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This research paper examines the concept of how people-centered and life cycle approaches might help move forward the implementation of the Cairo declaration 1994 and the Plan of Action of the International Conference on Population and Development (ICPD PoA 1994) and its subsequent reviews. ICPD PoA shifted the global conversation. It established women’s reproductive health and rights as a distinct goal. It promoted innovative thinking by placing population policies and programmes within a human rights framework and linking population dynamics and the development process.

While the global and Arab regional implementation of the Millennium Development Goals (MDGs) led to significant economic growth, inequality increased in the period between 1990-2015. The focus on outcome and results indicators meant that the monitoring of MDGs tended more towards an overall aggregate picture without much attention being paid to the actual processes and how population dynamics interact with and impact on the economic situation. The distortion in wealth distribution was strikingly unequal. Furthermore, despite a significant reduction in the number of maternal deaths – down from an estimated 523,000 in 1990 to 289,000 in 2013 -- the rate of decline so far has been less than half of what is needed to achieve the MDG target. Moreover, progress was unevenly distributed across countries and regions.

The shift to population and development adopted by the ICPD PoA in Cairo in 1994, and the principles of a people-centred, life cycle approach marked a step forward in defining a new framework based on sustainable development, with the individual as the focus, rooted in human rights, with due attention paid to environmental sustainability. In 2014, the United Nations Secretary-General released a report that documented the achievements, gaps, challenges, and emerging issues related to implementation of the PoA. That summary report covers a wide range of population and development issues. These include the human rights of those facing poverty, gender discrimination and other inequalities, gaps in health sector provision such as maternal and child health, sexual and reproductive health (particularly with regard to adolescents), STIs, international migration, and displaced people. While there has been substantial progress in delivering on the Cairo promise, it has been fragmented, as new challenges and opportunities emerge. The quality of care of reproductive health services has improved, but contraceptives prevalence still remains low, especially in poor communities, and among adolescents and the unmarried. The adolescent birth rate is still very high in poor regions, with higher rates in the poorest and least educated areas. Although there has been a reduction in unsafe abortions, particularly in countries that have addressed abortion as a public health issue, nonetheless, most abortions, particularly those in Africa,
remain unsafe. The 2014 report made a forward-looking recommendation, urging the need to address the remaining challenges. In the case of adolescents, the report stressed that universal access to sexual and reproductive health services, including youth-friendly services and comprehensive sexuality education from an early age, are essential in order that young people can protect themselves and lead healthy lives.

To mark the 25th anniversary of ICPD in 2019, the Nairobi Summit came up with a series of interrelated Nairobi Commitments, the aim being to achieve goals ranging from zero unmet needs for contraceptives, and zero maternal mortality to zero levels of gender-based violence, while addressing the sexual and reproductive health needs of adolescents. These Commitments aligned to an approach to address the importance of an individual’s life cycle experiences from conception to infancy, through adolescence and reproductive age to old age.

To reduce the number of maternal deaths, women need access to good-quality sexual and reproductive health care, and this requires effective interventions that keep people on the radar when implementing the development process. The SDGs brought greater focus to bear on people’s needs, making a more people-centered approach relevant. The resultant discussion saw agreement that key stages in people’s lives have relevance for their health, particularly in terms of reproductive health, and that these life stages are linked one to another. Thus, a life cycle model also became relevant to planning and implementing key interventions by development practitioners and by UN agencies including UNFPA and WHO.

This paper examines the achievements, gaps, challenges, and emerging issues related to the implementation of ICPD through regional and global reviews with a focus on Sexual and Reproductive Health. It also discusses the impact of applying a people-centered model and life cycle approach to promote and accelerate achieving the ICPD PoA-intended goals and results and the extent to which doing so might influence and shape establishing people-centered SDGs. The paper makes recommendations and presents lessons learned for further implementation of a life cycle approach for UNFPA that offers three transformative results.

We hope that the argument presented in this paper and the recommendations made can point the way as well as shed light on how to improve implementation of the ICPD PoA in order to achieve the well-being and welfare of people and ensure that women and girls can exercise their reproductive rights and are empowered to enjoy their rightful bodily autonomy.

Luay Shabaneh, PhD
Regional Director
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<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>CSE</td>
<td>Comprehensive Sexuality Education</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey.</td>
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<td>FGM</td>
<td>Female genital mutilation</td>
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<td>GBV</td>
<td>Gender-Based Violence</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>OECD</td>
<td>Organization for Economic Cooperation and Development.</td>
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<td>OHCHR</td>
<td>Office of the High Commissioner for Human Rights.</td>
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<td>RSHR</td>
<td>Reproductive and Sexual Health and Rights</td>
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<td>RTIs</td>
<td>Reproductive Tract Infections</td>
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<td>SDDs</td>
<td>Sexual dysfunctions disorder.</td>
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<td>SDGs</td>
<td>Sustainable Development Goals</td>
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<td>S-G</td>
<td>Secretary-General.</td>
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<td>SRHR</td>
<td>Sexual Rights, Health Rights.</td>
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<td>STIs</td>
<td>Sexual Transmitted infections.</td>
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<td>UHC</td>
<td>Universal Health Care</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNDESA</td>
<td>United Nations Department of Economic and Social Affairs</td>
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<td>UNECA</td>
<td>United Nations Economic Commission for Africa.</td>
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<td>UNECE</td>
<td>United Nations Economic Commission for Europe</td>
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<td>UNECLAC</td>
<td>United Nations Economic Commission for Latin America and the Caribbean.</td>
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<td>UNEP</td>
<td>United Nations Environment Programme</td>
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<td>UNESCAP</td>
<td>United Nations Economic and Social Commission for Asia and the Pacific</td>
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<td>UNESCWA</td>
<td>United Nations Economic and Social Commission for Western Asia</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>WHO</td>
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EXECUTIVE SUMMARY
In 1994, the United Nations International Conference on Population and Development (ICPD) held in Cairo concluded a Plan of Action (ICPD PoA) that was a turning point in the field of sexual and reproductive health (SRH). The PoA positioned population and development programmes within the broader framework of reproductive rights, gender equity, and women’s empowerment. Three goals of the PoA made substantive contributions to the field of maternal health, including comprehensive and universal use of reproductive health services, universal education, and support of child health services. The PoA also helped move population policies and programmes towards a people-centered focus with a strong emphasis on environmental sustainability and the individual’s needs and rights.

Using a life cycle framework for analysis, this paper presents conclusions and findings based on a literature review of key areas of SRH. The paper also presents evidence of progress made as reflected in the review of the ICPD PoA and it identifies gaps to be addressed in the future, especially through implementation of the Nairobi Commitments. In addition to regional experiences, evidence examples and lessons learned include summary examples on:

1. “Population Ageing as an Emerging Demographic Dynamic and Decreasing Fertility, and Population Growth”, which analyses the impact on development planning, and the importance of the life course approach for effective interventions;

2. “The ICPD Beyond 2014- The International Conference on Human Rights”, which endorses that paying attention to the ICPD cross cutting principles of human rights, life cycle approach, and gender approach to SRH programmes, equity access to SRH; quality of care, and general accountability, is key to acquiring a comprehensive approach to promote and integrate SRH aspects of ICPD into the 2030 Agenda;

3. UNFPA/WHO-commissioned articles that examine progress made and lessons learned in adolescent SRH interventions as part of the global review of ICPD PoA implementation. The five-article series provides lessons learned as well as guidance on how adopting a life cycle approach can accelerate the implementation of ICPD, and its impact;
While substantial progress has been made with regard to the ICPD agenda, it has been unequal and fragmented. New challenges and opportunities have arisen since Cairo. For example, while maternal mortality, an important marker for reproductive health, has declined, many obstacles remain. Despite the increase in overall contraceptive prevalence since Cairo, indicators reveal a high rate of unwanted pregnancies, and a resultant recourse to unsafe abortion, especially among adolescents. Reviews of ICPD and the post-2015 development agenda, show there are key challenges and critical issues on GBV and adolescent SRH that need to be tackled. Renewed political will and a critical examination of the successes and the setbacks that have caused progress to stall are essential for a viable post-2015 agenda. ICPD PoA is still a critical tool for articulating reproductive and sexual health. It continues to serve as the cornerstone of global policy frameworks for reproductive and sexual health, maternal mortality, unmet needs for contraceptives, advocacy for sexual and reproductive health for youth, and for women’s empowerment for a life free of violence. The ICPD PoA reviews, and the different examples cited above indicate how the people-centered, life cycle approach offers an effective strategy for implementing the promise of ICPD. Added to this, the findings of the various reviews and research outcomes cited here provide a useful tool as well as guidance on how to speed up implementation of the ICPD PoA through the realization of the Nairobi Commitments. This paper suggests an operational definition of the people-centered life cycle approach as a means to activate the three transformative results of the UNFPA strategy. It also makes recommendations on how to take the approach forward not just in terms of implementation but in order to gain a deeper understanding of the dynamics involved.
INTRODUCTION

2
2.1 Life cycle people-centered approach

A life cycle approach begins with the concept that the well-being and capabilities of an individual - particularly his/her health - depends on a cumulative and interlinked process. When it comes to health, that process requires access to health care, living in a safe environment, plus the accumulation of education, training and skills. Certain phases of life are crucial to this process. Starting from the early years, survival is key. Then comes early childhood education and all that follows in the slow build-up of the social and human skills that provide the essentials required for a fulfilled life through to and including old age. Investing in human capital can help countries achieve a demographic dividend as well. The idea behind the life cycle approach is about how each individual life span -our capabilities, our health, our productivity in economic terms - depends on the choices that are made at an earlier stage in the life cycle and how each step of our lives connects and leads to the next. This perspective of building human capital and an enabling environment, of ensuring the availability of reproductive and sexual health services and the information access to opportunities across the the life cycle span, is key to examining just how the promise made in Cairo to focus on the centrality of individuals in development and to measure that progress against the level of individual rights that people actually enjoy can be ascertained in determining the positive impact the development process can have on the lives of people, collectively and individually.

2.2 Life cycle people-centered approach for women’s SRH

The key stages of life are affected by environmental and socio-cultural challenges for each stage of child and adolescent life as follows:

1. Pregnancy: A woman’s health directly influences the health and development of the child. Access to timely and responsive health services, including skilled birth attendant are essential. Mothers can be vectors for transmitting communicable diseases to their babies including HIV/AIDS. For the child, infection is a major killer during pregnancy, and can otherwise be accountable for low birthweight.
2. **Neonatal Period:** The first 28 days of the baby’s life are critical, this being the period when the baby is at highest risk of death. Neonatal death is largely the result of socio-economic circumstances, including access to appropriate services at the time of delivery, and parental education.

3. **Early childhood:** Over 40% of the global burden of disease is attributed to environmental risks that affect children under five years of age. Seven in ten children in low- and middle-income countries die before the age of five, deaths due to preventable conditions such as pneumonia, malaria, malnutrition, all associated with environmental factors like lack of clean water, and sanitation.

4. **Early Adolescent:** Although vaccines protect children, other diseases like hepatitis A can be prevented by good hygiene. In the United States, cancer is the second biggest killer of children after accidents. Acute leukemia seems to be rising in developing countries. Among the environmental factors that may play a role are tobacco smoke, asbestos, ultraviolet light radiation, and pesticides. Parental lifestyle and social interactions beyond the family, such as school environment, peer pressure, and mass media, are increasingly influential in determining a child’s values, attitude and behavior patterns.

5. **Adolescence:** Many adolescents die prematurely because of accidents and risky behavior. Adolescent girls particularly from poorer environments are especially vulnerable to gender-based violence, unwanted pregnancies, and early marriage.

A life cycle approach for women’s SRH entails designing and implementing the intended interventions to protect and improve women’s maternal health. Such measures include service provision models and protocols that take into consideration linkages and interaction across the different stages of a woman’s life, from pre-menstruation to post-menopause.

Understanding women’s life stages starts, but is not limited to, biology. Social norms and behaviors can have substantive consequences for women’ SRH status. Modes of engagement are considered to be people-centered when they adopt an approach that designs interventions based on people’s needs, aspirations, and preferences for specific services.
An effective life cycle approach should involve a comprehensive package of services, awareness and advocacy interventions for each life stage that takes account of the specific issues associated with that particular phase of a woman’s life while preparing the way for the next stage. This should be done with an eye to building on the cross-stage linkages stipulated in the ICPD PoA, which repositioned population and development programmes globally within the broader context of reproductive rights, gender equity and women’s empowerment. These goals, as endorsed by the PoA, seek to contribute substantially to women’s health, including as they do, universal access to SRH services, promotion of child health and survival plus family planning.

The PoA states that in addition to sexual health, reproductive health includes counselling, information, education and services for prenatal care, safe delivery, post-natal care, breast feeding, and infant and women’s health care. It also includes treatment of infertility, abortion (as specified in paragraph 8.25), including prevention of abortion and management of the consequences of abortion. Provision is also made for treatment of Reproductive Tract Infections, sexually transmitted diseases, as well as advocacy for responsible parenthood. For governments and communities, an effective universal implementation of
the SRH interventions requires creating an enabling system and environment that is inclusive, people-centered and based on the life cycle approach. Taking a life cycle approach to SRH entails examining factors not just across a life span, but also across generations, events and occurrences that influence a range of issues, including menarche, fertility, pregnancy outcomes, gynecological disorders, and age at menopause. Since Cairo, published research supports the use of an integrated life cycle approach, considering, as it does the continuity of reproductive health, and the interrelationship between different influencing markers. Studies show that the factors that may have influenced a current health situation are often associated with other life cycle factors, from conception, infancy and childhood, adolescent, reproductive years, and post-reproductive years, onwards into old age. WHO’s “European Health for All” illustrates basic needs for each life stage as follows:

1. Infancy - Childhood 0-9 years old: at this age, children are exposed to differential feeding and nutrition discrimination as well as health care that favors a boy child, especially in poorer communities. These factors amount to an unfair initiation to life that can be critical for a girl child’s health during adolescence, and adulthood. Other issues include missing girl child due to sex selection cause dramatic decline in sex ratio, and selected abortion.

2. Adolescents 10-19: Early childbearing by adolescent girls, abortion, gender-based violence, STDs, RTIs HIV/AIDS, under-nutrition, are among the health threats girls may face during this period, while a rising trend in smoking adds to the risky behaviors for boys.

3. Reproductive Health years 20-44 years old: Unplanned pregnancies, coercive marriages, unmet needs for family planning and contraceptives, harmful practices, RTIs SDDs, HIV/AIDS.

3

CONCEPTUAL FRAMEWORK
The ICPD PoA was forward-looking on the issue of SRH, notably in relation to adolescents and young people insofar as it urged the international community to address young people’s reproductive and sexual health needs. Generally, adolescents are healthy in comparison with other age groups, but they have their own health risks that can be detrimental for their health for the rest of their lives. Adolescents become sexually active early, but they are neither equipped nor knowledgeable about how to obtain contraceptives, or about how to protect themselves against STIs. Generally, girls are less likely to get education about these matters than boys, since impoverished families tend to marry their daughters off early, exposing them to a variety of risks including high risk pregnancy and obstructed births.

Statistics in the literature assume strong linkages across life stages. For instance, adolescents account for 23% of recorded disease because of pregnancy and childbirth. Almost 16 million births take place annually to adolescent girls aged 15-19. It is estimated that 95% of young adolescent births take place in developing countries sometimes to girls aged 12-15. Furthermore, adolescent pregnancy is usually associated with high maternity and morbidity rates, in addition to an increased incidence of induced and unsafe abortion. In fact, pregnancy, and other maternity issues constituted a major cause of death among adolescent female’s in 2009, and adolescent pregnancy is associated with low birth rate and unsafe abortions, with 15% occurring among girls aged 15-19 years old. On the other hand, gender-based violence, which is high among adolescent girls, has an adverse impact on reproductive and sexual health, including STIs, mental disorder, and forced abortion. FGM is a significant problem in Africa, where 125 million girls are subjected to this harmful practice in 27 countries.

Since Cairo 1994, substantial progress has been made. Fewer women are dying in childbirth, and many have been saved from harmful cultural practices such as child marriage and genital mutilation. More women and couples are using contraceptives, and more women are participating in public life. Implementation of ICPD since 1994 attests to the importance of the people-centered approach. This was reflected in the global discussion on the world’s
development agenda in 2015, when the international community adopted the 2030 Agenda, reaffirming its commitment to put people, planet, and prosperity at the core of the Sustainable Development Goals, in this way highlighting that sustainable development is directly linked to fulfilling the aspiration of adolescent and youth.

But we should note that as yet the ICPD promise remains far short of being fully realized. There is unfinished work that needs to be completed in order to make a strong, evidence-based case for the kind of investment that will ensure sexual and reproductive health for all. The international community stated its clear commitment to the ICPD PoA at the people’s summit in Nairobi, where governments and civil society organizations, the private sector and academia all pledged their support to make universal access to reproductive health a reality as part of the drive for universal health coverage. All the participants made a clear commitment to UNFPA’s transformative outcomes -- zero preventable maternal death and maternal morbidity; access for all adolescents and youth, especially girls, to comprehensive and age-appropriate information and education plus quality reproductive health services; and achieving zero unmet needs for family planning and zero-level sexual and gender-based violence and harmful practices. The Nairobi Commitments have a built-in ripple or knock-on effect -- implementing one commitment can accelerate and ensure the implementation of another.
4 LIFE CYCLE PEOPLE-CENTERED APPROACH FOR UNFPA TRANSFORMATIVE RESULTS

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4.1 TR1: Zero preventable maternal deaths

ICPD marked a paradigm shift in addressing maternal health with its call to expand the way in which women’s health needs were met. It stressed the need to provide maternal health services as part of a continuum of client centered, quality and accessible SRH services. By positioning SRH as an integral part of sustainable development, it urged the international agenda to examine the underlying causes of poor maternal health. The shift in focus in the 25 years since Cairo, has shed considerable light on the social and root factors contributing to maternal mortality, and has helped signpost possible sustainable solutions.

More women are now able to delay and space their pregnancies because of the increase in access and use of contraceptives. This is especially true for beneficiaries in the developing world where contraceptive use increased from 8% in 1960 to 62% in 2007. However, there remain significant unmet needs for comprehensive family planning and reproductive health services (affecting around 222 million women). These unmet needs continue to impede efforts to reduce maternal mortality, given that each of the 75 million unintended pregnancies that happen every year place pregnant women at risk of maternal death or disability. Meeting those unmet needs for contraceptives is vital if maternal mortality is to be reduced. Addressing issues of early age marriage, gender disparities, quality of care and the need for skilled birth attendants can contribute significantly as well. Unsafe abortions are a major factor causing maternal mortality. Since ICPD, new approaches and interventions to deal with HIV/AIDS within the context of maternal care have emerged.

In Africa, maternal death is threatening to become widespread among adolescents. This makes it all the more pressing to ensure access for all adolescents and youth, especially girls, to age-responsive information, education and user-friendly comprehensive quality and timely services so that they can make informed decisions and choices regarding their sexual and reproductive health, and live free from gender-based violence and harmful practices. Hence the need to cover this important aspect in the overall response to achieve TR1.

The ICPD PoA stressed social inclusion, human rights, and the importance of addressing the needs and developing the capacities of the young. International agreements and commitments have taken note of the fact that a successful transition to adulthood with reference to sexual and reproductive health
outcomes entails several attributes. Key elements include a realization of the right to education, preferably up to and including secondary school, delaying marriage and the selection of partners, exercising the right to health, including access to friendly and confidential health services, and the promotion of gender equitable roles and protection from gender-based violence.

Available data showing that as of 2009, only 87% of children in developing countries, have primary education, being poor and female, underscore one of the most pervasive factors responsible for keeping children out of school. The figures show that more than half miss out on secondary school from 55% to 65% between 2007-2010. Interventions to promote girls’ education such as eliminating financial barriers, community mobilization and the like, while promising, remain unproven as yet.

ICPD recommended that governments enforce strict laws regarding age at marriage, recommending that it be set at 18 years old. Progress, however, has been slow. Among developing counties (with the exception of China) 35% of young women aged 20-24 marry below age 18, and 12% below age 15. Child marriages go hand in hand with educational opportunity. Such marriages reflect the exclusion of young people from education and from the decision-making process that determines when and whom they should marry.

Evidence from 77 developing countries suggests that around 11% of girls, and 15% of boys aged 15-18 initiated sex before they age 15. Multiple partner sexual relations were reported by a large proportion of young men -- -- from 2% in South Asia, to 22% in Latin America and the Caribbean. Condom use tends to be inconsistent.

Among young women, sexual relations were non-consensual for a significant number of women in minorities. Reported cases of sexual relations obtained by force, threat etc., range from 5% to 20%.

Access to reproductive health services, mainly pregnancy-related contraception, abortion, and treatment of infections - is limited for young people. For example, only, 55% of young women who gave birth as adolescents in developing countries, (except China), reported that skilled attendants were present at
delivery. Evidence shows that contraceptive services have failed young married women when compared to the experience of those aged 30-39. Data from 44 countries showed that the percentage of young women reporting unmet needs for contraception fell only twice in the period 2001-2006. Around one quarter of young women in Sub-Saharan Africa reported unmet needs for contraception, around one fifth in South Asia, and about one sixth in Latin America and the Caribbean.

Unmarried young people, particularly girls, face obstacles in acquiring family planning supplies, mainly because they are embarrassed to ask, or shop, and they worry that health workers can be judgmental and may reveal their secrets. In some instances, the young complain that they are excluded from using the services.

One example of gender disparity is when young girls and young women engage in multiple relationships with older men, and are prone to infection by STIs. Data disaggregated by age is unavailable. However, around 448.3 to 498.9 women per 100,000 were infected between 2005-2008 respectively.

Unintended pregnancies and abortions are observed among young women, with 22 million women undergoing unsafe abortions every year because of early childbearing, inadequate care during pregnancies and poor access to safe abortion. Maternal mortality claims the lives of 50,000 annually. Adolescent age 15-19, accounts to 14% of maternal death.

Since 1994, countries entered commitments to provide age-appropriate sexual and reproductive health information for adolescents. Most have yet to reach this goal. Adolescents need information, yet they remain uninformed about matters of sexuality and transmitted diseases. Only 24% of young women and 36% of young men reported knowing how to avoid HIV/AIDS -- far below the target of 95% by 2010.

ICPD recognized the links between young women’s agency and their ability to claim their rights. However, the reality is otherwise, given persistent gender inequalities. Around 11% of married young women aged 15-24 in Sub-Saharan Africa, and 35% in South Asia indicated they have decision making autonomy in seeking health care, or in making decisions in their homes.
Evidence based approaches to protecting adolescent girls from sexual risk have identified a number of proven core programmes that are effective. These range from safe social spaces, friendship networks, mentors, and life skills education, to information about services and health, financial literacy, and empowerment interventions.

Because of ICPD, countries undertook to protect young people from gender-based violence, having been made aware that many adolescents grow up witnessing violence at home and/or becoming victims themselves of domestic violence or violence outside the home. Young women face violence from their husbands, and partners. In Uganda, for example, the, data shows that more than half of young women in the 15-24 age group experienced marital violence.

Families, local communities, religious leaders, teachers, mass media and peer groups can all serve as instrumental agents for this cause. The available evidence suggests that parents seldom provide information or guidance on sexual and reproductive health issues. In India, less than 1% claim to have ever discussed reproductive health processes with a parent.

In light of the foregoing, it is clear that in order for a people-centered life cycle to achieve a zero maternal death level, the appropriate interventions and programmes should involve participation by women and adolescent girls at the planning and design stage. This at least would ensure that service provision is in line with their educational and learning preferences, and that services catering to the differing needs of the life stages involve not just married women but also adolescents and unmarried women.
Here the focus is on eliminating all forms of discrimination against women and girls in order to release and realize the individual’s full socio-economic potential. Worldwide, women and girls are at risk of different forms of violence at all ages, ranging from prenatal sex selection all the way through to the abuse of widows and elderly women. Throughout their lives, women are more likely to be poor, to suffer higher rates of disabilities due to violence, and to lack access to adequate nutrition and health care. These disparities persist and, more often than not, they intensify in old age. For example, poverty in old age, is linked more to old women living alone than to men, rendering women even more vulnerable to the risk of exploitation, violence, and abuse as they age.

A life course approach to GBV considers an individual’s entire progress through life. Such an approach examines how biological and social behavior factor into the course of a life as well as across generations and how this has a cumulative influence on health outcomes.

Women over 49 years of age comprise a quarter of women worldwide, and yet they are often excluded from internationally comparable data on GBV, even though they can be as subject to and as affected by abuse as younger women.

Adolescent girls can experience violence at the hands of trusted adults, partners, peers but also strangers. In Africa for example, 30-40% of adolescent girls become victims of sexual violence before the age of 15. Usually, interventions and services tend to prioritize certain categories of women over others. For instance, violence-screening programmes are more commonly offered as part of pregnancy-related health services, and thus older women and young girls tend to get excluded.

Violence against older women can be classified as elderly abuse. This approach, however, disregards the intersectional causes of violence, and for this reason it can prevent old women from seeking support, treatment, and justice. Adolescent girls’ violations often fall under violence against children, and violence against women, leaving it neglected as stand alone category of violence.
Regressive gender norms usually restrict and shape sexual and reproductive and sexual health care, including information and education. This leaves many without access to contraceptives and unable to manage their reproductive health. In Sub-Saharan Africa and Southeast Asia, more than 60% of adolescents indicate a wish to avoid pregnancy but have no access to contraceptives. Early and forced marriage can also lead to lifelong inequalities, since childbearing often forces girls to leave school, and poses significant health risks. Unplanned pregnancies come with severe health consequences such as unsafe abortion, pregnancy complications, and increased rates of maternal and infant mortality, plus exposure to a cycle of poverty, dependency and abuse.

The ultimate value of the life cycle approach is that it teaches that the sexual and reproductive health of girls and adolescents is crucial to every aspect of their lives, for them, for their families and for society as a whole. Interventions like comprehensive sexuality education provide a vital opportunity to dislodge the rigidity of persistent gender norms, and reveal more tellingly the harmful consequences of gender-based violence. Women and girls of all ages must be made visible in data collection, in order that their specific needs from dealing with gender-based violence to accessing sexual and reproductive health services can be addressed and documented in relevant detail so that appropriate and effective interventions and solutions can be planned, designed and put in place.

4.3 TR3: Zero unmet need for family planning

Despite progress since Cairo 1994, multiple barriers still exist, and millions of people, women especially, still have not fully realized their sexual and reproductive rights. It is a given that 190 million women want to avoid pregnancy and yet they do not use any contraceptives method.

About 25 million women undergo unsafe abortions, while one-in-three women experience intimate partner violence or non-partner sexual violence at some point in their lives exposing them to unwanted pregnancies and forced and unsafe abortions. Access to and the availability of family planning and contraceptives is the mainstay for women to prevent unwanted pregnancies and avoid unsafe abortions.
In 2013, the overall contraceptive rate for women aged 15-49 in developing countries was 62.6%. - 37.9% in least developed countries. Unmet need for family planning is a valuable indicator to identify levels of non-utilization and as a means to investigate the contributing factors. Unmet needs in developing countries are estimated at 12.4%, whereas in the least developed, it was 22.9. In addition to differences between countries, there are also differences when it comes to in-country comparisons, relative to the proportion of births identified as unwanted, or unintended, which can result in high abortion rates, mostly under unsafe conditions, especially in poorer areas. While data on desired pregnancy and abortion levels have improved, the figures remain unreliable. Nonetheless, with increased access to and use of contraceptives, more women can delay, space, and limit their pregnancies.

People-centred lifecycle for zero unmet need to family planning involve three important tasks

1. Creating demand through awareness-raising and spreading knowledge and skill starting at an early age and including all women and men of reproductive age regardless of their marital or union status. It is important for young adolescents to acquire knowledge about the importance of contraceptives and family planning.

2. Responding to demand through comprehensive service packages that include a variety of affordable methods for women and men of all ages from different settings, regardless of their economic welfare, is essential. Accessibility is the key here given the personal, community, economic, and cultural challenges that need to be overcome.

3. Adopting a people-centered approach by involving the intended beneficiaries in the design and ownership of the requisite response interventions and building on existing systems to ensure the sustainability of programmes is advisable.
5

FINDINGS AND THE WAY FORWARD

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The review examined how the ICPD agreement shifted the global conversation from demographic targets such as population size to the establishment of women’s reproductive health and rights and the way it should be adopted as a fundamental principle of government policy in relation to population growth, environmental sustainability, and development, by utilizing a people-centered approach. The resultant policies covered a range of life cycle issues, including girls’ education, and public participation, maternal and child mortality, violence against women.

The ICPD review report made several forward-looking recommendations highlighting emerging challenges particularly with regard to the young, to women and youth in conflict and post conflict zones, and to the reproductive and sexual health of people with special needs. The report stressed that universal access to sexual and reproductive health services, including youth-friendly services and comprehensive sexuality education and information, are essential from an early age if young people are to protect themselves and lead healthy lives.

The report encouraged governments “to remove legal barriers” that can prevent women and adolescent girls from access to safe abortion and if necessary to revise restrictions within existing abortion laws. All five reviews spoke of the need for adolescents to have access to sexual and reproductive health information, and services. The people-centered approach to reproductive health at all ages was endorsed by the Arab Sates Regional Conference on Population and Development in 2014 in Cairo, when, reviewing the implementation of the Cairo Declaration. It recommended adoption of “the Life Cycle comprehensive approach as a means of ensuring reproductive health services, the elimination of child and forced marriages, and addressing the risks associated with early pregnancy, while providing education and quality services enabling couples to make reproductive decisions based on reliable information, that ensured they gain access to quality services without financial or any other obstacles.

The people-centered approach as applied to the Latin America and Caribbean region urged that the existing population and sustainable development agendas apply the life cycle concept to interventions related to the needs of the elderly, in addition to migrants, indigenous people and other marginalized groups.
In similar fashion, most of the regions called for a comprehensive approach to sexual health education. The Latin America regional conference touched on all the perennially contentious issues --abortion, the needs of adolescents, sexual rights, sexual orientation, and gender equality. The conference went beyond the 1994 PoA on the issue of abortion. It called on governments to consider amending “laws” regulations, strategies and public policies about the voluntary termination of pregnancy in order to protect the lives and health of women and adolescent girls and to improve their quality of life and thereby “reduce the number of abortions”. The Asia and Pacific conference, on reviewing the ICPD PoA report, urged governments to reassess their abortion laws, and specifically to “repeal laws that punish women and girls who have undergone illegal abortion”, and to end imprisonment for such acts.

The UN’s five Regional Economic Commissions collaborated with UNFPA in conducting a global survey on the implementation of the ICPD PoA on the occasion of its 20th anniversary. The regional report for ESCAP concluded that the PoA is widely seen to address key socio-economic concerns including poverty reduction and promotion of sustainable national development. Nearly all countries in the Asia region reported their commitment to sexual and reproductive health and rights. The report commended the strong support for paying attention to significant life milestones in an individual’s life, and the acknowledged importance of non-discriminatory treatment for different groups and ages. Adopting a life-course approach helps frame forward-looking policy making and planning for the entire population, particularly the vulnerable. Adolescent and old women, indeed sometimes women from all age groups, are vulnerable, especially when they come from a poor background. Sometimes, women are denied SRH because of their social or economic status, e.g. When they are displaced, or refugees.

Progress was also reported on improving adolescent sexual and reproductive health information and services as well as those for the elderly. All the regions cited a need for comprehensive sexuality education. Latin America and Asia Pacific documented more specific demands, stressing the importance sharing accurate information about human sexuality and designing programmes that are gender-sensitive and youth-friendly. Latin America presented its case for a clear-cut definition of sexual rights.
The Arab States recommended enhancing access to quality affordable youth-friendly health services and age-appropriate sexual and reproductive health services and information for the benefit of youth and older people. In highlighting the value of youth empowerment, the report stressed how vital it was to give youth access to information about training, employment skills and opportunities so that they might realize their potential. The Arab States review also cited the availability of health and psychological services for women and girls who are survivors of physical and sexual and mental abuse, and the need to raise awareness and enhance the training of health providers.

Since Cairo 1994, more than 30 countries have broadened the circumstances under which abortion are legally allowed, a sign of the progress being made on this difficult and sensitive issue. Sexual health and sexual rights are now central to any discussions about women’s health issues and the broader human rights agenda.

The regional declaration of Africa supports the concept of sexual and reproductive health and rights, albeit on a less expansive basis than elsewhere in the world. Recurrent themes from the 2014 meeting featured in the Secretary-General’s Report index on health that stated: “Governments from all regions hold a common perspective that universal access to comprehensive, quality and integrated sexual and reproductive health is one of the highest priorities for the global agenda beyond 2014”.

The reviews reiterated the important linkages between the ICPD PoA and sustainable development, laying special emphasis on fertility and the rights of women and girls, population ageing and international migration. They noted how population policies contribute in so many ways to development by, for instance, providing sexual and reproductive health services, including family planning that can lead to a decline in fertility, which in turn frees up funding for health and collective well-being. The UN expert group meeting on the review of ICPD/PoA and its contribution to the follow up and review of the 2030 Agenda for Sustainable Development, concurred, affirming that the ICPD PoA’s relevance to realizing the population goals and targets of the 2030 Agenda.
6.1 ICPD review processes

Reviews of the ICPD PoA, research findings and other interventions have validated what Cairo generated about the effectiveness of a people-centered approach. New tools, guidance and examples gave impetus to the life cycle approach in population and development field. The Cairo agenda, having taken hold, gained further momentum the when the Nairobi Commitments set goals to achieve zero unmet needs for family planning, zero preventable health and maternal mortality, and zero sexual and gender-based violence. The growing influence of the ICPD PoA’s life cycle people-centered approach and how it was being implemented in the years that followed is reflected in reports and studies such as:

1. Data Analysis of the Demographic and Health Survey between 2005-2014, Contraceptives Unmet Needs (Guttmacher Institute)


3. The ICPD Beyond 2014, International Conference on Human Rights. “All Different, all humans all equal” (UNFPA, UNHCR, the Government of the Netherland) shed lights on the importance of life cycle

4. The report on Addressing Population Ageing in Asia and the Pacific Region, A Life Cycle Approach (UNFPA regional office for Asia and the Pacific)

5. The Twenty years after ICPD, Adolescent sexual and reproductive health emphasized on investment in SRH starting from early ages.
6.2 Data Analysis of the Demographic and Health Surveys

ICPD made the case that women, men and adolescents should have the freedom to control their SRH choices and be assured of user-friendly access to a wide range of services, ensuring confidentiality, and safe modern contraceptives. The survey data analysis reinforces the ICPD people-centered approach to contraceptive provision that caters to the individual needs of women, men, and adolescents, in keeping with the ICPD PoA and the Nairobi Commitments, to achieve universal access and reproductive health rights. The Guttmacher Institute reported data from 2017, showing that an estimated 36 million young women aged 15-19, either married or sexually active, indicated that they wished to avoid pregnancies, whereas the majority, some 20 million, were without access to modern contraceptives.

Rising levels of contraceptive use in developing countries have played a major role in enabling couples to have smaller families and in improving women’s and children’s health. However, the 2005-2014 Demographic and Health Survey (DHS) covering 52 countries, showed that women are still in need of contraceptives, and that those from disadvantaged or poor socio-economic backgrounds have difficulty accessing reproductive health services.

Socio-economic determinants include education, occupation, ethnicity, and economic standards as well as related structural violence towards women, and the status of women in the society. There are 190 million women who want to avoid pregnancy yet do not use contraceptive methods. Some 25 million women are estimated to have unsafe abortions every year. Most countries fall far short of the goal of involving all sectors of the community, women and young people especially, in having a say in the policies and decisions that will shape their lives.

The survey reveals that the apparent lack of knowledge about contraceptives among women had declined substantially compared to 1980s, and that side effects associated with modern contraceptives are becoming more and more common all over the world. The study reflects a wide range of reasons about the knowledge and use of contraceptives by women from different backgrounds (marital status, age, cultures, personal beliefs, and knowledge about contraceptives). While women were rarely unaware of contraceptives, no one single reason was cited by those wanting to avoid pregnancy for their non-use of contraceptives.
6.3 Monitoring Framework for ICPD PoA, UNECE

The Monitoring Framework was developed within the context of global and regional monitoring efforts, like the global indicator framework for the targets of 2030 Agenda. It was developed as part of the joint UNECE-UNFPA project -- “Enhanced integration of population dynamic into development planning: follow-up to the ICPD in UNECE”. The structure was cross-sectoral, adopting an evidence-based decision making process that took the relationship between population and development issues fully into account. By applying a people’s approach to development, it examined the totality of individual needs at different stages in life, then selected a set of indicators that measured population and development outcomes based on a life cycle approach, using available databases and existing monitoring systems.

The UNECE Regional Report summarized information on legislation, policies and strategies that had been adopted and implemented by UNECE member states in relation to ICPD/PoA. The report showed significant progress in policy development and programming, confirming the PoA’s relevance in delivering inclusive social and economic development, and a sustainable environment, based on gender equality and respect for human rights. Analysis of the thematic survey using the agreed quantitative and qualitative data in the member state databases, showed that societies can prosper under conditions of slow or zero population growth and aging, provided they adapt their institutions and equitable investment in education, health, and employment opportunities, independent of gender, age and origin. Nonetheless, the region faces many challenges in developing people’s potential given the significant differences in mortality and morbidity between countries and within countries, plus discrepancies and inequality when it comes to accessing sexual and reproductive health information and services. Other shortcomings include discrimination and social exclusion of migrant, minorities, and other disadvantaged groups, and increasing inequalities in terms of access to employment and income opportunities, which especially affects young people.

Policies in both low and high fertility countries should be based on the right of individuals to decide freely and responsibly on the number and spacing of their children. Not only should they have the information, services and means to do so, but such policies should be built on evidence and best practices. The recommendations stressed that policy makers should develop a holistic approach to ensure family-friendly, gender-sensitive and responsive services
across all relevant sectors, including health, education, employment and migration. Policies need to support all types of families, and especially address the needs of vulnerable families. They should also address individual needs and enable women and men to find a balance between family and work requirements so that they can find affordable care options for children and older persons. This would ensure life cycle care during an individual’s different phases of life as a care giver, and as the person in need of care, whether in childhood or in old age, or as a person who is physically or mentally-challenged.

The research findings indicated that below-level fertility does not constitute a threat when accompanied by adequate investment in health, education, and employment opportunities. This is a significant conclusion for the life cycle approach. Since continued training, education and provision of health care, regardless of age, confirms the contention of both the ICPD /PoA and the Nairobi Commitments that a life cycle approach is the best way to achieve and realize the SDGs. In emphasizing that people should be at the center of development, the report offered some specific recommendations.

Operationally, it called on governments to invest in human capital throughout the course of people’s lives, particularly in building the capacities of adolescents and young people and helping them develop their full potential and by allowing them a meaningful role at all stages when it comes to development activities. Meeting participants reiterated the right of all to quality education at all levels in a safe environment. They stressed that young people should be assured decent job opportunities through effective policies and programmes that generate secure employment and the kind of knowledge that would help them make informed decisions about their lives and families, and provide them with the requisite skills. Other recommendations cited the need to promote a healthy lifestyle among the young, by providing them access to youth-friendly health and social services that would lay the foundations for improving the lives of future generations of the elderly. Health and social policies and programmes should therefore be adopted to respond to such needs and they should be age appropriate. Moreover, prevention of discrimination against the elderly, securing the appropriate health care, as well as income and social networks for older people would allow societies to benefit from their productivity and contributions as caregivers, volunteers, and entrepreneurs, thereby reaping the benefits of the longevity dividend represented in current and future generations of older people.
For families, SRH over a life course offering the protection of sexual and reproductive health and rights is essential to achieve gender equality and social justice. This requires national legislation. Governments need to partner with civil society in order to protect against violations of sexual and reproductive health rights. Gender-sensitive life skills and sexuality education are essential to empower young girls to protect themselves. Professional groups such as health care providers, members of the judiciary, teachers, social workers and law enforcement personnel should be trained and made aware of human rights, gender-sensitive and responsive approaches concerning all individuals, regardless of background. This also ensures a life cycle intervention in population and development programmes. An additional recommendation was the need to pay more attention to improve overall access to information and counselling, including for unintended pregnancies.

Meeting participants called for comprehensive sexuality education training to be integrated into undergraduate and in-service training for teachers and social workers among others. They also recommended ensuring effective policies related to sexual and reproductive health services for the elderly, as part of life cycle care. Increasing access for men and boys to sexual and reproductive health information, counselling and services, was cited as another aspect of the people approach to population and development programmes. This should be reflected as a non-discriminatory commitment to equality before the law. In addition, laws should be enacted that allow education in an environment that is gender-sensitive and free from discrimination and violence. Finally, the meeting urged the strengthening of partnerships with civil society, especially the grassroots organizations closest to the people, and it further urged that they be provided with sustainable funding, given the key role they play in promoting the people approach to implementing the ICPD/PoA.
6.4 The International Conference on Human Rights; The ICPD Beyond 2014

This was another attempt to promote a people-centered approach based on the concept of people’s agency. The Cairo consensus resolved the discussion between development demands and human rights. To follow the Cairo agenda is to promote human rights for all. This is what it means to talk of reproductive right. The ICPD PoA human rights approach to reproductive health shaped the thinking of the development and human rights agencies. The Commission on Population and Development and the Commission on the Status of Women adopted strong rights-based positions on young people and on gender-based violence. The Commission on Human Rights adopted a resolution on preventable maternal mortality, morbidity and human rights, with similar progress noted at national and regional levels. Under the tagline “all different, all equal “, an International Conference on Human Rights was organized by UNFPA, the High Commission for Human Rights and the Government of the Netherlands. The conference became a platform for a diverse group of participants to identify ways and means to strengthen the operational links between human rights commitments and identify opportunities to strengthen implementation of the Programme of Action with special emphasis on sexual and reproductive health and rights and their intersection with gender equality and the rights of individuals at all stages of life.

Three fundamental arenas were identified in which action was taken to meet human rights obligations --namely, SRH, creating enabling legal policy environments; removing barriers to accessing information, education, and services; and enhancing people ‘s agency and ensuring their full potential.

The conference highlighted the progress made since Cairo in improving access to information, education, and services on sexual and reproductive health. Most notable was the improvement in maternal health which represented the greatest gains in sexual and reproductive health and human rights. The percentage of pregnant women who had at least one antenatal care visit increased globally from 64% in 1990 to 81% in 2010. Access to voluntary family planning and modern methods also improved, as did the response to the AIDS epidemic. In addition,
moves on the legal and policy fronts to end violence against women and girls “stood out “as examples of the progress being made, 125 countries having enacted specific laws on domestic violence, while many more set up dedicated programmes and services.

Participants recognized the groundbreaking accomplishment of the ICPD in designating the centrality of “people’s agency “to sexual and reproductive health and rights. The consensus was that one of the major achievements post-1994 had had been how a growing number of civil society organizations, non-governmental stakeholders, and social movements were galvanized to take up and promote the ICPD agenda that was to shape and redirect global, regional, national communities This development proved especially important for the life cycle approach to ICPD/PoA implementation. Civil society plays a crucial role, not just in terms of community service but also to the extent that it can and does influence government decisions and actions, including parliamentarians and public sector institutions, about sexual and reproductive rights. Civil society’s impact was acknowledged as a key catalyst in achieving the goals and objectives of the ICPD, and bringing them to bear on the inclusive framework of the post -2015 development agenda

The consensus also identified socio-economic inequalities as a major barrier preventing people living in poverty from having access to sexual and reproductive health services. Lack of information and education and gender inequalities were identified as among the obstacles hampering implementation of the ICPD PoA drive to enhance people’s agency to fully participate in the process. The conference identified a number of challenges standing in the way of full implementation of ICPD/PoA beyond 2014. These were summarized as equality, quality and accountability for people across life cycle.
6.5 Addressing Population Ageing, In Asia and the Pacific Region, A life Cycle Approach

ICPD+20 examined the decline in fertility levels reinforced by continued mortality levels and the resultant changes in the age structure of populations in most societies. In the more developed regions, approximately one in every six people is at least 60 years of age, a proportion that will be closer to one in every four by the year 2025. The situation in developing countries that have experienced very rapid declines in their fertility levels merits particular attention. Since women live longer than men, they account for the bulk of the ageing and elderly population, with elderly poor women being especially vulnerable in many countries.

In 2020, to coincide with the launch of the UN Sustainable Development Goals, the Asia and Pacific office of UNFPA undertook research into the people-centered approach and its advocacy of the centrality and rights of the individual in development policies and processes. The research focused on issues related to population aging, given the low fertility rate in the Asia and the Pacific region, which accounts for 60% of the world’s population. Since 1990, the region having experienced economic growth rates that helped pull 8% of the extremely poor out of poverty, significant improvements were reflected in the human development indicators, among them, access to health and education (OECD, An Emerging Middle Class).

By 2050, one in four people in the Asia and Pacific region (around 103 million), will be over 60 years of age. Fertility is expected to decline from the current 2.20 to 1.9 in 2050, a demographic development that demands a policy response. Contributing factors to fertility decline, which accelerates population ageing, include gender inequalities; rising economic disparities and emerging health and other disasters such as pandemics like COVID-19. The implications envisage difficult economic consequences such as downturn that will affect most notably, the vulnerable, the elderly and people with disabilities. Other groups that can suffer from the fallout include people in conflict situations, especially women. Sex selection in countries with strong preferences for male children brings repercussions too since fewer women are born, which affects fertility and childbearing, thus altering the dynamics of population ageing. As a consequence, many countries in the region found it necessary to speed up and prioritize developing policies to ensure social and economic sustainability.
UNFPA’s Asia and Pacific region office paper “Addressing Population Ageing in Asia and Pacific: A Life Cycle Approach” addressed population and development from a people-centered perspective in an effort to produce evidence and accompanying arguments to shape strategies for the region that examine the needs of all through the different life stages and that take account of the impact of demographic change on development.

The report presents ageing in “all or nothing” terms. It can be viewed as either an existential threat or wave that capable of undermining health and welfare systems, or as a “silver economy” opportunity that opens up markets for innovations and creative policy making. New tools are being developed to assist researchers and policy makers to monitor and evaluate policies. For example, in order to conduct a comprehensive analysis of population ageing policies, it has been found that the definition of older age is not homogenous and needs to be modified. A 65-year-old person in Japan does not have much in common with a 65-year-old in Liberia, nor, indeed, with a future 65-year-old living in the year 2050.

The report concluded that when it comes to sustainable population and development planning and determining what constitutes a healthy ageing pathway, multiple life-course situations have to be taken into account. These range from lifestyle and biological factors, and social and economic status; to demographics and health situations and psychological behavior.

Understanding the similarities and discrepancies in the ageing trajectory among older populations can enable those responsible for development efforts to identify the determinants that shape health across the life span. Understanding the life cycle factors contributing to later life health and well-being is vital not just to improving quality of life issues for the elderly but also for staying on top of the cost implications for current and future maintenance of health and social services. This must also be done with an eye to the long-term consequences for sustainable development, something that becomes especially acute in gender issue terms when where women live longer, since they often become more vulnerable and in need of support given that they may lack the health and social coverage they require.

The path to a healthy life starts as early as when a couple decide to have children, and it follows, step-by-step, through life. It has particular significance during pregnancy and childbirth, when a woman’s age and the number of her
pregnancies, plus ethical factors impacting sex selection or abortion all become matters of pressing concern. Education, risky behavior, support and care for adolescents, training and employment of men and women and their economic and social security, harmful practices against women, gender-based violence against women and girls, all of these factors shape and impact on the lives of individuals and their societies.

6.6 Population Development Composite Index (PDCI) in the Arab region, people-centered approach

UNFPA’s Arab States Regional Office constructed the Population Development Composite Index (PDCI) to quantify ICPD-PoA implementation and the position of Arab countries in terms of their progress towards meeting SDGs indicators within the context of the ICPD Beyond 2014 review and the post-2015 development agenda. The index aims to provide a scientific measure and the policy tools to promote and demonstrate the importance of supporting a people-centered population agenda as a key enabler for achieving SDGs.

The PDCI structure is derived from the thematic pillars of the “ICPD-PoA Beyond 2014” developed by UNFPA. It is based on 33 indicators divided into five categories namely: Dignity, Sexual and reproductive health (SRH), place and mobility, governance, and sustainability. It reflects the monitoring framework of the SDG indicators, seen from a population perspective. The framework combines results with contextual and process issues, meaning the latter cannot be separated from the overall framework, and therefore the five categories mutually reinforce and align with the SDGs.

The PDCI indicators were developed after several rounds of consultations, peer reviews and iterations to ensure that the chosen methodology matched that of other relevant indices, particularly the SDGs progress index. In 2019, UNFPA ASRO launched a PDCI pilot version. In 2020, a review was conducted to determine the final set of appropriate indicators for measuring the population and development agenda. Methodologically, the computation of the PDCI was conducted in two stages. In the first stage, standardized indicators were aggregated to estimate each of the five sub-indices for the five categories using the arithmetic mean with equal weights for each of the identified indicators. This allowed for full interchangeability and substitutability between indicators within each category. This was avoided in the second stage, and replaced by the geometric mean to reduce substitutability and ensure less sensitivity to extreme values.
Additionally, the necessary tests were carried out to ensure inter-consistency between individual indicators within each category, as well as testing the collinearity between indicators to determine the final list of indicators used to build the composite index. Accordingly, six of the initial 39 indicators listed were excluded to avoid collinearity and redundancy. Sensitivity analysis did not indicate significant differences when ranking countries using different weighting schemes, which justified using equal weights for simplicity. The analysis yielded the conclusion that PDCI is an instrumental tool to make SDGs more people-centered during implementation of the SDG agenda. The results illustrate large disparities between countries in terms of implementing the population and development agenda. Results also show that high scores in one category do not necessarily imply better performance in the others. This means the five ICPD categories can be integrated rather than associated, which makes the PDCI and its sub-indices valuable for evaluating achievements related to population policies and for setting priorities and allocating resources to interventions related to ICPD-PoA. By illustrating differences within countries and different levels of performance within the five categories for each country, the dashboard can usefully identify areas for improvement that require the attention of policy and decision makers.
CONCLUSIONS AND RECOMMENDATIONS
7.1 Conclusions

This paper examined how ICPD PoA influenced and shaped global development. Although not totally fulfilled, ICPD transformed the discussion about fertility, by recognizing that policies on development in fact cannot succeed without a people-centered approach that ensures women's health and rights, including reproductive rights for all. ICPD PoA made the case that sexual and reproductive health and reproductive rights are a matter of social justice, equality and equity. Therefore, reproductive, and sexual health services, and education should be made available and accessible through primary health care systems to individuals of all appropriate ages, including adolescents. A life cycle approach motivates the global agenda towards actions and interventions to further improve and strengthen the health of women and girls. It also serves to urge policy makers and development planners to realize that girls’ and women’s health is not a target isolated and separate from the needs of society at large, but is in fact integral to national development plans. The life cycle approach requires new efforts to ensure the availability of periodic, disaggregated data disaggregated by sex, age and socio-economic situation – so that planners can tailor and design an appropriate life course approach to the health and well-being of women and girls and society as a whole.

The POA warned that the cost and consequences of the lack of effective reproductive health interventions falls disproportionately on women and girls in poor communities. A life cycle approach to empowering people will lead to: reduced poverty and inequality, improved public health, especially women’s and children’s, and, by halting the spread of HIV and other sexually transmitted infections; will ensure that all girls can pursue their education and avoid early marriage and unwanted pregnancies, with support for women to enter and remain in the work force so that they can achieve personal and economic security; while individuals and couples are enabled to determine the size of their families; and, by raising savings and productivity, promote and enable economic growth.

SRHR issues and the empowerment of women and young people, all interface with how global population trends impact on communities and national development. This applies across the board, regardless of whether the context is one of population growth, youth bulge, ageing, migration, urbanization, or environmental degradation and imbalanced production and consumption patterns. Research findings and interventions across the different regions and
countries show this to be true. The post 2015-agenda, therefore, should concern itself with the issues of long-term population change, including, the number of women who cannot access reproductive health care, the women who will enter reproductive age in the coming decade, the needs of the displaced and those in conflict zones, as well as the demands associated with an ageing population.

7.2 Recommendations

A people-centered life cycle approach brings a value-added dimension to efforts to accelerate implementation of the ICPD PoA. This needs to be addressed comprehensively over the course of a lifespan and with a firm focus on people by drawing on these suggested measures:

**For Policy Makers**

1. Review the legal framework for SRH and GBV including laws of family and domestic violence in the Arab region and ensure compliance with life cycle approach.

2. In order to adopt a people-centered approach, governments and development practitioners are encouraged to involve target beneficiaries in the conceptual stages when initiating interventions directed to support women and girls. This should start with consultations from the very outset to be followed up at the design stage and then at regular intervals throughout implementation, including being consulted in all ensuing monitoring and evaluation activities. Such an approach will ensure both community accountability and ownership of the development agenda by the people who matter most.

3. To allocate budgets based on the life cycle approach to ensure the complementarity of efforts by the different governmental actors involved, and that the financing is invested according to people’s needs and rights at each life stage in order to provide the requisite funding for each stage of the way while looking ahead to meet the potential challenges of the next stage.
For Researchers

1. The review indicated the linkage between adoption of a people-centered life cycle approach and making the SDGs more focused on people’s rights and needs. However, strengthening this argument calls for more evidence and further analysis.

2. A more in-depth panel analysis following individuals through their different life stages to examine behavior and requirements at each stage and the impact this might have on other subsequent stages would be helpful. Dedicated data collection activities are therefore to be encouraged and welcomed.

For UNFPA and development practitioners

1. The analysis showed genuine linkages between women’s lives and the impact of behavior at each life stage on health status and general well-being in the stages ahead. Therefore, UNFPA is invited to develop KPIs for key SRH and GBV interventions to monitor the level of linkage between the different life stages to ensure better life cycle planning, monitoring and evaluation to accelerate achievements of the three transformative results.

2. UNFPA should promote the PDCI report as an instrument for strengthening the linkage between the ICPD PoA and the SDG agenda by advocating for a people-centered SDG implementation and by using PDCI as a monitoring tool.

3. A toolkit should be developed to train young professionals on operational aspects of the life cycle and people-centered approach in order to upgrade the capacity of government and partners, including development practitioners, about the cross-benefits of people-centered, life cycle planning and implementation. Special attention should be given to humanitarian settings since standard lists of indicators and KPSs may not be relevant, and innovative approaches may be required on a case-by-case basis.
4 National statistical offices should be encouraged to develop a set of indicators and provide data systematically on main indicators that accurately reflect how the life cycle, people-centered approach works to the benefit of all.

5 SRH and GBV services should be expanded to include counselling, services etc. to cover all age groups and to ensure that consultations involve people of different ages in order to reflect the interactions across the age span in the process of developing appropriate programmes and interventions.

6 While SRH and GBV matters concern human rights issues, they are also subject to different interpretations by communities based on culture and religious heritage. A more culturally-sensitive outcome can be a significant result when a people-centered/life cycle approach is applied. Bringing different generations into discussions and consultations can help when it comes to dealing with issues related to UNFPA’s mandate that some might consider to be sensitive such as comprehensive sexuality education, abortion and matters related to sexual orientation.
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