Inter-Parliamentary Union

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The Partnership
for Maternal, Newborn
& Child Health

Road map for action on women's, children's and adolescents' health

Handbook for Parliamentarians N° 31

Cover Page
Pediatric ward in Ho Chi Minh City, Viet Nam. © GODONG/BSIP

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Acknowledgements

Foreword

Investing in women's, children's and adolescents' health is a human rights imperative addressed in many international commitments and national laws. It is also a wise economic investment for the State. Healthy children grow up to become healthier adults. Healthy adolescents miss less schooling, marry and have children later – when they are ready – and become productive members of society. Healthy women miss less work and are better able to advocate for their own health and the health of their families.

Health is an area of political and strategic focus for the Inter-Parliamentary Union (IPU). In 2019, the IPU Assembly adopted the resolution *Achieving universal health coverage by 2030: The role of parliaments in ensuring the right to health*. This was preceded by the 2012 resolution *Access to health as a basic right: The role of parliaments in addressing key challenges to securing the health of women and children* and its 2017 addendum. These resolutions outline the important work of parliamentarians in delivering health, in particular for women, children and adolescents.
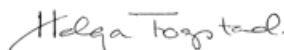
As legislators, overseers of government action and community leaders, members of parliament are well placed to make sure that democracy and parliamentary action improve health, and more specifically women's, children's and adolescents' health. Where parliamentarians are effectively engaged in this effort, they can become influential leaders who are able to stand up and use their constitutional prerogatives to deliver for the people.

This handbook builds on the 2013 IPU handbook *Sustaining parliamentary action to improve maternal, newborn and child health*. It provides an action-oriented road map to help parliamentarians decide how best to improve health outcomes for women, children and adolescents. It includes the decision-making road map that parliamentarians can follow. It further applies the framework to the EWEC Global Strategy 2016–2030, highlighting key issues of concern, indicators and interventions for each of the six focus areas for 2020: (a) early childhood development; (b) adolescent health and well-being; (c) quality, equity and dignity of care; (d) sexual and reproductive health and rights; (e) empowerment of women, girls and communities; and (f) humanitarian and fragile settings. The handbook also contains convenient pull-out sections setting out the road map and a short summary for each focus area, so that parliamentarians and their staff can adapt the proposed parliamentary action to their country contexts.

This handbook is the result of a long-standing close collaboration between the IPU and the Partnership for Maternal, Newborn & Child Health (PMNCH). We hope that it will inspire and help parliaments and parliamentarians worldwide to demonstrate strong political leadership and to fully exercise their legislative, budgetary and oversight powers in order to deliver for women, children and adolescents everywhere.

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Abbreviations

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHW	Community health worker
CRC	Convention on the Rights of the Child
CSE	Comprehensive sexuality education
CSO	Civil society organization
ECD	Early childhood development
EFM	Early and forced marriage
EWEC	Every Woman Every Child
FGM	Female genital mutilation
GBV	Gender-based violence
GDP	Gross domestic product
HIV/AIDS	Human immunodeficiency virus and Acquired immuno deficiency syndrome
HPV	Human papilloma virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD PoA	International Conference on Population and Development Programme of Action
IPV	Intimate partner violence
MISP	Minimum Initial Service Package
MDGs	Millennium Development Goals
NCDs	Non-communicable diseases
ODA	Official development assistance
QED	Quality, equity and dignity
SDGs	Sustainable Development Goals
SRH	Sexual and reproductive health
SGBV	Sexual and gender-based violence
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UHC	Universal health coverage
VAW	Violence against women
WCA	Women, children and adolescents
WCAH	Women's, children's and adolescents' health

Introduction

The right to health is a basic human right. Beyond that, having access to high-quality health services allows people to realize all their other rights. For that reason, investing in women's, children's and adolescents' health (WCAH) is an investment in people's rights, dignity and well-being. It is good for the economy, too. Healthy children grow up to become healthier and more productive adults. Healthy adolescents delay childbearing and perform better at school. Healthy mothers give birth to and raise healthier children. Healthy women miss less work and have more resources to dedicate to their family.

The Millennium Development Goals (MDGs) shaped the development agenda between 2000 and 2015, building on key human rights agreements such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC), and the International Covenant on Economic, Social and Cultural Rights (ICESCR). The MDG era saw significant advances in women's and children's health, as parliamentarians and other national stakeholders advocated for legal and policy changes to create an enabling environment. In 2010, the United Nations (UN) Global Strategy for Women's and Children's Health rallied the international community around priority actions and investments to accelerate progress. Parliamentarians played their part in supporting the strategy through the 2012 IPU resolution *Access to health as a basic right: The role of parliamentarians in addressing key challenges to securing the health of women and children*, identifying the key policy, legislative and budgetary actions they would take to help improve health outcomes in their countries.

Despite progress on WCAH in the MDG era, preventable deaths and the burden of ill-health among women, children and adolescents remain high. Today, one in three women globally experiences physical or sexual violence in their lifetime,[1] and over 295,000 women died in 2017 from preventable causes related to pregnancy and childbirth.[2] Worldwide, one in five women has no access to skilled health-care professionals capable of preventing or managing most complications during childbirth.[3] Up to 2.6 million newborns are stillborn[4] and about 2.5 million newborns die within their first month of life, mostly from preventable causes.[5] As many as 5.4 million children under age 5 die annually, even though most of these deaths could have been prevented or treated with simple, affordable interventions.[6] In developing regions, 214 million women of reproductive age who want to avoid pregnancy are not using a modern contraceptive method, and 44 per cent of pregnancies are unintended worldwide.

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1   World Health Organization (WHO), "Violence against women", 29 November 2017. www.who.int/news-room/fact-sheets/detail/violence-against-women.
2   United Nations Population Fund (UNFPA), WHO, United Nations Children's Fund (UNICEF), World Bank Group, the United Nations Population Division (2019). *Trends in Maternal Mortality: 2000 to 2017*, p.32. www.unfpa.org/featured-publication/trends-maternal-mortality-2000-2017.
3   WHO, "Global Health Observatory (GHO) data. Skilled attendants at birth: Situation and trends". www.who.int/gho/maternal_health/skilled_care/skilled_birth_attendance_text/en/ (accessed: 6 June 2019).
4   Joy E. Lawn and others, "Stillbirths: rates, risk factors, and acceleration towards 2030", *The Lancet*, vol. 387, issue 10018 (6 February 2016).
5   WHO, "Newborns: reducing mortality", 28 September 2018. www.who.int/news-room/fact-sheets/detail/newborns-reducing-mortality.
6   WHO, "Global Health Observatory (GHO) data. Under-five mortality: Situation". www.who.int/gho/child_health/mortality/mortality_under_five_text/en/ (accessed: 6 June 2019).

Annually, almost 4 million unsafe abortions occur among girls in the age group 15–19, contributing to maternal mortality and lasting health problems.[7] Many boys in the same age group die as a result of road-traffic accidents, interpersonal violence, self-harm and drowning. Up to half of all mental health issues start before 14 years of age, and suicide is one of the main causes of death among adolescents.

The Sustainable Development Goals (SDGs), adopted by UN Member States in 2015, seek to take the gains in women's and children's health even further, emphasizing the need to leave no one behind and reach all people. The updated Every Woman Every Child (EWEC) Global Strategy for Women's, Children's and Adolescents' Health 2016–2030 provides a road map for achieving health outcomes in the SDG era, shifting the emphasis from mere survival to thriving, and to transforming both individual health and well-being, and health and social systems in general. The updated strategy extends WCAH priorities to include adolescent health and all countries, as opposed to low- and middle-income countries only. It also calls for a cross-sectoral approach to improving health outcomes, with a focus on humanitarian and fragile settings where access, resource and security challenges make it harder to address WCAH. In line with the updated EWEC Global Strategy 2016–2030, the IPU Assembly adopted a 2017 addendum to the 2012 IPU resolution, promoting lifelong health for all and stressing the need for innovative approaches to WCAH implementation and resource mobilization challenges.

Key global agreements concerning WCAH:

- Sustainable Development Goals (SDGs)
- Every Woman Every Child (EWEC) Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)
- IPU resolution: *Access to health as a basic right: The role of parliaments in addressing key challenges to securing the health of women and children* (2012)
- *Handbook: Sustaining parliamentary action to improve maternal, newborn and child health* (2013)
- 2017 addendum to the 2012 IPU resolution
- IPU resolution: Achieving universal health coverage by 2030: *The role of parliaments in ensuring the right to health*

This handbook, which updates the publication entitled *Handbook: Sustaining parliamentary action to improve maternal, newborn and child health* (2013), brings the technical content in line with the broadened mandates of the SDGs, the EWEC Global Strategy 2016–2030 and the 2017 addendum to the 2012 IPU resolution. In response to parliamentary user-friendliness recommendations, it is designed as an action-oriented road map for parliamentarians, with practical examples to facilitate action. It follows a human rights-based approach to WCAH, supported by data and evidence-based policy,

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7   J. Darroch and others (2016), *Adding It Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents*. Guttmacher Institute.

in order to maximize health outcomes for women, children and adolescents (WCA), as well as for communities and societies at large.

Section I of this handbook introduces and presents the road map showing how parliamentarians can address WCAH nationally. It provides a general framework for understanding and engaging with WCAH, including developing and financing evidence-based policy solutions, as well as institutional oversight, public engagement and strong implementation mechanisms.

Section II applies the road map to the six focus areas for implementation of the EWEC Global Strategy:[8] (a) early childhood development; (b) adolescent health and well-being; (c) quality, equity and dignity of care; (d) sexual and reproductive health and rights; (e) empowerment of women, girls and communities; and (f) humanitarian and fragile settings. It provides a set of actions, illustrations and examples of legislative, programme and policy successes for each of these six areas, so that parliamentarians can apply the lessons learned and implement the findings in their own countries.

Section III contains the conclusion, and calls on parliamentarians to continue advocating and acting for the health rights of women, children and adolescents, and to hold all relevant stakeholders accountable for delivering on WCAH commitments.

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8   These focus areas were endorsed by the High-Level Steering Committee for EWEC in September 2017. The graphic below is based on their work in setting these priorities.

Early childhood development: Investing in health, nutrition and well-being during the early years of life has a profound impact on brain development, affecting a child's learning, health, behaviour and ultimately income.

Adolescent health and well-being: Investments in adolescents' health and well-being can transform the lives of young people and generate significant economic returns, yielding a triple dividend: health benefits for adolescents, for the adults they will become, and for the next generation.

Quality, equity and dignity in UHC: QED efforts aim to ensure equitable access to high-quality care throughout pregnancy, childbirth and the postnatal period, and that all women, newborns, children and adolescents have a positive experience of care that respects and fulfils their rights.

Sexual and reproductive health and rights: Providing a comprehensive package of services that addresses sexual and reproductive health needs and rights throughout the life course benefits women, adolescents, children and societies at large and is highly cost-effective.

Empowerment of women, girls and communities: Laws, policies and social norms that advance gender equality and combat discrimination, coercion and violence are crucial to ensuring that populations and communities survive, thrive and transform; women, children and adolescents must be agents of change in these processes.

Humanitarian and fragile settings: Humanitarian and development sectors must align to ensure that the needs of women, children and adolescents are met in humanitarian and fragile settings, including access to adequate quality services and interventions across the life course.

(Source: The Partnership for Maternal, Newborn & Child Health (PMNCH) (2019). *Advocacy Brief: Putting women, children and adolescents at the heart of universal health coverage*, p.3)

Section I. How parliaments and parliamentarians can address WCAH in the SDG era

This decision-making road map is divided into four elements, in order to guide parliamentary action in developing or reviewing approaches to WCAH:

1. Identifying the problem or gap

2. Developing and advocating for legislative and policy solutions

3. Mobilizing financing

4. Strengthening accountability and engagement

In Section II, the road map is applied to each of the six focus areas of the EWEC Global Strategy 2016–2030: (a) early childhood development; (b) adolescent health and well-being; (c) quality, equity and dignity of care; (d) sexual and reproductive health and rights; (e) empowerment of women, girls and communities; and (f) humanitarian and fragile settings. The aim is to help parliamentarians develop national strategies for advancing WCAH.

Roadmap for action on women's, children's and adolescents' health

1. Identifying the problem or gap

What do constituents say?

- What are you learning about WCAH at town hall meetings and through other constituent communications?

- Are WCA having trouble accessing health services and information?

What do the data say?

- Do you have data about the problems you are identifying?

- Are data disaggregated by sex, region, income level, education level or other key factors?

- Have you read reports containing statistics about WCAH in your country (from civil society, international organizations, the ministry of health and other ministries)?

- How does your country's performance stack up against that of your neighbours?

- What additional data do you need to understand the underlying causes of the problem and start developing a policy solution?

What do partners say?

- Have you been able to engage with civil society and other partners to learn about the key challenges WCA face in realizing their right to health?

- Through their experience serving these populations, what do partners have to say about the data, implementation and barriers to access?

- Are the public and private sectors engaged and communicating with one another about access to health care, quality of care, health-care coverage, health-care workforce issues and other matters?

What do you see?

- Do you notice any disparities in access based on sex, income level, location, education level or other factors?

- Do you notice any missing data or questions left unanswered by the data that suggest systemic issues that need to be addressed?

- What other sectors (such as education or justice) are implicated in the problem you have identified?

- Are the funding and programmatic priorities clearly set in relevant policies and legislation? If not, can you ensure funding priorities are linked to programme performance and results?

2. Developing and advocating for legislative and policy solutions

Review the legal and policy landscape

• What existing legal and policy instruments relate to the problem, and are they working?

• If not, can you identify where the breakdown is occurring?

• Is the law or policy explicit on implementation and enforcement? Are existing policies lacking related legislative instruments? Can you promote adoption of more specific instruments or action plans to support implementation?

• If laws are implemented locally, are outcomes affected by gaps in resources, capacity or accountability?

• Have you considered whether international commitments might be able to fill national legal and policy gaps?

Assess community engagement and identify barriers to implementation

• Are communities appropriately engaged in, and aware of the importance of protecting and promoting WCAH?

• If not, could communities be the barrier to implementation and enforcement?

• Were communities consulted on policy development?

• Can communities be appropriately engaged now?

• Are reports, reviews and agreed government actions made available to the public and widely shared with communities?

• What do civil society organizations (CSOs) and partners have to say about legal barriers, policy frameworks and barriers to implementation?

• Do the available data say anything about implementation, or do you need additional data?

• Are social or cultural stigmas, discrimination or other barriers preventing WCA from accessing health services, even if those services might be available to them?

• Do reports from relevant ministries adequately capture the situation experienced in communities as regards implementation and other challenges?

Review policy effectiveness: research and reporting

• Are research, data collection or other monitoring and implementation effectiveness mechanisms built into the existing law or policy?

- If not, can you advocate for funding to be allocated to such mechanisms?

- How can you incorporate monitoring, evaluation, action on findings and strong reporting into the structure of the law or policy?

- Have potential barriers to implementation (social, cultural, structural, geographic or other) been included in research and reporting?

Technical guidance relating to WCAH

- Guttmacher-*Lancet* Commission on Sexual and Reproductive Health and Rights (SRHR)
- Global SDG Indicators Database
- Every Woman Every Child resources
- EWEC Global Strategy 2016–2030 resources
- Global Accelerated Action for the Health of Adolescents (AA-HA!)
- PMNCH: Prioritizing adolescent health: a technical guidance
- WHO: Nurturing Care for Early Childhood Development
- WHO: Standards for improving quality of maternal and newborn care in health facilities
- *The Lancet Global Health* Commission on High Quality Health Systems in the Sustainable Development Goals (SDG) Era (HQSS Commission)

3. Mobilizing financing

Assess available health resources

- What information is available to you about health resources and finances?

- What percentage of GDP goes on health spending?

- What percentage of health financing comes from official development assistance (ODA), and is this money earmarked for specific health programmes or initiatives?

- How does your country's financial commitment to health and WCAH align with regional and international commitments on health financing?

- How does your country's financial commitment to health and WCAH compare with similar commitments in neighbouring or comparable countries?

- How do domestic resources for health compare with international resources for health?

Identify whether financing is a barrier to advancing WCAH

- Do relevant ministries, CSOs and partners indicate whether financing is a barrier to policy implementation, and if so, how?

- Is a lack of financing hindering policy implementation?

- Are sufficient finances allocated to WCAH?

- Are finances allocated to the right things, and are they disbursed appropriately?

- Have ministries, CSOs and partners analysed health financing and recommended ways to address financing barriers?

Remove or reduce financing barriers

- Have you identified any barriers to increasing health spending, and if so, what?

- What can be done to increase public spending on health?

- Do you see any potential for private-sector partnerships or other ways to raise more funds for the health sector?

- If your country's health sector relies heavily on international financing, is there a transition plan to increase reliance on domestic sources or other sources?

Improve value for money in health spending

- Did the health spending analysis find any issues with the disbursement or allocation of health financing?

- Is money allocated to proven interventions?

- Can you use data, and support from CSOs and partners, to show the economic benefits of investing in health?

- Are any health interventions cross-sectoral, and could they benefit from funding or programmes in other sectors (such as education or justice)?

- Have you pursued financing for WCAH from innovative mechanisms like the Global Financing Facility (GFF), Gavi and the Global Fund to Fight AIDS, Tuberculosis and Malaria, or from other sectors?

4. Strengthening accountability and engagement

Assess accountability and oversight

- Does the policy or programme have a clear accountability structure, such as an adjudication board, an independent commission or a dedicated ombudsperson to hear complaints?

- Is periodic reporting on the results of the policy or programme required, and if so, to whom?

- If an accountability mechanism already exists, has its effectiveness been reviewed or assessed?

- Do resources dedicated to accountability support maximum intervention efficiency and effectiveness?[9]

- Have the underlying issues impacting the policy or programme been thoroughly debated or addressed in parliament?

- Does budgetary accountability exist for the policy or programme?

- Has implementation of the policy or programme delivered observable improvements or outcomes for WCAH?

- Is policy development research and monitoring data reliable, timely and disaggregated to give a clear picture of the problem and the policy's effectiveness?

- If data are not available, how can the law or policy be adjusted to require the collection of such data, so that decisions are made equitably and that the greatest benefits accrue to those left furthest behind?

- Are government agencies, both within and beyond the health sector, complying with accountability requirements in laws and policies, such as reporting, reviewing and addressing problems?[10] If no accountability requirements exist, can they be added?

Assess public engagement

- Were communities, constituents and partners consulted when the policy or programme was developed, or when budget priorities were set?

- Were they consulted when the policy or programme was reviewed (for effectiveness or spending)?

- Is civil society and private-sector participation transparent and inclusive?

9   Independent Accountability Panel (IAP) (2016), *2016: Old Challenges, New Hopes: Accountability for the Global Strategy for Women's, Children's and Adolescents Health*, p. 55. http://iapreport.org/2016/downloads/IAP_Report_September2016.pdf.

10   *Ibid.*

- Where the private sector plays a major role, either as a financier or service provider, what special arrangements are in place for private-sector accountability for health goals and standards?[11]

Assess parliamentary engagement

- What working groups, committees, caucuses or similar bodies exist for the key issues as identified?

- What is the composition of these groups? Are they made up solely of parliamentarians, or do they include experts from ministries and civil society?

- What additional voices or data are needed to help to move the legislation or policy forward?

- Is partnership engagement part of the mandate of the groups, etc.?

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11 *See* IAP (2018), *Private Sector: Who is Accountable? for Women's, Children's and Adolescent Health*, p. 30. http://iapreport.org/img/pdf/ IAP2018REPORT_web.pdf.

Section II. Addressing key issues in WCAH through effective parliamentary action

This section applies the road map presented in Section I to the six focus areas of the EWEC Global Strategy 2016–2030: (a) early childhood development; (b) adolescent health and well-being; (c) quality, equity and dignity of care; (d) sexual and reproductive health and rights; (e) empowerment of women, girls and communities; and (f) humanitarian and fragile settings. Since this section focuses on action and application, it is structured around a series of illustrative case studies and examples in which countries have enacted the policy development, engagement and accountability principles and other elements in Section I.

Open air school in Krishnadevpur village, north of Kolkata, India.
© REUTERS/Ahmad Masood

a. Early childhood development

Early childhood development (ECD) is the process by which young children develop skills such as language and self-regulation, especially in the first three years of life. It lays the foundation for a child's abilities, success and health in later life.[12] It encompasses aspects of good health, adequate nutrition, responsive caregiving, security and safety, and opportunities for early learning.[13] Poor ECD may lead to poor nutritional status and stunting, which impacts brain function and adversely affects both cognitive and behavioural outcomes.[14] The health consequences of poor ECD are associated with poor productivity later in life, including lower wages at work.[15] The 43 per cent of children at risk of not reaching their developmental potential are likely to earn about one quarter less than they otherwise would, keeping families trapped in a cycle of

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12   Maureen M. Black and others (2017), "Early childhood development coming of age: science through the life course", *The Lancet*, vol. 389, issue 10064, p. 79.

13   Nurturing Care for ECD Framework launched at the World Health Assembly in 2018. *See* WHO, "10 facts about early childhood development as a social determinant of health". www.who.int/maternal_child_adolescent/topics/child/development/10facts/en/ (accessed 23 September 2019).

14   Maureen M. Black and others (2017), *supra* n. 12, at p. 80.

15   *Ibid*.

poverty.[16] Exposure to physical, biological and chemical risks during a child's early years can have significant, long-term and adverse effects.[17] Given the far-reaching impacts of ECD, parliamentarians can improve human development outcomes and national economic performance by prioritizing ECD and incorporating it into existing policies and programmes. In this sense, promoting ECD is often both affordable and feasible.

1. Identifying the problem or gap

Parliamentarians looking to identify problems or gaps in ECD policies, and design effective solutions, can consider government reports, constituent feedback and input from partners. They can also analyse data on child development in the areas of health, learning and psychosocial well-being, and on pre-primary organized learning. Technical guidance from international organizations can also be helpful for identifying ECD challenges and solutions. The SDGs call for children to be developmentally on track in learning and psychosocial well-being, for increased participation in organized learning,[18] and for a reduction in undernourishment and stunting.[19] Holistic development from pregnancy up to age 3 is a particularly important aspect of ECD, because it is at this age that children lay the foundations for their health, well-being and productivity – foundations that will last throughout childhood, adolescence and adulthood.[20] Other health and psychosocial elements of ECD include engaging children in activities that prepare them for school, reducing the number children left alone or in the care of another child under age 10, increasing access to learning materials at home, and increasing access to early learning activities for economically disadvantaged children.[21] Improving pre-primary school enrolment also has measurable impacts on later school enrolment and performance.

Conducting an ECD legislation and policy review

Identify whether ECD is firmly supported in national law and policy by:

- *Reviewing the current legal landscape for ECD:*
  - *Does an ECD law exist? What are its main components?*
  - *Do other laws in the health, education and youth sectors affect ECD?*
- *Reviewing indicators that measure child health, well-being and nutrition:*
  - *percentage of children in pre-primary education;*
  - *percentage of children engaged in activities that prepare them for school;*

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16 The Lancet (2016), *Advancing early childhood development: from science to scale*: *An executive summary for The Lancet's series*, p. 6.

17 *Supra* n.12.

18 *See* SDG Target 4.2.

19 *See* SDG Target 2.1, 2.2. The global nutrition targets call for a 40 per cent reduction in the number of children under 5 who are stunted, for exclusive breastfeeding, early initiation of breastfeeding and continued breastfeeding, and for a minimum acceptable diet. WHO, UNICEF (2017), *Global nutrition monitoring framework: Operational guidance for tracking progress in meeting targets for 2025*, p. 3-4, 16, 25.

20 WHO, UNICEF (2018), *Nurturing care for early childhood development: A framework for helping children survive and thrive to transform health and human potential*. Geneva. https://apps.who.int/iris/bitstream/handle/10665/272603/9789241514064-eng.pdf.

21 UNICEF, "Home environment", December 2017. data.unicef.org/topic/early-childhood-development/home-environment/.

- *percentage of children left alone or in the care of another child under age 10 for more than one hour per week;*
- *percentage of children with learning materials at home;*
- *ratio of children engaged in learning activities by income;*

- *Implementing proven functional interventions to improve ECD:*
  - *iodine supplementation before and during pregnancy;*
  - *antenatal corticosteroids for women at risk of pre-term birth;*
  - *kangaroo mother care for small infants;*
  - *breastfeeding and complementary feeding promotion, education and support;*
  - *responsive caregiving with stimulation and early learning opportunities;*
  - *mental health care for parents, including during the perinatal period;*
  - *smoking-cessation interventions;*
  - *elimination of environmental toxins (such as lead, mercury and pesticides);*
  - *parental support programmes;*
  - *early childhood care and education;*

- *Assessing and improving the supporting policy environment for successful ECD:*
  - *adequate paid parental leave to enable parents to care for their children;*
  - *breastfeeding breaks at work;*
  - *paid sick leave to enable parents to provide nurturing care;*
  - *minimum wages at sufficient levels to lift families out of poverty;*
  - *free pre-primary education;*
  - *poverty alleviation strategies.* [22]

2. Developing and advocating for legislative and policy solutions

Since ECD is a multipronged, multisectoral issue, a dedicated national law or policy can establish the coordination and tracking mechanisms necessary to achieve measurable improvements. An ECD law or policy can also create a strong legal basis for early education, school feeding programmes, and breastfeeding protection, promotion and support, as well as channelling funds, human resources and multisectoral coordination efforts towards improving ECD outcomes. Parliamentarians can promote ECD nationally by auditing related laws and policies (on issues such as education, health, nutrition and youth) in order to understand what protections might exist – even if their country does not have a dedicated ECD law or policy. Chile's experience in adopting an ECD

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22 Linda M. Richter and others (2017), "Advancing Early Childhood Development: from Science to Scale 3: Investing in the foundation of sustainable development: pathways to scale up for early childhood development", *The Lancet*, vol. 389, issue 10064, pp. 103–118.

law illustrates how policies and programme outcomes can help determine how the law should be designed and applied.

> *In 2005, the Government of Chile responded to mounting evidence of the importance of ECD by introducing a new multisectoral policy entitled* Chile Crece Contigo *(or "Chile Grows with You").* [23] *Noting inequality in academic performance and access to services according to income, the policy specifically provided for differentiated childhood and educational services based on a child's family income, including free pre-primary education for children in the poorest 40 per cent of households.* [24] *The policy proved so successful that the Chilean Parliament unanimously adopted the* Chile Crece Contigo *Law in 2009.* [25] *In 2005, Chile's pre-primary school gross enrolment ratio was around 80 per cent. After the new law was adopted, it jumped to 112 per cent, likely because many children were quickly absorbed into the new system even though they were technically older than pre-primary age. By 2016, the ratio had stabilized and was climbing steadily towards 85 per cent.*

In the 2017 IPU addendum, parliamentarians emphasized the importance of multisectoral collaboration for WCAH, and for ECD in particular, by committing to "enhance collaboration across key sectors of government for women's, children's and adolescents' health and well-being, including but not limited to the education, gender, civil registration, nutrition, statistics, infrastructure and environment sectors".[26]. Under Art. 6(2) of the Convention on the Rights of the Child (CRC), States must "ensure to the maximum extent possible the survival and development of the child."[27] Other international instruments, such as the International Code of Marketing of Breast-milk Substitutes, also impact ECD policies.[28]

Where ECD laws or policies exist, their multisectoral nature can make enforcement and implementation challenging. High-level political commitment to ECD is crucial for the effective implementation of ECD interventions, as is buy in from subnational and local government entities.[29] Finding ways to increase the participation of parents in ECD interventions can also improve implementation since many ECD indicators relate to the child's experience within the household. Political prioritization of ECD can also make a major difference in how effective these policies are.

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23 Michelle J. Neuman and Amanda E. Devercelli (2013), *What matters most for early childhood development: a framework paper*. The World Bank. p. 28.

24 *Ibid.*

25 Law No. 20.379 (Chile).

26 Inter-Parliamentary Union (IPU), "Review and Follow-Up Action on the 2012 IPU Resolution *Access to health as a basic right: The role of parliaments in addressing key challenges to security the health of women and children*," 137th IPU Assembly, 29 September 2017.

27 Convention on the Rights of the Child (CRC), UN General Assembly Resolution 44/25 (1989). The Committee on the Rights of the Child stated in its General Comment No.7 that the right to survival and development can only be implemented in a holistic manner, through the enforcement of all the other provisions of the Convention, including rights to health, adequate nutrition, social security, an adequate standard of living, a healthy and safe environment, and education and play, as well as through respect for the responsibilities of parents and the provision of assistance and high-quality services. The Committee also recognizes that young children have particular requirements for physical nurturing, emotional care and sensitive guidance, as well as for time and space for social play, exploration and learning. CRC/C/GC/7/Rev.1 (2005).

28 WHO (1981), International Code of Marketing of Breast-milk Substitutes. www.who.int/nutrition/publications/code_english.pdf.

29 Rebecca K. Sayre and others (2015), *Investing in early childhood development: Review of the World Bank's recent experience*. The World Bank. p. 39.

> *Côte d'Ivoire's National Development Plan 2016–2020 set a vision of investing in human capital for transformational development, with ECD recognized through strong policies on childhood nutrition and breastfeeding. The President appointed a multisectoral National Council to implement the childhood nutrition aspects of the plan. The prioritization of ECD through specific development objectives, with oversight by a National Council, has resulted in reductions in stunting and improvements in exclusive breastfeeding rates and postnatal care.* [30]

3. Mobilizing financing

Many countries are yet to devote the domestic resources needed to capture the human development and economic growth potential of supporting ECD. Low- and middle-income countries spend only an estimated 1 per cent of their health budgets on ECD interventions, such as vitamin A and micronutrient supplements, and treatment for acute malnutrition.[31] In high-income countries, spending on children in the age group 0–5 stands at about 25 per cent of national median household income,[32] while pre-primary education spending is low, averaging just 0.07 per cent of gross national product (GNP)[33] or about 0.6 per cent of gross domestic product (GDP).[34] Meanwhile, only 2 per cent of international aid spending on education goes to early education.[35] Colombia has filled some of these funding gaps by mobilizing private-sector support for ECD through employer-employee cooperatives.[36] Colombia also takes 3 per cent of payroll taxes to fund the government agency responsible for delivering ECD services.[37] India, a federal State, funds ECD through contributions from both national and subnational governments, although it does not require local governments to contribute to ECD programmes.[38]

While it may be difficult to mobilize domestic funds for ECD, the economic case for investing in ECD is clear. Stunting, which is caused by poor maternal health and nutrition, poor childhood nutrition and childhood infections, is linked to poor cognitive development and performance at school, a greater likelihood of living in poverty, and even adult obesity where children gain weight too quickly after age 2.[39] As well as affecting a child's individual development later in life, stunting also impacts the economy as a whole. The World Bank estimates that a 1 per cent loss in height due to stunting is associated with a 1.4 per cent loss in economic productivity,[40] and that stunted

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30 Daniel Kablan Duncan, "Early childhood development at the heart of nutrition", Early Childhood Matters, 18 June 2019. earlychildhoodmatters.online/2019/early-childhood-development-at-the-heart-of-nutrition/.

31 Results for Development Institute (R4D) (2016), *Financing early childhood development: An analysis of international and domestic sources in low- and middle-income countries*, vol. I, p. 9.

32 Vidya Putcha and Jacques van der Gaag (2015), *Investing in Early Childhood Development: What is Being Spent, And What does it Cost?* Global Economy and Development at Brookings, p. 8.

33 R4D (2016), *supra* n.2, at p. 9.

34 Putcha and van der Gaag (2015), *supra* n.32, at p. 7.

35 R4D (2016), *supra* n.2, at p. 12.

36 *Ibid.* at p. 9.

37 *Ibid.* at p. 7.

38 *Ibid.* at p. 14.

39 WHO (2014), *WHA Global Nutrition Targets 2025: Stunting policy brief*, p. 2.

40 The World Bank (2006), *Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action*, p. 24. siteresources. worldbank.org/NUTRITION/Resources/281846-1131636806329/NutritionStrategy.pdf.

children earn 20 per cent less as adults than their non-stunted counterparts.[41] Moreover, every child deserves a fair and equal chance in life, and supporting ECD programmes and interventions is one of the most effective ways for parliamentarians to promote children's development.

4. Strengthening accountability and engagement

Again, because ECD is a multisectoral issue, proper accountability requires a national strategic plan developed in consultation with all relevant stakeholders and institutions. Including local and subnational governments in these consultations is important, since the burden of implementing ECD programmes and policies often falls on government entities at these levels. Transparent engagement with stakeholders, partners, communities and implementing agencies is also critical to the success of ECD approaches and interventions. Yet it can be difficult to ensure that the voices and views of children are represented in policy development. While older children can participate to some degree, reflecting the interests of the youngest children requires special effort from parliamentarians, including on safeguarding.[42] Civil society organizations are often best placed to represent young children's voices, with many also working as implementers and partners in ECD programmes alongside parents and teachers. Communication materials and forums are an effective way to inform children, parents and teachers about children's ECD rights, and to teach them how to assert and protect those rights when they are violated. Such materials and events will need to be designed with input from schools and CSOs. In Bangladesh, an ECD network was set up, combining policymakers and ECD partners and implementers, to strengthen ECD approaches. Pre-primary enrolment rose sharply in just a few years after the network was created.

> *The Bangladesh ECD Network (BEN), a government and civil society forum, allowed child-focused CSOs to work with government on developing and implementing ECD policies and programmes.[43] In 2010, Bangladesh adopted a National Education Policy based on the work of BEN. One goal of the policy was to increase pre-primary enrolment, with targets and roles for both government and civil society in achieving that goal. The policy also supported the devolution of decision-making in pre-primary education to local government. Although CSOs already provided a large share of ECD services in Bangladesh, the inclusion of civil society voices was instrumental to the success of the policy, which resulted in just five years, in pre-primary enrolment of three times as many children – from 895,000 to 2.86 million children.*

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41 WHO (2014), *supra* n. 39.

42 *See* UNICEF (2015), *Accountability for Children's Right*s. www.unicef.org/policyanalysis/rights/files/Accountability-for-Childrens-Rights-UNICEF.pdf.

43 *See* Apolitical, "The unprecedented rise of pre-primary education in Bangladesh", 27 October 2017. apolitical.co/solution_article/unprecedented-rise-pre-primary-education-bangladesh/ (accessed: 4 April 2019).

PARLIAMENTARY ACTION FOR EARLY CHILDHOOD DEVELOPMENT

1. Identifying the problem or gap

- *Ensure that ECD is firmly supported in national law, and that enabling and supportive legislation is fully adopted.*
- *Identify any barriers to adoption or implementation.*
- *Review child health, nutrition and well-being indicators, and how these indicators are used in decision-making (see ECD legislation and policy review above).*

2. Developing and advocating for legislative and policy solutions

- *Ensure a strong legal basis for early education.*
- *Adopt laws and policies to protect and promote breastfeeding.*
- *Review national laws and policies against international ECD commitments:*

  – *Convention on the Rights of the Child (CRC)*
  – *International Covenant on Economic, Social and Cultural Rights (ICESCR)*
  – *Covenant on the Rights of the Child in Islam (CRCI)*
  – *WHO: Global Nutrition Monitoring Framework: Operational guidance for tracking progress in meeting targets for 2025*
  – *WHO: Nurturing Care for Early Childhood Development*

- *Take a lead role in strengthening political commitment to ECD.*
- *Educate local governments, communities and parents about the importance of ECD, and about relevant laws and policies.*

3. Mobilizing financing

- *Make the economic case for ECD by understanding and communicating the impacts of stunting on the national economy.*
- *Advocate for increased and more effective spending on ECD as a basic human right.*

4. Strengthening accountability and engagement

- *Ensure that the voices of communities, including children, are represented in ECD policy and programme development and implementation, and in priority-setting.*
- *Develop a national strategic plan or policy for ECD that clearly identifies specific institutions or agencies as being accountable for performance and outcomes.*
- *Ensure that accountability mechanisms are in place for subnational government entities implementing ECD policies and programmes.*

Satara is training to become a mid-wife in northern Nigeria.
© Lindsay Mgbor/Department for International Development

b. Adolescent health and well-being

Some 1.2 million adolescents age 10–19 die every year, mostly from preventable causes.[44] For girls, the leading causes of these deaths are road-traffic accidents, self-harm and maternal health conditions. For boys, the main causes are road-traffic accidents, interpersonal violence and drowning.[45] Adolescence is also the time of life when young people develop healthy or unhealthy behaviours related to their education, sexual and mental health, nutrition and life skills (including substance abuse, violence and physical activity). As such, adolescence strongly influences a person's health and well-being in adult life. Schools can be convenient places for adolescents to access health services and information. They might also be able to access youth-friendly health services outside of school, although parental consent requirements pose legal barriers to accessing such services in many countries. Elsewhere, adolescents may be legally permitted to access health services, but health practitioners may not welcome them or they may face social stigmas in accessing the care they need, especially when it comes

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44 WHO, "Adolescent deaths and burden of disease". www.who.int/maternal_child_adolescent/epidemiology/adolescent-deaths-burden-disease/en/ (accessed: 19 September 2019).

45 IAP (2019), *IAP Accountability brief: An accountability agenda to ensure universal health coverage for adolescents*. Geneva. https://iapewec.org/wp-content/uploads/2019/09/BLS19103_Parliaments-Adolescent-Accountability-003.pdf.

to their sexual and reproductive health and rights (SRHR).[46] At the same time, many women begin childbearing in adolescence. Aside from being socially and economically challenging, childbearing at a young age can cause multiple health and developmental challenges for both mothers and their children. Many adolescent men lack guidance in making decisions about their health, and adolescence is a critical time to challenge entrenched gender stereotypes and allow men and boys to develop healthy attitudes towards each other – and towards women. For parliamentarians, investing in adolescent health has a dual benefit. First, it improves health access and outcomes for adolescents. Second, it raises educational attainment because healthier adolescents also learn better at school. This, in turn, improves economic opportunities for all adolescents, and for girls in particular, since it reduces early and forced marriage and adolescent pregnancy.

1. Identifying the problem or gap

Adolescents face specific health challenges. Road-traffic accidents, lower respiratory tract infections, self-harm, diarrhoeal diseases and drowning are the main causes of death among adolescents.[47] The leading causes of non-fatal health burdens in the age group 10–19 are iron deficiency anaemia, road-traffic accidents, depressive disorders, lower respiratory tract infections and diarrhoeal diseases.[48] Sexually transmitted infections (STIs) and other communicable diseases such as tuberculosis (TB) can also be contracted in adolescence, and their effects are compounded when adolescents lack access to health and youth-friendly services due to stigmas around sexuality and sexual health, discrimination against youth, and legal barriers to access. Nevertheless, expanding effective health access for adolescents and removing barriers such as parental consent could make a major difference to adolescent health. For example, Malawi, Uganda and South Africa have lowered the age of parental consent for HIV testing and counselling to 12 years. In other words, it is entirely possible to lower the age of parental consent for selected health services while leaving it higher for others.[49]

Parliamentarians can advocate for cross-cutting policy interventions to improve adolescent health, since "some of the best investments in adolescent health and well-being lie outside the health sector".[50] Education quality and access, nutrition, sanitation and life skills, and economic empowerment and participation also have far-reaching impacts on adolescent health. There is a strong link, for instance, between early and forced marriage, teenage pregnancy, low educational attainment, intimate partner violence (IPV) (including sexual abuse) and poor health outcomes. Early childbearing adversely affects the health of young mothers and their children: nutritional status, health outcomes and educational attainment are all lower than among older mothers and their children, while maternal and infant mortality rates are higher.[51] Girls who fall pregnant in adolescence are likely to under-perform at school, and each additional

46 See, e.g., WHO (2012), *Making health services adolescent friendly: Developing national quality standards for adolescent-friendly health services*. Geneva. https://apps.who.int/iris/bitstream/handle/10665/75217/9789241503594_eng.pdf;jsessionid=45CA49493BC813E2A9A021FF650D4025?sequence=1.

47 WHO (2017), *Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to support country implementation*, p. 13.

48 *Ibid.* at p. 18.

49 UNFPA (2017), *Harmonizing the Legal Environment for Adolescent Sexual and Reproductive Health and Rights*, p. 10.

50 UNFPA, "The Lancet: Investing in adolescent health, education could bring tenfold economic benefit", press release, 19 April 2017. www.unfpa.org/press/lancet-investing-adolescent-health-education-could-bring-tenfold-economic-benefit.

51 Peter Sheehan and others (2017), "Building the foundations for sustainable development: a case for global investment in the capabilities of adolescents", *The Lancet*, vol. 390, issue 10104, p. 1799.

year of education for a girl is associated with a 6.5 per cent reduction in mortality for her under-5 children.[52] Adolescent health also impacts national economies: early and forced marriage and adolescent pregnancy are estimated to cost countries at least 1.7 per cent of GDP,[53] while the annual cost to the global economy is expected to exceed US$ 600 billion annually by 2030 on account of uncontrolled population growth and under-5 stunting and mortality.[54]

Other adolescent health issues can be addressed with specific interventions. Estimates suggest that increasing coverage of the two-dose human papilloma virus (HPV) vaccination programme in 75 low- and middle-income countries could prevent 5.1 million deaths from HPV-related cervical cancer by 2030.[55] Increasing school-based comprehensive sexuality education (CSE) has also proven effective: adolescents who receive CSE start having sexual intercourse later, have it less often and with fewer sexual partners, take fewer risks, and use condoms and other contraceptives more often.[56]

Disease burden and reproductive health issues aside, injury rates – especially from road-traffic accidents and interpersonal violence – are especially high among adolescents. In some countries, interventions to limit unsafe driving by young drivers, such as low blood-alcohol limits, may help to reduce the number of injuries and deaths from road-traffic accidents. In countries where most accidents involving adolescents are not caused by young drivers, legal interventions to improve road safety – such as lower speed limits, seatbelt and helmet laws, and mobile-phone laws – will prove most effective.[57] Interpersonal violence can be addressed by targeting firearms access, as well as alcohol use and access, and by improving life skills development for adolescents.[58] Community policing and personal counselling have also been shown to reduce interpersonal violence rates.[59]

Adolescence is also a critical time of life for promoting physical activity and healthy lifestyles. Adolescents should be taught about the importance of exercise as part of the school curriculum, and schools should provide adequate safe space for physical activity.[60] Meanwhile, school-based tobacco prevention programmes, awareness-raising campaigns and readily available smoking-cessation information have all proven successful at reducing adolescent tobacco use and addiction,[61] which causes long-term health impacts.

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52 Marco Schäferhoff and others (2015), *Estimating the costs and benefits of education from a health perspective: background paper for the Oslo Summit on Education for Development. Executive summary.* SEEK Development. p. 3.

53 *See* Henrietta H. Fore and others, "This is the economic cost of child marriage", World Economic Forum, 1 June 2018. www.weforum.org/agenda/2018/06/the-cost-of-child-marriage.

54 Quentin T. Wodon and others (2017), *Economic Impacts of Child Marriage: Global Synthesis Report*, p.9. When girls do not complete their education because of early or forced marriage or other reasons, they are likely to earn half of what girls who complete secondary education earn. Globally, US$ 15–30 trillion is lost due to low educational attainment for girls. Improving secondary education rates could also reduce fertility by one third and under-five mortality by one fifth. *Ibid.* at pp. 4–5.

55 Peter Sheehan and others (2017), *supra* n. 48, at p. 1799.

56 United Nations Educational, Scientific and Cultural Organization (UNESCO) (2018), *International technical guidance on sexuality education: An evidence-informed approach*, revised edition, p. 28.

57 AA-HA!, *supra* n.45, at p.36.

58 *Ibid.* at p.40.

59 *Ibid.*

60 *Ibid.* at p.58.

61 *Ibid.* at p.59.

Adolescents with mental health problems are less likely to grow up to become healthy and productive adults. Conditions such as depression and anxiety account for 16 per cent of the global burden of disease among adolescents,[62] and up to 20 per cent of adolescents experience mental health conditions, potentially leading to a higher risk of injury, self-harm and substance abuse, and to lower quality of life.[63] Reducing health-care access barriers and doing more to raise awareness of mental health issues – including through online media and community engagement – can help to reduce the stigma around mental health, as well as encouraging adolescents to recognize mental health issues in themselves and their peers, and to seek help.[64] The problem is compounded in humanitarian and fragile settings, where adolescents are at greater risk of mental health conditions and find it harder to access services.

Multisectoral strategies and interventions for adolescent mental health:[65]

- *Providing psychosocial support, interventions and services, such as individual counselling, psychotherapy and other emotional and behavioural interventions*

- *Running individual and group interventions focused on improving emotional self-regulation, interpersonal skills and stress management*

- *Detecting and managing alcohol and tobacco use*

- *Managing self-harm and suicide risks*

- *Caring for children and adolescents with developmental delays*

- *Promoting stable caregiving and appropriate boundaries and structures for adolescents*

- *Delivering caregiving and communication training*

- *Promoting adolescent mental health awareness and literacy*

- *Running community interventions to prevent adolescent self-harm and substance abuse*

- *Incorporating mental health into primary care training programmes*

2. Developing and advocating for legislative and policy solutions

Adolescent and youth-friendly health services can be protected and reflected in national youth laws, and in reproductive health laws and policies. Burkina Faso's Reproductive Health Act, for instance, guarantees the right to reproductive health services for adolescents without discrimination.[66] Colombia, meanwhile, was able to implement youth-friendly health services in several provinces through a series of legal instruments

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62 Partnership for Maternal, Newborn & Child Health (PMNCH) (2019), *Adolescent Mental Health: Time for Action*, draft, p.1. www.who.int/pmnch/knowledge/publications/summaries/en/.

63 *Ibid.*

64 AA-HA!, *supra* n.45, at p. 59.

65 PMNCH (2019), *supra* n. 62, at p. 2.

66 Reproductive Health Act (Burkina Faso), No.2005-049/AN (2005), Art. 8; UNFPA (2017), *Review of Adolescent and Youth Policies, Strategies and Laws in Selected Countries in West Africa*, p. 22.

and decrees related to youth, including the Youth Law and the Code for Children and Adolescents.[67] Yet adolescents carry a high burden of disease.[68] They are at greater risk of contracting STIs like HIV and HPV, and of unwanted pregnancies when they lack access to sexual health information and services. Parental consent is the main barrier to accessing these services,[69] so parliamentarians can make a practical difference to adolescent health by having this barrier removed.

As with early childhood development, "the most impressive results for adolescent health and well-being are those achieved through multi-sectoral, multi-level, scaled-up approaches involving local levels of implementation."[70] Multilevel approaches consider all intervention points in an adolescent's life and environment: individually, in families, at school and within the wider community.[71] Programmes and policies that protect adolescents' rights to health can only be effective if adolescents themselves participate.[72] It is also important to engage parents, communities and schools, because adolescent health issues may conflict with cultural and religious values around adolescence and adolescent sexuality. Education and awareness-raising on specific adolescent health issues, such as tobacco use, interpersonal violence and road safety, can be incorporated into school curricula.

> *Argentina's SUMAR programme provides adolescents with medical, dental and ophthalmic check-ups, referrals, nutrition information and counselling, SRH services and counselling, pregnancy testing, contraceptive information and services, immunizations, mental health consultations, and urgent care for suicide attempts and sexual violence.*[73] *The programme hinges on the relationship between the federal and provincial governments. The provinces retain decision-making authority for health programme implementation under the existing decentralized health system delivery scheme, while the federal government pays provincial governments based on the number of beneficiaries served in health programmes, as well as their attainment of certain indicators.*[74] *The provinces then incentivize health facilities according to the number of services they provide that meet certain quality standards. This arrangement, in which provincial governments enjoy autonomy in setting spending priorities and designing service delivery, has increased service availability for adolescents in Argentina.*

Internationally, parliamentarians have also pledged to address and protect adolescent health. These commitments could serve as a guide for national legislation and policy efforts. The 2017 addendum to the 2012 IPU resolution treats adolescents as a key group in developing national health interventions and policies, calling for "awareness-

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67 Silvia Huaynoca and others (2015), "Documenting good practices: scaling up the youth friendly health service model in Colombia", *Reproductive Health*, 12:90, p. 2, 7.

68 UNICEF (2017), *Reducing age-related barriers to sexual health services: Learning to change policy toolkit*, p. 9.

69 *Ibid.*

70 IAP (2017), *Transformative accountability for adolescents: Accountability for the health and human rights of women, children and adolescents in the 2030 Agenda*, p. 25.

71 Every Woman Every Child (EWEC) (2017), *Technical Guidance for Prioritizing Adolescent Health*, p.15.

72 See Global Consensus Statement: Meaningful Adolescent & Youth Engagement, www.who.int/pmnch/mye-statement.pdf (accessed: 19 September 2019).

73 EWEC (2017), *supra* n. 71.

74 *Ibid.*

raising campaigns on sexual and reproductive health with a focus on adolescents".[75] The SDGs can also provide guidance on the life-course approach to national health interventions – an approach that is beneficial for adolescent health.[76] Similarly, adolescent reproductive health and rights are protected in the International Conference on Population and Development Programme of Action (ICPD PoA),[77] while CRC affirms that all adolescents under age 18 enjoy the right to the highest attainable standard of health and well-being.[78] These international legal instruments also support parliamentary action to remove parental consent requirements and other legal barriers.

3. Mobilizing financing

Investing in adolescent health brings "a triple dividend for adolescence, adulthood, and the next generation."[79] Yet only 1.6 per cent of total development assistance for health was dedicated to adolescents in the period to 2015, even though adolescents carry 11 per cent of the global disease burden.[80] Domestic resources are therefore critical to protecting and promoting adolescent health. In fact, by health, social and economic metrics, every dollar invested in selected adolescent health interventions yields an estimated tenfold return.[81] In 75 low- and middle-income countries, for instance, investing US$ 5.20 per capita per year in specific adolescent interventions is expected to save approximately 12.5 million lives and prevent over 30 million unintended pregnancies by 2030.[82] One way to mobilize resources is to invest in cross-sectoral programmes and approaches that have a proven positive impact on adolescent health. For example, implementing the two-dose HPV vaccination programme in 75 low- and middle-income countries would only cost about US$ 0.10 per capita.[83] In many of the countries with the highest rates of early and forced marriage, targeted interventions and efforts to increase school attendance among girls can be achieved by spending about US$ 3.80 per capita.[84] Meanwhile, investing in adolescents' mental health can improve school performance which, in turn, leads to higher lifetime earnings and a greater individual contribution to the tax and social welfare system.[85]

4. Strengthening accountability and engagement

The Independent Accountability Panel for Every Woman, Every Child, Every Adolescent (IAP) calls upon States to "ensure that multi-sectoral plans and monitoring, review and

75   IPU (2017), *supra* n. 26.

76   SDG 3.8.

77   International Conference on Population and Development Programme of Action (ICPD PoA), Sec. 7.41 et seq.

78   CRC, General Assembly Resolution 44/25 (1989), Art. 24.

79   Peter Sheehan and others (2017), *supra* n.48, at p. 1802.

80   Zhihui Li and others (2018), "Global Development Assistance for Adolescent Health From 2003 to 2015*", JAMA Network Open*, vol. 1(4):e181072. jamanetwork.com/journals/jamanetworkopen/fullarticle/2696504.

81   WHO, UNICEF (2018), *Adolescent Health: The Missing Population in Universal Health Coverage*, p. 5.

82   *Ibid.* at p. 22.

83   Peter Sheehan and others (2017), *supra* n.47, at p. 1798.

84   *Ibid.* at p. 1799.

85   David McDaid (2011), *Making the Long-Term Economic Case for Investing in Mental Health to Contribute to Sustainability.* European Commission. p. 9.

remedy systems" are in place to protect adolescents' rights to health.[86] In maintaining effective oversight, the IAP recommends that parliamentarians request multisectoral assessment reports, ensure that independent reviews and independent oversight institutions are adequately funded and supported, and incorporate adolescent voices into adolescent health policymaking and review.[87] Several SDG targets and indicators also deal directly with adolescent health, including addressing the nutritional needs of adolescent girls,[88] eliminating violence and harmful practices towards adolescent girls,[89] and improving access to hygiene and sanitation facilities, especially for girls.[90] Engaging adolescents in oversight of adolescent health programmes can help to shape more effective interventions. In line with the principles of the Global Consensus Statement on Meaningful Adolescent & Youth Engagement, this participation should be rights-based, transparent and informative, voluntary and free from coercion, respectful of adolescents' views, backgrounds and identities, and safe for adolescents.[91]

> *In Gujarat, India, adolescents received training and support to help them assert their rights under various government programmes.[92] They were able to effect change by advocating for their legal rights to sanitation and transportation at school, and for health workers to turn up to work and carry out their duties. By participating in this way, adolescents ensured they received the services to which they were legally entitled, as well as gaining valuable civic activism skills that would stand them well in later life.*

Although ministries of health and education typically take the lead on adolescent health, other ministries and agencies have a role to play in maintaining a robust accountability framework.[93] These include ministries of justice, gender, social protection, housing, transportation and urban planning, youth and sports, labour, environmental protection, agriculture and telecommunications. Civil society and young people themselves can likewise play a strong role in making sure adolescents' needs are addressed. For example, the ACT!2030 movement brings together young people from 12 countries in driving accountability for adolescent SRHR.[94] Human rights commissions can also be empowered to monitor and oversee adolescent health interventions.[95] In Malawi, for example, the Human Rights Commission has successfully exercised oversight in this area, building on existing public participation and accountability arrangements to improve protections for adolescent health and rights.

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86 Transformative Accountability for Adolescents, supra n.64, at p. 24 (The IAP identified a number of issues relevant to adolescent health that should be considered when designing accountability frameworks, including poverty, discrimination, gender inequality, malnutrition, harmful practices, violence, traffic accidents, use of tobacco, commercialization of unhealthy foods, self-harm and unsafe sex).

87 Independent Accountability Panel, IAP Accountability Brief 2 – Advanced Copy.

88 SDG Target 2.2.

89 SDG Targets 5.2, 5.3.

90 SDG Target 6.2.

91 *See* Global Consensus Statement on Meaningful Adolescent & Youth Engagement, p. 2. www.who.int/pmnch/mye-statement.pdf.

92 Transformative Accountability for Adolescents, supra n. 64, at p. 40.

93 *Ibid.* at p. 24.

94 *See* www.act2030.org.

95 IAP (2017), *supra* n. 64, at p. 26.

Malawi's Human Rights Commission launched a nationwide public inquiry into violence against women (VAW) and SRHR.[96] *The inquiry, which focused on adolescent girls and other vulnerable groups, involved local public hearings convened by a panel of judges, human rights commissioners and civil society representatives. An independent national task force was then set up to monitor implementation of the resulting recommendations. The process had secondary benefits, too, since public officials were better equipped to protect citizens from human rights violations.*

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96   *Ibid.* at p. 29.

PARLIAMENTARY ACTION FOR ADOLESCENT HEALTH AND WELL-BEING

1. Identifying the problem or gap

- *Assess existing legislation and policies to determine whether adolescents benefit from a comprehensive package of essential health interventions:*

  – *Health-promoting schools, including health education and school hygiene interventions*
  – *Child online protection*
  – *Mental health services*
  – *Iron supplementation and anaemia prophylaxis*
  – *HPV vaccinations*
  – *CSE*
  – *Sexual and reproductive health (SRH) counselling and services*
  – *Prevention, diagnosis and treatment of non-communicable diseases (NCDs)*
  – *Information, counselling and treatment for HIV and other STIs*

2. Assess implementation of adolescent health policies and programmes

- *Review parental consent laws and practice.*
- *Document and assess how adolescents use health services, and assess whether health services are youth-friendly.*
- *Monitor rates of early and forced marriage (disaggregated by region, income level, educational attainment and other factors) and identify community barriers to implementation.*
- *Assess adolescent substance use and abuse rates.*
- *Assess and understand adolescent injury rates and causes.*
- *Developing and advocating for legislative and policy solutions*
- *Remove legal barriers for adolescents to access health services, including age and parental consent requirements.*
- *Ensure policies to address inequalities and discriminatory practices in adolescents' access to services are in place, and that there are no barriers to access for vulnerable groups such as adolescents with disabilities, and lesbian, gay, bisexual, transgender and intersex (LGBTI) adolescents.*
- *Assess and improve school hygiene programmes and practices.*
- *Expand coverage of the two-dose HPV vaccination programme.*
- *Deliver CSE in schools.*
- *Adopt and enforce legislation that prevents harmful practices such as female genital mutilation (FGM) and early and forced marriage.*
- *Improve road safety by adopting helmet, drinking-age, mobile-phone and speed-limit laws.*
- *Reduce adolescent access to firearms and improve life skills education and interventions.*
- *Dedicate funding to preventing TB and other communicable diseases.*
- *Implement evidence-based substance abuse prevention programmes.*

3. Mobilizing financing

- *Allocate funding to raising school enrolment rates among adolescents, and scale up school-based interventions for adolescent health.*
- *Commission cost studies and use the results to determine the cost of adolescent health interventions, as well as the projected savings for the national economy and health system from improved adolescent health outcomes.*
- *Increase funding and support for youth-friendly health service provision, including training front-line health workers.*

4. Strengthening accountability and engagement

- *Request multisectoral assessment reports, independent reviews and independent oversight institutions for adolescent health, and create and enforce remedy and action processes.*
- *Have adolescents participate meaningfully in policy development, implementation and review, and ensure that such participation is inclusive, intentional and mutually respectful.*
- *Ensure that young people's ideas, perspectives, skills and strengths are incorporated into the design and delivery of programmes, strategies, policies and funding mechanisms and into the functioning of organizations that affect their lives, their communities and their countries.*
- *Engage parents and communities in policy development, implementation and review.*

Talking about young women's health at Justice High School in Falls Church, Virginia, USA.
© AFP/Alastair Pike

c. Quality, equity and dignity of care

Quality, equity and dignity (QED) of care is a concept that covers more than just high-quality services. It also requires care to be equitable, with health outcomes reaching all people and groups equally, in a way that promotes human and individual dignity. Quality of care can be defined as care that is safe, effective, timely, efficient, equitable and people-centred.[97] Associated standards measure the "extent to which health-care services provided to individuals and patient populations improve desired health outcomes."[98] Parliamentarians can take action through law and policy to promote QED of care for the benefit and protection of women, children and adolescents.

1. Identifying the problem or gap

The adverse effects of QED gaps and problems are both significant and far-reaching. Over 295,000 women die annually during pregnancy and childbirth.[99] Every year, according to the WHO, there are "2.6 million stillbirths, and 2.7 million deaths of

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97 WHO, "What is Quality of Care and why is it important?". www.who.int/maternal_child_adolescent/topics/quality-of-care/definition/en/ (accessed: 5 April 2019).

98 WHO (2017), *Quality, Equity, Dignity: The Network to Improve Quality of Care for Maternal, Newborn and Child Health*, p. 2.

99 UNFPA and others (2019), *supra* n.2, at p. 32.

babies during the first 28 days of life. Better care can prevent many of these deaths."[100] Improving quality of care is therefore fundamental to keeping mothers and babies alive. Increasing access and equity of care, using a life-course approach, can also make a difference for older women, who often do not have the same access to health services as men or younger women.[101] In a survey by the White Ribbon Alliance, the top reported concern among over one million women was respectful and dignified health care.[102]

Basing quality of care measurements on health outcomes alone overlooks the fact that people respond to health interventions in unpredictable ways.[103] Comparing data about the treatments patients actually receive against the treatments recommended in national guidelines is one of the accepted standards for measuring QED.[104] Yet some low-income countries do not have national treatment guidelines at all, while existing guidelines may be poorly implemented in others.[105] Moreover, robust data may not be available because of inaccurate or piecemeal medical record-keeping.[106] In such cases, parliamentarians can support the establishment of national treatment guidelines and adopt policies to improve the way medical record-keeping is monitored. Both of these measures are essential first steps towards measuring and improving quality of care. WHO also includes quality of care in its framework for measuring the implementation of universal health coverage (UHC),[107] and the organization has drawn up a detailed list of quality of care standards, especially for maternal, newborn, child and adolescent health.

WHO standards for improving quality of maternal and newborn care in health facilities[108]

Standard 1: Every woman and newborn receives routine, evidence-based care and management of complications during labour, childbirth and the early postnatal period, according to WHO guidelines.

Standard 2: The health information system enables use of data to ensure early, appropriate action to improve the care of every woman and newborn.

Standard 3: Every woman and newborn with condition(s) that cannot be dealt with effectively with the available resources is appropriately referred.

Standard 4: Communication with women and their families is effective and responds to their needs and preferences.

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100 WHO, "10 Ways to improve the quality of care in health facilities", 17 February 2017. www.who.int/en/news-room/feature-stories/detail/10-ways-to-improve-the-quality-of-care-in-health-facilities (accessed: 5 April 2019).

101 WHO (2017), *Women, Ageing, and Health: A Framework for Action: Focus on Gender*, p. 18.

102 White Ribbon Alliance (2019), *What Women Want: Demands for Quality Reproductive and Maternal Healthcare from Women and Girls*, p. 38. www.whiteribbonalliance.org/wp-content/uploads/2019/06/What-Women-Want_Global-Results.pdf.

103 Johanna Hanefeld, Timothy Powell-Jackson and Dina Balabanova (2017), "Understanding and measuring quality of care: dealing with complexity", *Bulletin of the World Health Organization*, 95:368, p. 368.

104 *Ibid.* at p. 369.

105 *Ibid.*

106 *Ibid.*

107 *See* WHO and International Bank for Reconstruction and Development (IBRD)/World Bank (2017), *Tracking Universal Health Coverage: 2017 Global Monitoring Report*.

108 WHO (2016), *Standards for Improving Quality of Maternal and Newborn Care in Health Facilities*. www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en/. Additional quality statements are available to elaborate on each standard for quality of care as identified by PMNCH.

Standard 5: Women and newborns receive care with respect and preservation of their dignity.

Standard 6: Every woman and her family are provided with emotional support that is sensitive to their needs and strengthens the woman's capability.

Standard 7: For every woman and newborn, competent, motivated staff are consistently available to provide routine care and manage complications.

Standard 8: The health facility has an appropriate physical environment, with adequate water, sanitation and energy supplies, medicines, supplies and equipment for routine maternal and newborn care and management of complications.

2. Developing and advocating for legislative and policy solutions

National health plans can be designed with QED in mind, including specific QED implementation arrangements. In Honduras, the right to quality and equity of care is enshrined in the Constitution, which protects the right to "adequate medical services" and requires the Ministry of Health to "assign priority to the neediest groups" when delivering services.[109] Some international instruments also contain guidance on implementing QED. The 2017 IPU addendum supports QED with a specific commitment to "invest in improving the quality of care in health services, and ensure that all women, children and adolescents can access and receive quality care with equity and dignity."[110] Through SDG 3, States have committed to ensuring healthy lives and promoting well-being for all, at all ages. ICESCR,[111] CRC,[112] CEDAW[113] and the Convention on the Rights of People with Disabilities (CRPD)[114] also protect individual rights to health and well-being, including for vulnerable groups such as women, children and adolescents.[115]

Quality, equity and dignity laws and policies must take into account the decentralized nature of many health and political systems. QED standards are likely to be set nationally and implemented locally. India, for instance, has established a national council to oversee compliance with nationally set minimum standards of care under the Clinical Establishments (Registration and Regulation) Act.[116] However, the national council relies on having effective state and district councils, meaning state governments need to adopt resolutions to put these legal requirements into effect locally.[117] This additional, local step can hinder QED implementation, and similar challenges may occur in other

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109 Constitution of the Republic of Honduras (1982), Art. 123, 149.

110 Point 11 of the 2017 IPU addendum also reaffirms the commitment of parliamentarians to achieving UHC (including quality of care) by 2030 "through allocating adequate funding to the health sector in line with international commitments and recommendations".

111 *See* Art. 12.

112 *See* Art. 24.

113 *See* Art. 12.

114 *See* Art. 25.

115 *See* Human Rights Council (2014), *Technical guidance on the application of a human rightsbased approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age*, A/HRC/27/31. In its General Comment no.14 (2000), the Committee on Economic, Social and Cultural Rights clarified that the right to health does not mean the right to be healthy, or that States are responsible for making every citizen healthy, since many factors impacting health are beyond the States' control. However, the comment does emphasize that the right to health is a precursor to the realization of all other rights, and is uniquely linked to, and links between all other rights.

116 The Clinical Establishments (Registration and Regulation) Act (2010), India, Art. 3(1).

117 *Ibid.* at Art. 1(2).

federal States where health care is devolved to provincial or district entities. Tanzania has struggled with a lack of national support for local enforcement of quality of care standards. The country sought to address quality of care issues through a national assessment scheme, providing small federal grants to failing facilities to give them an opportunity to improve before being closed or de-funded.

> *In 2015, Tanzania's Ministry of Health oversaw a nationwide assessment of health facilities, rating quality of care between zero and five stars.[118] Only 2 per cent met the minimum standard of at least three stars, and 34 per cent received zero stars.[119] Originally, the intention was to close down poor-performing facilities. However, the exercise revealed that many of these facilities were in hard-to-reach and disadvantaged areas. With the help of parliamentarians, especially those representing affected areas and constituencies, failing facilities received small grants to prepare for a second assessment, in which they aimed to earn at least one star.[120] Because health services are decentralized in Tanzania, the star-rating exercise was also linked to district performance contracts, and the Ministry of Local Government was involved in the review process to ensure ongoing improvements. Innovative incentive models such as those of Tanzania could be used in other countries with decentralized health systems, in order to help failing health facilities raise quality of care standards instead of being shut down.*

3. Mobilizing financing

When considering how to mobilize financing for quality of care, parliamentarians can justify investing more by highlighting the high costs of *not* investing. Poor quality of care is responsible for as many as 8.4 million deaths per year in low- and middle-income countries, and costs up to US$ 1.6 trillion in lost productivity annually.[121] There are many ways to invest in quality of care. One option is to employ more health workers. The evidence suggests, for instance, that expanding community health worker (CHW) programmes can reduce maternal and child deaths and improve treatment for childhood illnesses.[122] Parliamentarians can also channel health-sector investments into staff training, especially in rural areas, and into professional development opportunities for all health workers.[123] Other investment options that can help to improve quality of care and dignity of services include funding improvements in health facilities, technologies and equipment, expanding water and sanitation services, and ensuring facilities have stable electricity supply.[124]

Poor quality of care erodes people's trust in the health system, and the State loses any advantages it may have gained from pooling risk and costs through health insurance

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118 Talhiya Yahya and Mohamed Mohamed (2018), "Raising a mirror to quality of care in Tanzania: the five-star assessment", comment, *The Lancet*, vol. 6, issue 11, p. 1155.

119 *Ibid.* at p. 1156.

120 *Ibid.*

121 National Academies of Sciences, Engineering, and Medicine (NASEM) (2018), *Crossing the Global Quality Chasm: Improving Health Care Worldwide*, p. 129.

122 WHO, Organisation for Economic Co-operation and Development (OECD) and World Bank (2018), *Delivering Quality Health Services: A Global Imperative for Universal Health Coverage*, p. 42.

123 *Ibid.* at p. 44.

124 *Ibid.* at p. 45.

schemes and bulk rates for services and drugs.[125] These conditions compound the challenges of the high costs of care. Short-term investments to improve quality of care may be a necessary first step, especially in countries where the health system requires a major overhaul. As part of a health-sector strengthening plan, Costa Rica mobilized loans from donors to raise quality of care to a level that meant people were willing to use the system, with a view to it eventually becoming self-sustaining through pooled insurance and other sources of private and public funding.

> *Costa Rica has engaged in broad health sector reforms, first by consolidating political support around the reform agenda, and then by mobilizing loans from both the World Bank and the Inter-American Development Bank, using most of the money to modernize the primary care network.[126] This strategy allowed citizens to observe how quality of care was improving, thereby increasing their trust in the system. It also created a window to raise additional domestic resources and roll out longer-term plans to stabilize the health system financing model. Life expectancy has almost doubled over the past 70 years, in part as a result of these investments.[127] Costa Rica is therefore a clear and compelling example of the economic case for investing in quality of care.*

High-income countries face specific challenges in financing health care in general, and supporting the cost of high-quality care in particular. For such countries, the World Bank recommends that effective health financing reforms should support the goal of attaining universal coverage.[128] The main elements of financing for health in high-income countries are risk pooling, typically through a national insurance scheme, and prepayment for services.[129] Private health insurance, medical savings accounts and other types of private revenue collection can be viewed as supplementary tools for achieving universal coverage.[130] Other important expansions of care for high-income countries include long-term care coverage[131] and sliding scales for co-payments and out-of-pocket yearly maximums.[132]

4. Strengthening accountability and engagement

In many countries, quality of care standards are established and monitored by a dedicated unit within the ministry of health, which may collaborate with other quality of care bodies.[133] QED oversight is now an international issue. EWEC has established the Quality of Care Network, led by Bangladesh, Côte d'Ivoire, Ethiopia, Ghana, India,

125 *See ibid.* at p. 49.
126 Pablo Gottret, George J. Schieber and Hugh R. Waters, eds. (2008), *Good practice in health financing: lessons from reforms in low and middle-income countries*. World Bank. pp. 217–218.
127 *Ibid.* at p. 220.
128 Pablo Gottret and George Schieber (2006), "Financing health in high-income countries", *in Health Financing Revisited: A Practitioner's Guide*, p. 279. https://openknowledge.worldbank.org/bitstream/handle/10986/7094/370910Health0f101OFFICIAL0USE0ONLY1. pdf?sequence=1&isAllowed=y.
129 *Ibid.*
130 *Ibid.*
131 *Ibid.* at p. 282.
132 *See* WHO Regional Office for Europe (2018), *Financial Protection in High-Income Countries*, p. 19. www.who.int/health_financing/ events/who_europe_uhc_day_report_web.pdf.
133 WHO, OECD and World Bank (2018), *supra* n.105, at p. 61.

Malawi, Nigeria, Tanzania and Uganda.[134] The network helps countries achieve their SDG targets (ending preventable maternal, newborn and child deaths, ending preventable stillbirths, and working towards UHC by improving quality of care).[135] In fragmented health systems, QED oversight mechanisms are harder to design and implement because services are delivered at various decentralized levels, and by multiple public and private providers. In 2012, Mexico's Ministry of Health rolled out the National Strategy for Quality Consolidation in Health-care Facilities and Services to address discrepancies in quality of care and to raise standards nationwide.[136]

Since quality of care standards are highly technical, they cannot be developed without significant input from medical professionals. Public engagement is also important, since it carries a dual benefit: it helps to make quality of care standards more effective, and it also ensures that the equity and dignity elements of QED are represented. By engaging transparently with the public, health-care providers can get essential feedback and data while at the same time building trust in the health system.[137] CHWs can be called upon to facilitate this process, and can also be a good source of quasi-institutional public engagement.[138] Japan, for example, launched a public engagement initiative to bring more innovation into the health sector by appointing young experts to participate in health-sector reform. This initiative yielded new ideas about how to use technology to enhance health-care services, and to empower individuals to better manage their own health.[139]

134 WHO, "Nine countries commit to halve maternal and newborn deaths in health facilities", 14 February 2017. www.who.int/maternal_child_adolescent/news_events/news/quality-of-care-network/en/.

135 EWEC and PMNCH/WHO (2017), Progress in Partnership: 2017 Progress Report on the Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health, p.15-16; WHO (2017), *supra* n.98, at p. 2.

136 Svetlana V. Doubova and others (2018), "Quality governance in a pluralistic health system: Mexican experience and challenges", comment, *The Lancet*, vol. 6, issue 11, p. 1150.

137 *See* WHO (2017), *WHO community engagement framework for quality, people-centred and resilient health services*, p.12-13; WHO, "Community engagement for quality, integrated, people-centered and resilient health services". www.who.int/servicedeliverysafety/areas/qhc/community-engagement/en/ (accessed: 9 April 2019).

138 *See, e.g.*, WHO (2017), *supra* n.120, p. 13, 36.

139 Marc Yates, "Innovation, Sustainability, Prosperity: Japan's Healthcare Vision", Eye for Pharma, 5 January 2018. http://social.eyeforpharma.com/column/innovation-sustainability-prosperity-japans-healthcare-vision.

PARLIAMENTARY ACTION FOR QUALITY, EQUITY AND DIGNITY OF CARE

1. Identifying the problem or gap

- *Assess QED in the health sector throughout the life course, including for older women, and across subnational units (provinces, districts, sectors and others).*
- *Review implementation of the WHO standards for improving quality of maternal and newborn care in health facilities (see above for details).*

2. Developing and advocating for legislative and policy solutions

- *Establish a right to quality and equity of care through legal and policy instruments.*
- *Ensure that national treatment guidelines are adopted and implemented.*
- *Improve oversight of medical record-keeping.*
- *Review national health plans and strategies for QED of care, including tracking of related indicators under SDG 3, and in particular:*
    - *3.1.2: Proportion of births attended by skilled health personnel;*
    - *3.b.3: Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis;*
    - *3.c.1: Health worker density and distribution.*

3. Mobilizing financing

- *Assess and understand the costs of poor-quality health care in your country.*
- *Assess and understand the implications of higher costs for higher quality of care (high-income countries).*
- *Expand CHW programmes and training.*
- *Prioritize and gradually expand funding for health facilities, including water and sanitation, health technology and health worker training.*

4. Strengthening accountability and engagement

- *Ensure that the ministry of health, working with other relevant ministries, provides periodic reporting on QED of care.*
- *Create opportunities for constituents or users to share their experiences with the health system (QED of care in particular) and establish adequate remedy and action mechanisms.*
- *Obtain first-hand feedback on QED of care from health workers, including CHWs.*
- *Assess legislation and related health-sector plans and strategies for accountability measures, such as independent institutions and policy frameworks for QED at local health centres, and local implementation levels.*

Launching a reproductive health campaign in Puebla, Mexico.
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d. Sexual and reproductive health and rights

Sexual and reproductive health and rights (SRHR) are closely related to human rights and sustainable, equitable development. Reproductive health problems are among the leading causes of death and ill-health for women and girls of childbearing age in less-developed countries, due to unintended, early and frequent pregnancies, STIs, unsafe abortions, and pregnancy and childbirth complications.[140] Sexual and reproductive health (SRH) problems can be addressed throughout the life cycle through a package of services and interventions that includes CSE, family planning counselling and services, comprehensive maternal and newborn care, and detection and treatment of infertility, reproductive tract cancers, and HIV/AIDS and other STIs. The International Conference on Population and Development Programme of Action (ICPD PoA), adopted in 1992, marked a detailed global consensus on the importance of SRH in the international development agenda. In 2018, the Guttmacher-*Lancet* Commission on Sexual and Reproductive Health and Rights provided new and comprehensive guidance on the

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140 UNFPA, "Sexual and reproductive health – Reproductive health and development". www.unfpa.org/sexual-reproductive-health (accessed: 10 April 2019).

importance of SRHR in the SDG era, focusing on a rights-based approach to SRHR and aiming to improve quality of services and equity of access to those services.[141]

1. Identifying the problem or gap

The Guttmacher-*Lancet* Commission's integrated definition of SRHR creates a useful basis for policy dialogue on SRHR. The Commission defines SRH as "a state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity."[142] This is a positive approach to sexuality and reproduction, centred on the rights of individuals to make choices about what impacts their bodies, and to be able to access services that support that right.

Investing in family planning can yield high returns nationally, especially in less-developed regions. The fertility rate in the least developed parts of the world is 3.9, compared with a global average of 2.5 and 1.7 in more developed regions.[143] High fertility compounds the effects of poverty on families[144] and, coupled with poverty, also contributes to high maternal and infant mortality. Worldwide, 45 million women receive inadequate antenatal care, which is another factor in high maternal and infant mortality.[145] Every year, over 295,000 women die in childbirth in less developed regions, and almost half a million infants die in their first month of life.[146] At the same time, the contraceptive prevalence rate in the least developed regions stands at 42 per cent, while the global rate is 63 per cent.[147] As a result, over 200 million women have an unmet need for contraception.[148] Meeting this need could save as many as 76,000 women from maternal death each year.[149]

Parliamentarians can also address other gaps in SRHR for women, children and adolescents. More than half a million new cases of cervical cancer were detected in 2018, even though transmission of HPV, the virus that causes most types of cervical cancer, can be prevented in many cases.[150] One million women and girls acquire HIV annually, and 25 million unsafe abortions occur each year.[151] Parliamentarians can promote SRHR policies that align with the SDGs by increasing the availability of modern contraceptive methods, making more SRHR information and services available in an equitable way, preventing STI transmission by increasing vaccine and information

141 Ann M. Starrs and others (2018), "Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher-*Lancet* Commission", *The Lancet*, vol. 391, issue 10140, p. 2642.

142 *Ibid.* at p. 2646.

143 UNFPA, World Population Dashboard. www.unfpa.org/data/world-population-dashboard (accessed 24 July 2019).

144 *Ibid.*

145 Manjulaa Narasimhan and others (2018), "Investing in sexual and reproductive health and rights of women and girls to reach HIV and UHC goals", comment, *The Lancet*, vol. 6, issue 10, p. e1058.

146 Sneha Barot, "The Benefits of Investing in International Family Planning—and the Practice of Slashing Funding", Guttmacher Institute, 1 August 2017. www.guttmacher.org/gpr/2017/08/benefits-investing-international-family-planning-and-price-slashing-funding (accessed: 25 July 2019).

147 UNFPA, World Population Dashboard, *supra* n. 126.

148 Manjulaa Narasimhan and others (2018), *supra* n.146, at p. e1058.

149 Guttmacher Institute (2017), *Adding It Up: Investing in Contraception and Maternal and Newborn Health, 2017*, p.3. www.guttmacher.org/sites/default/files/factsheet/adding-it-up-contraception-mnh-2017.pdf.

150 World Cancer Research Fund (WCRF), "Cervical cancer statistics". www.wcrf.org/dietandcancer/cancer-trends/cervical-cancer-statistics (accessed: 25 July 2019).

151 Manjulaa Narasimhan and others (2018), *supra* n.131, at p. e1058.

availability, addressing abortion and maternal care, and incorporating cross-cutting issues such as gender-based violence (GBV) and early and forced marriage into SRHR policies. Specifically, they can advocate for the following interventions:

- CSE in schools;

- Modern contraceptive counselling and services, ensuring that various types and methods are offered;

- Greater availability of antenatal, childbirth and postnatal care;

- Safe abortion services and treatment for complications from unsafe abortions where provided for by the law;

- Prevention and treatment of HIV and other STIs;

- Prevention and detection of sexual and gender-based violence (SGBV), and services for victims;

- Prevention, detection and treatment of reproductive cancers;

- Information, counselling and services for infertility;

- Information, counselling and services for sexual health and well-being.[152]

2. Developing and advocating for legislative and policy solutions

Many countries have adopted reproductive health laws that specifically address the health rights of WCA. Nepal enshrined the right to reproductive health services, including abortion, in its 2015 Constitution.[153] Globally, parliamentarians committed to protecting the SRHR of women and adolescents in the 2017 IPU addendum, by using their "oversight and budgetary powers to ensure adequate funding for programmes and policies" related to SRH,[154] and by engaging communities in "awareness-raising campaigns on sexual and reproductive health with a focus on adolescents."[155] Implementing these rights nationally, however, is often a challenging process, since parliamentarians, governments, health-care providers and constituents may have differing views on a range of issues: what bodily autonomy means and how to guarantee it, how best to ensure access to safe abortions where provided for by the law, how CSE should be presented to adolescents, how to define, prevent and punish GBV, and how to extend confidential access to family planning services to women and adolescents.

The treatment of SRHR in international instruments shows that these rights are related not only to health, but also to other equity and empowerment goals. These instruments can also provide guidance for policymakers where gaps in national law exist. The

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152 Jesseca Boyer (2018), "A Time to Lead: A Roadmap for Progress on Sexual and Reproductive Health and Rights Worldwide", *Guttmacher Policy Review*, vol. 21, p. 37.
153 The Constitution of Nepal (2015), Art. 38(2).
154 2017 IPU addendum, point 2.
155 *Ibid.* at point 7.

SDGs, for instance, promote universal access to SRH services from both a gender equality and a health rights standpoint.[156] It can, however, prove difficult to implement and enforce SRHR laws and policies locally. As well as raising awareness of these laws and policies, parliaments can improve SRHR protections by adopting laws in related areas such as gender equality, adolescent pregnancy, harmful practices, and women's equal participation in public and political life – and by ensuring such laws are properly implemented.[157] These other laws and policies can help to secure buy in from law-enforcement officers, teachers and other front-line civil servants – especially at decentralized levels – in supporting SRHR for all. Parliamentarians can also support audits of existing laws and policies to secure special protections for marginalized groups, making sure they are included throughout the process of programme and policy development, implementation and evaluation.[158] In the Philippines, for instance, implementing the Responsible Parenthood and Reproductive Health Act (2012) has proven challenging. This example shows how enforcement can be difficult when the support of local governments and community groups is required.

> *In the Philippines, Congress debated the Responsible Parenthood and Reproductive Health Bill for 14 years before it was finally adopted in 2012. Conservative groups continued to challenge the law in the Supreme Court. Some of these challenges were successful, and portions of the act were struck down. A revised version of the act eventually moved forward for implementation in 2017. Some of the successful challenges limited adolescents' access to SRH services and allowed officials to refuse to implement the law without the threat of criminal punishment.[159] Others hinged on the Constitution, which recognizes the sanctity of life and calls on the State to equally protect the life of a mother and the life of an unborn child "from conception". These challenges attempted to limit access not only to abortion, but also to certain types of approved contraception.[160] While President Duterte strongly supports the act and its advances for SRHR, the country's decentralized health system means that "local government implementation of family planning is dependent on the priorities, capacities and personal beliefs of local government officials and local health officials."[161] The Philippines has the fastest-growing HIV infection rate in the Asia-Pacific region.[162] It also has a high rate of adolescent pregnancy, with 8.6 per cent of adolescent women in the age group 15–19 having already begun childbearing.[163]*

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156 SDG 3 (health and well-being), SDG 5 (gender equality).

157 International Planned Parenthood Federation (2015), *Sexual and reproductive health and rights – the key to gender equality and women's empowerment*, p. 7.

158 Manjulaa Narasimhan, Ian Askew and Sten H Vermund (2016), "Advancing sexual and reproductive health and rights of young women at risk of HIV", comment, *The Lancet*, vol. 4, issue 10, p. 684.

159 Cristyn Lloyd, "Whatever happened to the Philippines' reproductive health law?" Southeast Asia Globe, 24 July. https://southeastasiaglobe.com/whatever-happend-to-the-philippines-reproductive-health-law/.

160 The Constitution of the Republic of the Philippines (1987), Art. II, Sec. 12.

161 *See* Cristyn Lloyd, *supra* n. 143.

162 *See* UNAIDS (2018), *Miles to go - Global AIDS Update 2018*, p. 206.

163 Philippine Statistics Authority/USAID (2017), *National Demographic and Health Survey – Philippines*, p. 69.

3. Mobilizing financing

Domestic resources – State resources and individual out-of-pocket expenditures combined – cover a large proportion of SRHR expenses in less developed countries.[164] Although some ODA is spent on SRHR, HIV/AIDS reduction takes the lion's share and there is less emphasis on family planning.[165] Moreover, the re-adoption of the global gag rule has further reduced the amount of ODA available for SRH services.[166] Since SRHR interventions rely heavily on domestic resources, parliamentarians can advocate for more investment by demonstrating how improving access to family planning and other SRH services yields dividends and financial savings for both the health system and the State. High-income countries, which do not rely on ODA, also face challenges in mobilizing financing for SRHR due to social stigmas, regressive policies and discrimination against marginalized groups. In the United States, for instance, the Title X Family Planning Program provides access to SRHR services for low-income patients, adolescents and other underserved groups.[167]

While SRHR funding has faced challenges, the cost of expanding access to contraception is surprisingly low. In less developed regions where contraceptive use is limited, the cost of expanding access to contraceptives is about US$ 1 per person per year.[168] Indeed, meeting all women's unmet contraceptive needs in developing regions, including expanding access and scaling up services, would cost about US$ 1.93 per person per year.[169] Estimates put the cost of delivering CSE at between US$ 7 and US$ 33 per student in Nigeria, India, Estonia and the Netherlands, although the estimated cost is higher in countries that rely on international organizations to pilot and implement these programmes.[170]

4. Strengthening accountability and engagement

For parliamentarians, SRHR-specific oversight and accountability strategies include securing women's and adolescents' representation in existing health programmes, and ensuring that the health-sector coordinates efforts with other sectors that impact SRHR.[171] Parliamentarians can also ensure that all maternal deaths are reported to a central authority and that health facilities review all such deaths.[172] Other measures include introducing universal birth registration and having a "passport to protection" for girls and women – moves that will improve vital statistics systems and support accurate data collection and proper accountability in SRH service delivery and accessibility.[173]

164 High-Level Task Force for ICPD (2015), "Policy Considerations for Financing Sexual and Reproductive Health and Rights in the Post-2015 Era", *Reproductive Health Matters* vol. 23, issue 45, 159–163, p. 160.

165 *Ibid.*

166 Heather D. Boonstra, "The Global HER Act Would Repeal the Harmful Global Gag Rule", Guttmacher Institute, 7 February 2019. www.guttmacher.org/article/2019/02/global-her-act-would-repeal-harmful-global-gag-rule.

167 *See* Jesseca Boyer (2018), *supra* n. 153, at p. 38; www.hhs.gov/opa/title-x-family-planning/index.html.

168 Guttmacher Institute (2017), *supra* n.149, at p. 3.

169 *Ibid.*

170 Jari Kivela, Evert Ketting and Rob Baltussen (2013), "Cost analysis of school-based sexuality education programs in six countries", *Cost Effectiveness and Resource Allocation*, 11:17, p. 5.

171 WHO (2015), *Every Woman, Every Child, Every Adolescent: Achievements and Prospects: The Final Report of the independent Expert Review Group on Information and Accountability for Women's and Children's Health*, p.62.

172 WHO (2014), *Every Woman, Every Child: A Post-2015 Vision: The Third Report of the independent Expert Review Group on Information and Accountability for Women's and Children's Health*, pp. 39–40.

173 WHO (2015), *supra* n.156, at p. 6.

Public engagement is critical to the effectiveness of SRHR policies and interventions, and to effective service delivery. Engaging with communities also raises awareness of the importance of SRHR. Men and boys must also be appropriately involved in policy development and implementation because they have a key role to play in family planning decisions.[174] Adolescent participation is just as crucial, since adolescence is an important time for preventing unwanted pregnancies and STI transmission, and for improving SRHR knowledge and practices.[175] Ministries of health and other stakeholder institutions should publish certain SRHR implementation and access information. But parliamentarians must exercise caution in how these data are monitored and interpreted, since they can equally be used to misinform the public.[176] Parliamentarians can also strengthen accountability by making sure disclosure requirements detail what information and data must be made public, and they can further demonstrate their commitment to SRHR through public oversight of institutions that fail to comply with these requirements. Rwanda, for instance, has made family planning a national priority, supported by a clear and comprehensive implementation plan reaching all the way to the lowest levels of local governance. This example should serve as a model for parliamentarians considering how to engage the public and important stakeholder institutions in advancing SRHR.

> *In Rwanda, the contraceptive prevalence rate increased more than tenfold in just 10 years. In 2000, only 4 per cent of married women of reproductive age were using modern contraceptive methods. By 2010, that figure had risen to 45 per cent.[177] Rwanda's success can be attributed to strong political support for family planning at a time when gender equality and women's empowerment were becoming national cross-cutting priorities across all sectors, programmes and levels of government.[178] The country also invested in CHWs, who educated citizens about the importance of family planning and referred individuals to appropriate service providers for treatment, procedures and contraceptives.[179] Building on this positive momentum, Rwanda also started an ongoing, national conversation about family planning, tying this process to monthly community-work days (*umuganda*), with relevant announcements and discussions following community efforts to improve local roads, schools and other infrastructure.[180] This focus on CHWs as representatives of and to communities, coupled with consistent public engagement and community conversations about family planning, continues to yield results. In 2015, some 48 per cent of married women were using a modern contraceptive method,[181] and almost all sexually active men and women, both married and unmarried, had knowledge of at least one such method.[182]*

174 UNFPA (2017), *Engaging Men in Sexual and Reproductive Health and Rights*, Sec. I.

175 *See ibid.* at Sec. b.4.

176 WHO (2015), *supra* n. 156, at p. 66: "CoIA envisaged that by 2013, all stakeholders would be publicly sharing information on commitments, resources provided, and results achieved nationally and globally. As our Country Profiles show, there is a complete absence of data to measure progress towards this recommendation."

177 *See* data.worldbank.org/indicator/SP.DYN.CONM.ZS?locations=RW.

178 USAID (2012), Three Successful Sub-Saharan Africa Family Planning Programs: Lessons for Meeting the MDGs, p. 21.

179 *Ibid.* at pp. 24–25.

180 *Ibid.* at p. 22.

181 National Institute of Statistics of Rwanda, Ministry of Health (Rwanda) and ICF International, *Rwanda Demographic and Health Survey 2014-15*, p. 85. https://dhsprogram.com/pubs/pdf/FR316/FR316.pdf

182 *Ibid.* at p. 84.

PARLIAMENTARY ACTION FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

1. Identifying the problem or gap

- *Audit health laws and policies, as well as gender equality, empowerment and other non-health laws, to see how they impact implementation of SRHR laws and policies.*
- *Ensure that national policies and laws prioritize interventions that promote access to SRHR, including safe abortions and post-abortion care where legal.*
- *Consult constituents, CSOs and partners to understand the extent to which SRHR laws and policies cover marginalized groups.*

2. Developing and advocating for legislative and policy solutions

- *Adopt laws and policies that promote access to SRHR for all, and specifically for WCA, and take steps to remove legal barriers to access.*
- *Plan and run community awareness-raising activities for your constituents on SRHR policies and programmes.*
- *Ensure that all people – women and girls, men and boys – are consulted on SRHR policy development.*
- *Extend access to family planning and address unmet family planning needs.*
- *Make antenatal care more affordable and more widely available.*
- *Make the HPV vaccine and cervical cancer screening more widely available.*

3. Mobilizing financing

- *Quantify the cost of national investment in contraceptives and CSE in your country.*
- *Determine any additional data you need to illustrate the high cost of not providing family planning and other SRH interventions.*
- *Audit existing policies and programmes, such as education programmes, to see whether and how SRHR services could be incorporated, and to identify potential cost-control opportunities.*
- *Review funding for SRHR in the national budget, as well as other sources of funding.*

4. Strengthening accountability and engagement

- *Audit existing health laws and policies, and how these laws and policies are implemented, to see whether and how they reflect the unique needs of WCA, and how their rights are ensured.*
- *Require all maternal deaths to be reported to a central authority or agency.*
- *Introduce universal birth registration.*
- *Assess public disclosure requirements in SRHR laws and policies for relevant agencies and ministries, make improvements as necessary, and ensure remedies are available and protected by law.*

Women drying chili pepper in Bangladesh.
© NURPHOTO/Kazi Salahuddin Razu

e. Empowerment of women, girls and communities

Empowerment of women, girls and communities is closely linked to the health rights of WCA. When women are empowered, they have fewer children, enjoy better access to work opportunities, are more likely to access health services, and are less likely to experience domestic violence. These positive health outcomes are passed on to the next generation, since empowered women's children are more likely to survive and receive better childcare and health care.[183] Empowerment and health also come together around a number of other specific issues. These include early and forced marriage (EFM); harmful practices such as FGM and VAW; women's, girls' and adolescents' participation in decision-making for SRHR and other health matters; and gender-responsive budgeting, especially in health programming and policies.

183 Partners in Population and Development/PMNCH (2013), *Promoting women's empowerment for better health outcomes for women and children*, p. 2. www.who.int/pmnch/knowledge/publications/strategybriefs/sb_gender.pdf.

1. Identifying the problem or gap

While the empowerment challenges that affect health and health access can be complex, understanding them can lead to better, more relevant and more effective policies. Where women and communities are empowered, they can better advocate for themselves and their health, and they enjoy better access to health services. Empowerment challenges, such as VAW and harmful practices like FGM and EFM, affect the health of WCA in specific ways, by increasing rates of HIV and STI infection, abortion, low birth weight and premature births, alcohol use, depression and suicide, and death from homicide.[184] One third of women worldwide will experience VAW or intimate partner violence (IPV) in their lifetimes.[185] Yet VAW is also linked to other health indicators such as adolescent pregnancy, other unintended pregnancy, miscarriage, stillbirth, intrauterine haematoma, nutritional deficiency, gastrointestinal problems, anxiety and post-traumatic stress disorder, and NCDs such as hypertension, cancer and cardiovascular diseases.[186] Some 40 per cent of girls in the least developed countries are married before age 18,[187] and this practice strongly correlates to high rates of childbearing, including early childbearing. In fact, pregnancy and childbirth complications are the leading cause of death among girls in the age group 15–19.[188]

Where available data are used in the context of health and empowerment to identify gaps in the legal and policy framework, parliamentarians can advocate for data to be disaggregated by sex and other characteristics such as income and region. Having disaggregated data helps to identify disparate impacts or outcomes, and to improve policy effectiveness.[189] Parliamentarians need to work closely with CSOs and other partners to put the data into context and use it to support effective policy solutions. The focus on empowerment in the EWEC Global Strategy 2016–2030 and the SDGs further underscores the need for parliamentarians to consider cross-sectoral policy approaches and empowerment outcomes when designing policy solutions to WCAH issues. For example, community mobilization around family planning and reproductive health, and the effective use of mass media to engage communities and individuals, especially women and girls, in protecting their health, can be important gaps in empowerment and health.[190]

> *The Women's Empowerment Principles (WEPs) include the following health-related action on gaps, and indicators:*
>
> - *Assess and understand differential impacts on women and men in different work environments, especially potential risks to reproductive health.*
>
> - *Establish a zero-tolerance policy towards violence and harassment at work.*

184 WHO (2013), *Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-partner Sexual Violence*, p. 21. Geneva.
185 WHO, "Violence Against Women: Key Facts", 29 November 2017. www.who.int/news-room/fact-sheets/detail/violence-against-women.
186 WHO (2013), *supra* n.169, at pp. 21–22.
187 UNICEF (2019) *Child marriage*. Geneva. https://data.unicef.org/topic/child-protection/child-marriage/.
188 Girls Not Brides, "What is the impact of child marriage: Health". www.girlsnotbrides.org/themes/health/ (accessed 25 July 2019).
189 Partners in Population and Development/PMNCH (2013), *supra* n. 168, at p. 4.
190 WHO (2017), *An evidence map of social, behavioural and community engagement interventions for reproductive, maternal, newborn and child health*, pp. 48–49.

- *Improve access to employer-sponsored health coverage and access to health services.*

- *Respect women's and men's rights to take time off work for medical care for themselves and their dependents.*

- *Establish protections for the safety of women and men travelling to and from work.*

- *Encourage employers to train security and other staff to recognize signs of VAW, human trafficking and similar issues.*[191]

2. Developing and advocating for legislative and policy solutions

While only 12 per cent of States have stand-alone constitutional provisions on women's rights, almost all national constitutions recognize the right to equality according to various protected classifications, including sex.[192] Many countries have national laws that include specific and direct protections for women's empowerment, such as gender equality laws or laws that criminalize GBV, EFM and FGM. In many States, there is also a legal requirement to employ gender-responsive budgeting in public programmes, which can support empowerment policies and programmes. National gender equality laws may also directly address women's rights to health. For instance, Thailand's Gender Equality Act establishes a Gender Equality Promotion Committee, but the definition of "unfair gender discrimination", for which the committee is responsible, is limited to one sentence in the act.[193] Vietnam's Law on Gender Equality aims to achieve equality in socioeconomic development for men and women. It addresses women's equal rights to access health information and services, including reproductive health matters such as contraceptive use, and includes a special provision for disadvantaged women to receive SRH services.[194]

Women's empowerment, and its link to WCAH, is also reflected in international instruments. In the 2017 IPU addendum, parliamentarians affirmed that "gender is a key determinant of health". They stated their support for gender-sensitive budgeting to address the health needs of women and girls, and pledged to "address the social, economic and cultural burdens that cause many of the inequalities between the health status of women and men."[195] The addendum also calls for reaching out to the most marginalized WCA,[196] and for collaboration across sectors, to ensure they are able to realize their rights to health.[197] States have also committed to achieving gender equality and empowering all women and girls in SDG 5, including ending all forms of discrimination, and eliminating all forms of violence and all harmful practices against women and girls, including VAW, EFM and FGM.[198]

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191 UN Women (2011), *Women's Empowerment Principles: Equality Means Business*, p. 6. www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2011/10/women-s-empowerment-principles_en%20pdf.pdf?la=en&vs=1504.

192 UN Women (2017), *Policy brief no. 8: Why and how constitutions matter for advancing gender equality: Gains, gaps and policy implications*, p. 2.

193 Gender Equality Act, Thailand (2015), Sec. 3.

194 The Law on Gender Equality, Vietnam (2006), Art. 17.

195 2017 IPU addendum, point 6.

196 IPU (2017), *supra* n. 26, at point 8.

197 *Ibid.* at point 10.

198 *See* CRC, Art. 24; CEDAW, Art. 2(f) and 5(a); CEDAW General Recommendation 14 & 19, Committee on the Elimination of all Forms of Discrimination Against Women, A/45/38 (1990); UN General Assembly Resolution 48/104, Declaration on the Elimination of Violence Against Women (1993) (protects women from VAW and also specifically identifies FGM as a form of VAW).

In some countries, parliamentarians will need to adopt laws banning harmful practices in order to uphold these international commitments on empowering women, girls and communities. It can, however, prove challenging to enforce empowerment-related laws and policies for WCAH, with much depending on local law-enforcement agencies and communities. Banning early and forced marriage, for example, requires law-enforcement officials to be willing and able to arrest those who break the law. Communities and their leaders must be made aware that early and forced marriage and other harmful practices are illegal and carry health risks, and must have a working relationship with law enforcement in order to protect girls from these practices. Parliamentarians can play their part by supporting the creation of a dedicated child protection unit, with officers specially trained to prevent practices such as EFM and FGM. A gender desk or unit can also support efforts to enforce VAW and IPV laws. Specially trained female officers could be tasked with receiving reports of VAW and other harmful practices, as part of a confidential reporting procedure. When women and girls report incidents of VAW and IPV, law-enforcement agencies could refer them for appropriate care.

3. Mobilizing financing

When women are economically empowered, their families can earn more income, and they are better able to meet the financial demands of their families, including health costs. Empowered women are more mobile and have greater agency, meaning they are better able to access health services. They are also in a stronger position to advocate for their own health and the health of their children. Likewise, investing in women's health and empowerment is good for business: healthy and empowered women spend less time off work, are less prone to unwanted pregnancies, and are less likely to suffer from diabetes and other chronic conditions.[199]

In less developed countries, gender equality and women's empowerment programmes have tended to rely heavily on ODA for funding.[200] Yet in 2015–2016, only 4 per cent of bilateral aid had gender equality as its main objective – a figure that has not moved substantially since 2010.[201] In the same period, gender equality was a secondary objective for 33 per cent of bilateral aid, while 63 per cent failed to target gender equality at all. Moreover, in the economic and productive sectors, where there are cross-sectoral linkages with women's empowerment and health, only 1 per cent of aid targeted gender equality.[202] Blended financing models, which combine ODA or other public funding with private-sector funding, can also be used for women's economic empowerment, where links to women's health access and health knowledge can be made.[203] Where such models are employed, the ODA or public funding component

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199 *See, e.g.*, McKinsey Global Institute (2015), *The Power of Parity: How Advancing Women's Equality Can Add $12 Trillion to Global Growth*, p. 45; "HERproject: Investing in Women Workers for Health and Business Returns", 1 June 2010, BSR.org. www.bsr.org/en/our-insights/case-study-view/herproject-investing-in-women-workers-for-health-and-business-returns.

200 In recognition of the importance of empowerment for WCAH, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the world's largest public health funder, launched a Gender Equality Strategy Action Plan in 2014 in order to promote WCAH through empowerment initiatives and incorporate empowerment into other health financing and programmes. The Global Fund (2014), *Gender Equality Strategy: Action Plan 2014-2016*. www.theglobalfund.org/media/1247/publication_genderequalitystrategy_actionplan_en.pdf.

201 Jorge Moreira da Silva, "Can Blended Finance Help Fill the Gender Equality Funding Gap?", Women Deliver, 26 September 2018. https://womendeliver.org/2018/can-blended-finance-help-fill-the-gender-equality-funding-gap/.

202 *Ibid.*

203 *Ibid.*

should be used to drive development outcomes and to hold programming and implementation to the highest quality standards.[204]

Domestic investments in gender equality and women's empowerment are also critical to helping WCA fully realize their rights to health. The costs to national economies of not investing in women's empowerment aspects of health are staggering: research has shown that the cost of VAW (including FGM and IPV) to the global economy stands at about US$ 1.5 trillion, or about 2 per cent of global GDP.[205] Moreover, failing to eradicate early and forced marriage by 2030 will cost the global economy trillions of dollars in welfare and health services for young mothers and their children.[206] The economic gains from ending early and forced marriage will increase over time, as those countries most affected see their economies and populations continue to grow at a steady rate.[207] Pakistan's Lady Health Worker Programme shows how a health-empowerment programme can yield economic benefits while at the same time improving women's health outcomes.

> *Under the Government of Pakistan's Lady Health Worker Programme, over 100,000 women were employed as CHWs to bring reproductive health information and services to women in their communities.[208] As well as reaching women who may otherwise not have had access to reproductive health services, the programme also elevated the social position of the women health workers and raised the profile of women in the health-care profession. The programme achieved a double economic dividend because beneficiaries reported that they felt more empowered to make decisions about family planning and health.[209]*

4. Strengthening accountability and engagement

Women's empowerment, and its impacts on health, require a multisectoral response involving stakeholders from a wide range of sectors including health, justice and law enforcement, education, child protection, economy, food security and nutrition, and youth participation.[210] Some countries have an independent gender equality body that can monitor women's empowerment and health programmes and interventions. For instance, Rwanda's Gender Monitoring Office[211] is mandated to monitor gender mainstreaming, the fight against GBV, and progress towards gender equality.[212] Similarly, the Zimbabwe Gender Commission, which is established in the Constitution,

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204 OECD (2018), *OECD DAC Blended Finance Principles for Unlocking Commercial Finance for the Sustainable Development Goals*, p. 6.

205 *See* remarks by UN Assistant Secretary-General and Deputy Executive Director of UN Women, Lakshmi Puri, at the high-level discussion on the economics costs of violence against women, 21 September 2016. www.unwomen.org/en/news/stories/2016/9/speech-by-lakshmi-puri-on-economic-costs-of-violence-against-women.

206 Save the Children (2018), *Working together to end child marriage: How governments can end child marriage by accelerating coordinated action across education, health, protection and other sectors*, p. 3.

207 Quentin T. Wodon and others (2017), *supra* n. 50, at p. 61.

208 Partners in Population and Development/PMNCH (2013), *supra* n.184, at p. 2.

209 *Ibid.* at p.2.

210 *See* Save the Children (2018), *supra* n. 191, at p. 4.

211 Constitution of the Republic of Rwanda (2003), as amended to date, Art. 185.

212 *See* Gender Monitoring Office – Gender Accountability for Sustainable Development (n.d.). www.gmo.gov.rw/index.php?id=188 (accessed: 10 April 2019).

is responsible for monitoring issues related to gender equality through research, investigations, advocacy and, where applicable, support for criminal prosecutions.[213]

On a similar note, beneficiaries and communities must participate in overseeing health services and holding providers to account.[214] Women and communities must be involved at every level of the system – locally, where a large share of health-care decisions are made, right up to nationally, where policies and strategies are set.[215] At the same time, providing women and communities with opportunities to hold health systems and service providers accountable contributes to their empowerment.[216] In practical terms, the law must provide a way for users to complain about health services, especially poor quality of care involving differential treatment of women, and such complaints must be channelled to the right places. For accountability reasons, it is particularly important to track certain procedures such as forced sterilizations, caesarean sections and some hysterectomies, as well as instances where women with HIV/AIDS are denied treatment.[217]

In terms of engagement, parliamentarians can work with communities and local leaders to determine key health and empowerment issues and design locally responsive solutions. While engaging women and girls is an important part of the policy development and monitoring process, engaging men and boys, and making them aware of the issues, will also lead to more effective policy implementation for empowerment and health rights. Parliamentarians, working with communities and local leaders, are uniquely positioned to advocate for programmes that empower women with health knowledge, and promote broader gender equality goals by equipping women to be leaders in such programmes.

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213 Constitution of Zimbabwe (2013), as amended to date, Sec. 246.
214 *See* Pan American Health Organization (PAHO), *Guide for analysis and monitoring of gender equity in health policies*, p. 77.
215 *Ibid.* at p. 78.
216 *Ibid.*
217 *Ibid.* at p. 79.

PARLIAMENTARY ACTION FOR EMPOWERMENT OF WOMEN, GIRLS AND COMMUNITIES

1. Identifying the problem or gap

- *Ensure that population data collected by the national statistics office are disaggregated by factors such as sex, region and income level.*
- *Assess the existing policy response to empowerment issues such as VAW, EFM and FGM, as well as to health access issues, by working with partners and CSOs to identify the issues and root causes of health-empowerment challenges.*
- *Identify challenges in women's economic participation that may be impacting their health (see discussion of Women's Empowerment Principles above).*
- *Assess existing community mobilization efforts around family planning and reproductive health.*
- *Assess how mass media is used to engage communities and individuals, especially women and girls, in protecting their health, and whether such usage is effective.*

2. Developing and advocating for legislative and policy solutions

- *Audit existing laws on health and gender equality to determine whether they reflect empowerment of women, girls and communities.*
- *Review crime statistics on the enforcement of VAW, EFM and FGM laws.*
- *Create or empower special women's and children's protection units within law enforcement to deal with these crimes and to refer survivors to appropriate and confidential health services.*

3. Mobilizing financing

- *Consider blended international–domestic funding models to drive empowerment in health financing.*
- *Require gender-responsive budgeting in economic sectors and create opportunities for health and economy officials to collaborate on policy.*

4. Strengthening accountability and engagement

- *Review existing gender monitoring arrangements, and review mechanisms and agencies to determine whether health-sector issues fall under their mandate.*
- *Review complaints mechanisms and accountability procedures for national health services to ensure that relevant agencies are accessible and responsive.*
- *Engage communities, including men and boys, in health policy design, development, monitoring and implementation, in order to obtain first-hand feedback from local users.*

Rohingya women refugees in a makeshift camp in Teknaff, Bangladesh.
© ANADOLU AGENCY/Zakir Hossain Chowdhury

f. Humanitarian and fragile settings

One in every 70 people in the world is living in a humanitarian crisis and needs assistance.[218] Humanitarian and fragile settings include conflict, displacement, epidemics and natural disasters. The health needs of WCA in such settings include basic health services, mental health services, food security, access to safe drinking water and sanitation, and protection from sexual abuse and exploitation. Family planning resources and prenatal care can be almost non-existent in humanitarian settings, especially in the early phases of a crisis, while rates of sexual violence, FGM and early and forced marriage often increase. The average humanitarian crisis now lasts for nine years.[219] Efforts to protect the rights of women and children in the midst of a humanitarian crisis must focus on access to health care, SRHR and preventing sexual violence.

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218 United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) (2019), *Global Humanitarian Overview*, p. 4. www.unocha.org/sites/unocha/files/GHO2019.pdf.
219 *Ibid.*

1. Identifying the problem or gap

Organizations delivering aid and services in humanitarian and fragile settings do so with limited resources, infrastructure and access, and often have to deal with different types of response. Up to 124 million people were living in food insecurity in 2017,[220] and crises also impact empowerment and opportunity, with girls in conflict settings being 2.5 times more likely than boys to be out of school.[221] Although international humanitarian law prohibits sexual violence in times of war,[222] rates of EFM and sexual violence nevertheless increase. Over 80 per cent of women report experiencing sexual violence in some of the worst conflict-affected areas, and up to 20 per cent do so in many other conflict zones.[223] The effects of heightened sexual violence often remain long after the conflict has ended.[224] Despite all this, GBV prevention and survivor support receive only a tiny proportion of humanitarian funding.[225] Yet the protracted nature of modern-day conflicts takes a lasting toll on public health – not just during the crisis itself but for many years to come, as people miss out on education and struggle to access reproductive and other health services.

The lack of reproductive health services in a crisis can have far-reaching impacts. Over 60 per cent of preventable maternal deaths occur in countries experiencing humanitarian crises,[226] and up to 17 per cent of all maternal deaths worldwide occur in humanitarian settings.[227] Access to family planning resources can prevent up to 32 per cent of maternal deaths and up to 10 per cent of child deaths,[228] yet unmet family planning needs can come close to 40 per cent in conflict zones.[229] Children and infants living near conflict-affected areas are also more likely to die prematurely, and mortality rates remain above average for many years after the conflict ends.[230] In Uganda, health service delivery was successfully adapted to a humanitarian setting. This example serves as a road map for parliamentarians facing similar issues within their borders.

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220 Food Security Information Network (2018), *Global Report on Food Crises*, p. 2. Rome. https://docs.wfp.org/api/documents/WFP-0000069227/download/?_ga=2.92279262.299860260.1564170475-845857020.1564170475.

221 UNOCHA (2019), *supra* n.203, at p.4.

222 *See* International Committee of the Red Cross (ICRC), "How Does Law Protect in War? Sexual Violence in Armed Conflict". casebook.icrc.org/highlight/sexual-violence-armed-conflict (accessed: 16 July 2010).

223 Emma Sidebotham, Joanne Moffatt and Kevin Jones (2016), "Sexual violence in conflict: a global epidemic", commentary, *The Obstetrician & Gynaecologist*, vol. 18, p. 247.

224 *See* Jennifer J. Mootz, Sally D. Stabb, and Deborah Mullen (2017), "Gender-Based Violence and Armed Conflict: A Community Informed Socioecological Conceptual Model From Northeastern Uganda", *Psychology* of *Women Quarterly*, vol. 41:3.

225 EWEC (2017), *Advocacy Roadmap: Humanitarian and Fragile Settings*, p. 2. www.everywomaneverychild.org/wp-content/uploads/2017/02/Humanitarian_EWEC-Advocacy-Roadmap-2017_final.pdf.

226 Arthur Erken (2017), "Maternal deaths and humanitarian crises", correspondence, *The Lancet*, vol. 389*.* www.thelancet.com/action/showPdf?pii=S0140-6736%2817%2930949-2.

227 Helena Nordenstadt and Hans Rosling (2016), "Chasing 60% of maternal deaths in the post-fact era", comment, *The Lancet*, vol. 388. www.thelancet.com/action/showPdf?pii=S0140-6736%2816%2931793-7.

228 Sarah K Chynoweth, "Advancing reproductive health on the humanitarian agenda: the 2012-2014 global review", p.7, *in Reproductive Health in the Changing Humanitarian Context: Findings from the IAWG on Reproductive Health in Crises' 2012-2014 Global Evaluation*, Inter-Agency Working Group on Reproductive Health in Crises. http://iawg.net/wp-content/uploads/2016/08/IAWG-Global-Evaluation-2012-2014-1.pdf.

229 Lara S. Ho and Erin Wheeler (2018), "Using Program Data to Improve Access to Family Planning and Enhance the Method Mix in Conflict-Affected Areas of the Democratic Republic of the Congo", *Global Health: Science and Practice*, vol. 6:1, p. 162. Unmet family planning needs across all less developed countries stand at about 24 per cent. Guttmacher Institute, "Unmet need for modern contraception, 2017. www.guttmacher.org/infographic/2017/unmet-need-modern-contraception-2017 (accessed: 15 April 2019).

230 *See* Zachary Wagner and others (2018), "Armed conflict and child mortality in Africa: a geospatial analysis", *The Lancet*, vol. 392, pp. 861–863.

Uganda's Ministry of Health recognized the increased risk of material, newborn and child mortality in conflict settings and called in medical NGOs to design and deliver reproductive health services that met national standards in the conflict-affected north of the country. Reproductive health supplies were shipped to identified health clinics, and teams of mobile doctors and nurses were brought in to increase capacity and service provision. Over 80 per cent of the women who benefited from these services identified as unable to read or having difficulty reading, and almost 85 per cent had never finished primary school.[231] By the end of the three-year project, 22.6 per cent of women were using a modern contraceptive method (compared with a baseline of 7.6 per cent), and over 50 per cent of these women said they got their family planning supplies from a public health centre.[232] Over the same period, unmet family planning needs dropped by 16.4 per cent.[233]

2. Developing and advocating for legislative and policy solutions

Protecting WCAH in times of crisis carries unique challenges in ensuring continuity of services, access and equity of access. Fairly allocating domestic and international resources to WCAH needs can also prove complex. While saving civilians' lives is the first priority in an emergency, the protracted nature of refugee and humanitarian crises often demands a longer-term view, with more comprehensive services. WCA in conflict zones and humanitarian settings need special protections, and parliamentarians have a key role to play in ensuring that domestic and international aid work together to protect their health in particular. Parliamentarians can also take the lead in developing more comprehensive approaches to WCAH in emergencies by developing prevention, risk-reduction, preparedness, response and recovery plans with input from local governments and constituencies, and working closely with national and international humanitarian organizations.

There are a number of special legal and policy instruments that provide guidance on protecting WCAH rights in complex humanitarian emergencies.[234] The Global Action Plan on Promoting the Health of Refugees and Migrants, for instance, identifies the need for short- and long-term health interventions for refugees and migrants, continuity and quality of care, and mainstreaming of refugee and migrant health into global, regional and national health agendas.[235] The Inter-Agency Working Group on Reproductive Health in Crises,[236] meanwhile, has developed the Minimum Initial Service Package (MISP) as a framework for protecting reproductive health rights in a humanitarian crisis, including specific provisions for WCAH.[237]

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231 Sara E. Casey and others, "Availability of long-acting and permanent family-planning methods leads to increase in use in conflict-affected northern Uganda: Evidence from cross-sectional baseline and endline cluster surveys", *Global Public Health*, vol. 8:3, p. 289.

232 *Ibid.* at p. 289, 291.

233 *Ibid.* at p. 290.

234 In addition to specialized instruments, Section 10 of the ICPD PoA also affirms that refugee women and children have the right to access health services and information, and to participate in the planning of refugee assistance activities.

235 Promoting the health of refugees and migrants: Draft global action plan, 2019–2023, A72/25 Rev. 1, adopted at the 72nd Session of the World Health Assembly, 23 May 2019.

236 *See* http://iawg.net/ for an extensive range of resources and tools on implementing the MISP and managing reproductive health needs in humanitarian and fragile settings.

237 UNFPA, "What is the Minimum Initial Service Package?", April 2015. www.unfpa.org/resources/what-minimum-initial-service-package.

> ### *Five priorities for protecting and promoting reproductive health during emergencies (based on the MISP)*
>
> 1. *Identify an organization or agency to lead the implementation of the MISP and/or protection efforts for women's, children's and adolescents' health.*
>
> 2. *Take measures to prevent and manage the consequences of sexual violence by working with local law enforcement and/or developing ad hoc procedures for reporting and protection.*
>
> 3. *Reduce HIV and STI transmission through awareness-raising and condom provision.*
>
> 4. *Prevent maternal and newborn death and illness by facilitating prenatal care, emergency obstetric care, and support and awareness-raising around maternal and newborn health and nutrition.*
>
> 5. *Plan for comprehensive sexual and reproductive health care, integrated into primary health care insofar as possible.*
>
> *Parliamentarians can use these objectives as a road map for protecting WCAH rights in humanitarian and fragile settings.*

Although enforcing all rights in a humanitarian or fragile setting may be difficult, parliamentarians can take preventive action to fully protect WCAH rights before a conflict erupts. One way to do this is to ensure that all people enjoy the same basic rights to health and health access. Parliamentarians can also publicly condemn attacks on health facilities and health workers during conflicts, and take steps to hold other States and armed groups to account for violating international humanitarian law.

3. Mobilizing financing

In 2016, former UN Secretary-General Ban Ki-Moon put forward an Agenda for Humanity to address people's immediate humanitarian needs, transcending humanitarian and development divides and contributing to longer-term development gains.[238] The Grand Bargain, an agreement between large donors and aid providers, builds on these principles by aiming to ensure that more of the funding allocated to help people in crisis actually reaches its intended recipients. It encourages donors to harmonize their reporting requirements, deliver more direct cash aid, raise the share of humanitarian aid going to local and national responders to 25 per cent, and increase multi-year funding commitments to improve consistency and predictability in response and development.[239] These changes in the way humanitarian aid is delivered are predicted to generate an extra US$ 1 billion over five years for people in need.[240] Parliamentarians have a responsibility to ensure that donors honour their commitments and invest along these lines, and can advocate for additional funding, for monitoring, and for programmes to be brought in line with the Grand Bargain.

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238 Agenda for Humanity: Platform for action, commitments and transformations. https://agendaforhumanity.org/ (accessed: 26 July 2019).

239 *See* High-level Panel on Humanitarian Financing (2016). *Report to the Secretary-General: Too important to fail—addressing the humanitarian financing gap*.

240 Initiative: Grand Bargain, Agenda for Humanity, www.agendaforhumanity.org/initiatives/3861 (accessed 19 July 2019).

Another way parliamentarians can protect WCAH in emergencies is by advocating for reproductive health funding in humanitarian and fragile settings. Official development assistance for reproductive health in conflict-affected countries is almost 300 per cent higher than it was in 2002.[241] Yet in less developed regions, non-conflict-affected countries received almost 60 per cent more ODA per capita for reproductive health than their conflict-affected counterparts, even though needs are greater and more urgent in times of conflict.[242] Between 2009 and 2013, fewer than 15 per cent of humanitarian appeals mentioned family planning.[243] The New Way of Working (NWOW) calls on humanitarian and development actors to work collaboratively together to reduce risk and vulnerability in future crises.[244] Parliamentarians should build on this guidance to ensure that funding is directed to reproductive health in emergencies, and that humanitarian and development actors pool their expertise to protect WCAH in both the short and long terms.

There are various innovative financing and funding mechanisms to help States address the challenges of supporting refugee health. Some examples are given below:

- *The World Bank, through the Learning on Gender and Conflict in Africa (LOGiCA) trust fund, supported a cognitive processing therapy programme for survivors of sexual violence in conflict. The evaluation found significantly lower levels of anxiety, depression and post-traumatic stress disorder (PTSD) among survivors who received the therapy.[245]*

- *The Global Concessional Financing Facility (GCFF), part of the World Bank Group, provides lower-rate International Bank for Reconstruction and Development (IBRD) loans to middle-income countries affected by refugee crises.[246]*

- *The Contingent Emergency Response Component (CERC), another World Bank mechanism, allows countries to quickly re-allocate up to 5 per cent of undisbursed investment project balances following a crisis, including to refugee health interventions.[247]*

- *The Central Emergency Response Fund (CERF), established by the UN General Assembly in 2005, funds humanitarian efforts with a focus on rapid response and underfunded emergencies.*

241 Preeti Patel and others, "Tracking official development assistance for reproductive health in conflict-affected countries: 2002–2011", p.61 *in Reproductive Health in the Changing Humanitarian Context: Findings from the IAWG on Reproductive Health in Crises' 2012-2014 Global Evaluation*. http://iawg.net/wp-content/uploads/2016/08/IAWG-Global-Evaluation-2012-2014-1.pdf.
242 *Ibid.* at p.63.
243 Sarah K. Chynoweth (2016), *supra* n.213.
244 *See* UNOCHA (2017), *New Way of Working*. www.agendaforhumanity.org/sites/default/files/20170228%20NWoW%2013%20high%20res.pdf.
245 World Bank, "Addressing Violence Against Women in War-Torn Regions", 9 December 2013. www.worldbank.org/en/news/feature/2013/12/09/addressing-violence-against-women-in-war-torn-regions (accessed: 15 April 2019).
246 Adanna Chukwuma and others, "Financing health services for refugee populations: how to pay the bill?" World Bank Blogs, 20 June 2010. Washington, D.C. http://blogs.worldbank.org/health/financing-health-services-refugee-populations-how-pay-bill.
247 *Ibid.*

- *Refugee health insurance schemes could be another way to provide for WCAH in humanitarian and conflict settings, especially where refugees are allowed to work or where donor organizations can pay the insurance premiums.*[248]

- *The International Committee of the Red Cross (ICRC) launched their "Humanitarian Impact Bond" in 2017, with social investors providing the initial capital to open physical rehabilitation centres in three conflict-affected countries in Africa.*[249] *At the end of the five-year term, outcome funders (mainly government donors) will pay back the social investors according to the results achieved.*[250]

4. Strengthening accountability and engagement

Emergencies typically involve multiple stakeholders, actors and legal regimes. For this reason, coordination is a critical component of accountability for WCAH. Parliamentarians can play an important oversight role by facilitating coordination between donors, implementers and other agencies and stakeholders, and by advocating for governance and oversight mechanisms that protect the rights of WCA to access health care and health information in emergencies. They can help build national health standards into the emergency response, strengthen prevention, risk reduction and preparedness, ensure WCAH issues are reflected in response, recovery and rehabilitation plans and, where feasible, mobilize national assistance to supplement the international response.[251] Parliamentarians can hold national government agencies and ministries to account for protecting WCAH in humanitarian and conflict settings, allocate funding to health-sector coordination efforts, and even create an ad hoc committee to monitor WCAH during the crisis. Parliamentarians can also hold relevant government agencies accountable for ensuring that women and adolescents are properly engaged in developing service delivery approaches that protect their rights, and have adequate redress mechanisms when their rights are violated.

In conflict, emergency and humanitarian settings, the rule of law and national governance often come under considerable strain. In cases where national governments are weakened and cannot fulfil their oversight and leadership role, parliamentarians can work with their regional counterparts to protect WCAH, and regional human rights institutions may provide some remedies and exert pressure for better governance and protections. Ad hoc efforts, led by parliamentarians in the region, could also prove effective in improving oversight where national parliamentarians are unable to act due to political pressures or resource issues.

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248 *Ibid.*

249 ICRC, "The world's first "Humanitarian Impact Bond" launched to transform financing of aid in conflict-hit countries", 6 September 2017. www.icrc.org/en/document/worlds-first-humanitarian-impact-bond-launched-transform-financing-aid-conflict-hit.

250 *Ibid.*

251 *See* Inter-Agency Working Group on Reproductive Health in Crises/Women's Refugee Commission (2011), *Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations: Distance Learning Module (Chapter 2)*, pp. 16–17.

**PARLIAMENTARY ACTION FOR HUMANITARIAN AND
FRAGILE SETTINGS**

1. Identifying the problem or gap

- *Assess the reproductive and other health needs of women and girls in any fragile or humanitarian settings within your borders.*
- *Understand the sexual violence risks that women and girls face in any fragile or humanitarian settings within your borders.*
- *Work with partners to understand service delivery gaps and limitations, such as sanitation, food aid and other health services, in any fragile or humanitarian settings within your borders.*

2. Developing and advocating for legislative and policy solutions

- *Determine whether the right to access health services applies to all people in your country and, if not, what you can do to extend that right.*
- *Work with partners and CSOs to develop prevention, risk-reduction, preparedness, response and recovery plans that provide special protections for the health and well-being of WCA.*
- *Evaluate health services that would be available in an emergency against the MISP, or adopt a policy to implement the MISP should an emergency occur.*
- *Condemn attacks on health facilities and health workers in emergencies.*

3. Mobilizing financing

- *Familiarize yourself with the Grand Bargain and ensure donor agencies are applying these standards to humanitarian aid.*
- *Advocate for humanitarian aid to be allocated to reproductive health needs in emergencies.*

4. Strengthening accountability and engagement

- *Ensure that donors, service providers, government and other stakeholders coordinate in addressing the health needs of WCA in emergencies by creating an oversight body or ad hoc oversight committee, allocating the necessary funding or developing another accountability mechanism or plan.*
- *Adopt plans and policies to implement national health standards in emergency settings.*
- *Assess and make contact with regional bodies and partners that might be able to assist in either exerting political pressure or demanding that governments and international partners be held to account in an emergency.*

Section III. Conclusion

Women, children and adolescents have the right to the highest attainable standard of health. Empowering them to realize this right yields many other social and economic dividends. While every country comes with its own set of challenges, parliamentarians have a range of tools at their disposal to address these challenges, whether they concern political will, resource mobilization, accountability or implementation.

Parliamentarians have committed to protecting women's, children's and adolescents' health through both international instruments and national law. The Sustainable Development Goals, the Every Woman Every Child Global Strategy 2016–2030 and the 2017 IPU addendum all affirm these commitments and provide detail and new perspectives on priorities and actions throughout the life course. For parliamentarians, the task now is to action these commitments in their own countries.

Parliamentarians must set bold, progressive national agendas that align with international commitments, and must ensure that relevant ministries and agencies work closely with local governments to safeguard the equitable and effective implementation of policies and programmes. It is incumbent on parliamentarians to hold governments to account for policy outcomes, to oversee budget appropriations and spending, and to make these oversight processes transparent and inclusive.

Efforts should focus on increasing early childhood development opportunities, making it easier for adolescents to access health information and services, improving quality, equity and dignity of care, expanding sexual and reproductive health and rights information and services, empowering women, children and adolescents to realize their rights to health, and protecting these rights in emergencies. These interventions will have a measurable and sustainable impact on women's, children's and adolescents' health.

Parliamentarians are uniquely positioned to shape the policy and legal environment in which these protections can flourish, to remove barriers that prevent women, children and adolescents from realizing their rights to health, to commission multisectoral assessment reports with independent reviews, and to nurture citizen engagement and accountability with strengthened remedy mechanisms.

By following the examples in this handbook and using the tools provided in the decision-making framework in Section I, parliamentarians can make a real difference to women's, children's and adolescents' health – not just through better, evidence-based national policymaking, but also through innovative, context-sensitive implementation solutions on the ground. Because, taken together, these local changes will add up to a global movement that advances women's, children's and adolescents' health worldwide. And parliamentarians will be at the forefront of that movement.

Annex: References

IPU handbook

- Handbook N° 21: Sustaining parliamentary action to improve maternal, newborn and child health, 2013

Databases and data portals
- EWEC Global Strategy 2016–2030 data portal

- WHO Maternal, Newborn, Child and Adolescent Health data portal

- World Bank Open Data

- Global Health Observatory (GHO) data

- UNICEF datasets

- Demographic and Health Survey data

Technical guidance
- Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights

- SDG Indicators metadata repository

International instruments
- International Conference on Population and Development Programme of Action (ICPD PoA), 1994

- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979

- Convention on the Rights of the Child (CRC), 1989

- International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966

Other resources
- Gavi

- The Global Fund to Fight AIDS, Tuberculosis and Malaria

- Global Financing Facility

- Global Concessional Financing Facility

- UN Central Emergency Response Fund

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