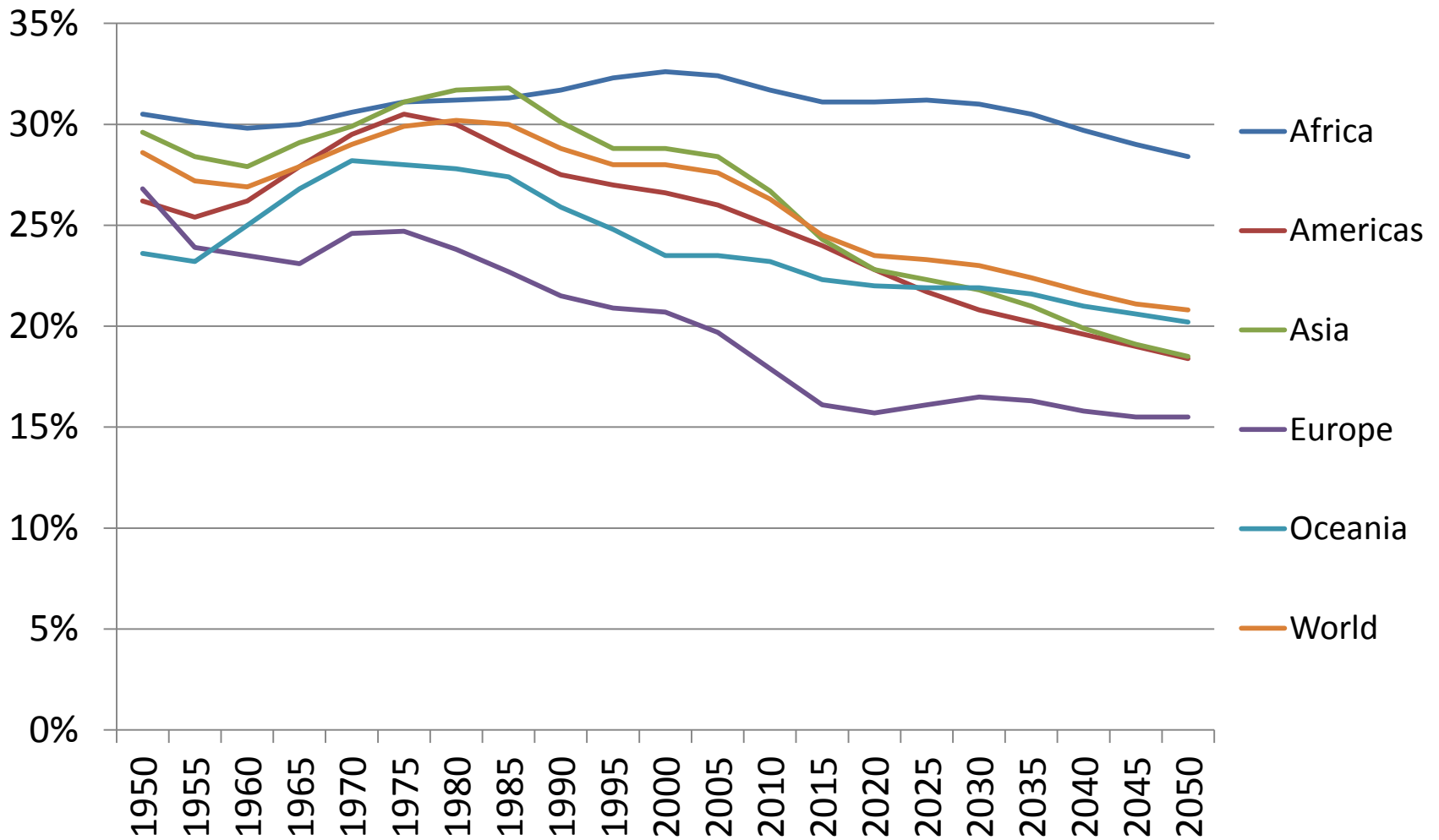
Accountability demands *population* data – on use of SRH, by wealth, location:

- But weak population data – census quality, frequency
- Only 109 of 193 member states have complete coverage of birth registration
- Very weak data on highly vulnerable populations – esp. for those with insecurity of place – e.g. migrants, IDPs, homeless,
- With rapid urbanization and high mobility...are SRH services responsive to vulnerability, mobility?

Key weaknesses in SRHR data

- **Sexually Transmitted Infections** – surveillance *extremely* weak outside the wealthiest countries
- **Health information systems** – SRH worker density, client records, *quality & continuity of care* – e.g. maternal-child pairs lost to FU
- **Utilization of SRH by young people** – no DHS data < 15, weak clinical data.... And yet this group is crucial for the coming 20 years

The demographic importance of young people 10-24 yrs, 1950-2050



Accountability for youth SRHR?

- **SRH health service data for adolescents & young people** is VERY limited
- **Comprehensive Sexuality Education (CSE)** - Weak data on content, mode of delivery
- Mobility, employment, social protection of young people - where are youth congregating? Responsive systems?

Thank you



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