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IFMSA Policy Document Family Planning and Access to Contraception

Proposed by the Team of Officials

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Policy Statement

Introduction:

Autonomous choice over whether to have children, how many to have and the timing and spacing of children is a human right which has significant benefits to health and development across communities and population. Yet there is a high unmet need for services and products supporting family planning around the globe, which often correlates with a lack of implementation of other tools to promote development, such as access to education, highlighting the intersectional, multifactorial role that family planning plays with other sectors in sustainable development. The right to family planning can be achieved through universal access to reproductive health services such as contraceptive counselling and contraceptives and fertility treatments. There are multiple barriers to implementation and sustainability of these services. However, with comprehensive international and local strategy and collaboration between sectors and organisations, governments and NGOs, these barriers can be tackled.

IFMSA position

The International Federation of Medical Students' Associations (IFMSA) affirms that the decision to choose the number, timing and spacing of children is a human right, essential to the achievement of sustainable development. The realization of this right for all can be achieved through universal health coverage and access to services, including family planning services and accessible, affordable contraception. It is imperative that these are accessible to all, including young people, unmarried people, LGBTQIA+ community, people living in rural and remote locations and people from a low socioeconomic background. The IFMSA believes that the realization of reproductive health and rights begins with comprehensive sexuality education and that all people, especially women and girls, should be empowered and supported in autonomous decision-making over their own bodies and formation of family through reproduction.

Call to Action

IFMSA calls for **Governments** to:

- Adopt legislation to ensure equality of access to a broad range of contraception and other family planning methods and services including fertility treatments, regardless of gender, age, sexual orientation, ethnicity, socioeconomic status.
- Ensure that resources and funding are allocated to the continuous training of healthcare workers who provide family planning services.
- Integrate family planning into strategies and policies to achieve universal health coverage as well as develop policies on sexual and reproductive health and rights, providing comprehensive and evidence-based information concerning effective methods of family planning.
- Strengthen contraception supply systems and improve coordination of supply efforts to ensure universal access as well as promote and support community-based distribution of contraceptives.
- Provide adequate funding of domestic and international programs and services aimed at prevention and management of unintended pregnancies, including full provision of contraceptive methods and access to emergency contraception and safe abortion.



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- Decriminalize abortion and adopt legislation which protects unrestricted access to safe, comprehensive abortion care.
- Promote comprehensive sexual education at schools to empower adolescents to make autonomous choices over their sexual and reproductive health.
- Conduct and support ethical research on access to family planning and contraceptive services.

IFMSA calls for **NGOs and international agencies** to:

- Participate in, support and organize activities to raise awareness about family planning services, and their importance.
- Work with governments to facilitate access to family planning services through developing and implementing policies and providing resources.
- Work with communities to address concerns, fears and stigma surrounding family planning.
- Ensure meaningful youth participation in the development and implementation of policies and activities on family planning and access to contraceptives.

IFMSA calls for **universities and medical schools** to:

- Include evidence-based information on modern family planning methods including abortion in medical school curricula.
- Conduct ethical research on interventions and programs addressing barriers to accessing family planning and contraceptives as well as their improvement and development IFMSA calls for hospitals, health services and health service providers to:
 - Work closely with communities to facilitate education on family planning services and contraception
 - Ensure that sexual and reproductive health services including family planning services are accessible, equitable and evidence-based as well as culturally sensitive and relevant
 - Provide equal access to contraceptives to all groups, especially young people and adolescents, sex workers, people with disabilities, diverse sexual orientations and gender identities.
 - Provide continuous and updated training to health workers about the various methods of contraception and how to provide patient-centred family planning care as well as improving their cultural competences for family service delivery
 - Support ethically conducted research on access to family planning and contraceptive services.

IFMSA calls for **medical students and NMOs** to:

- Develop projects targeting medical students and doctors that increase awareness on evidence-based modern family planning and contraceptive methods to minimize the use of outdated and ineffective methods.
- Advocate for increased and non-discriminatory accessibility to effective, affordable contraceptive methods, safe abortion and infertility treatments by engaging with key stakeholders such as governments and by partnering with other civil society organizations.
- Promote gender equity for women and non-cisgender people in NMO activities and structures, internally and externally, to encourage sexual and reproductive autonomy, especially in vulnerable populations.



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Position Paper

Background information:

Autonomous choice over whether to have children, how many children to have and the timing and spacing of children is a human right [1]. This right, to choose and plan one's family, has significant benefits to health and development across communities and populations [2]. Indeed, family planning is essential to sustainable development and the 2030 agenda [5]. It is an integral part of the global movement towards ensuring quality of life for people alive today as well as generations to come.

Yet there is a high unmet need for services and products supporting family planning around the globe [3]. This need often correlates with a lack of implementation of other tools to promote development, such as access to education, highlighting the intersectional, multifactorial role that family planning plays with other sectors in sustainable development [4].

The right to family planning can be achieved through universal access to reproductive health services such as contraceptive counselling and contraceptives and fertility treatments. There are multiple barriers to implementation and sustainability of these services [1]. However, with comprehensive international and local strategy and collaboration between sectors and organisations, governments and NGOs, these barriers can be overcome.

Discussion:

International Recognition and grounding in human rights

While people, especially women, have been managing their reproductive health for thousands of years, it wasn't until the 1950's that the family planning movement began to take off with the first national population policy in India, the establishment of the International Planned Parenthood Federation and significant financial and technical aid for population programs in lower and middle income countries [6].

Today, reproductive rights, including the right to family planning, are well established under international law and human rights treaties. The right to health, self-determination and the principle of non-discrimination all supporting the right to decide freely over the number, timing and spacing of children [1]. Major International events have improved the progress of family planning throughout history, which include: the Committee on the Elimination of all Forms of Discrimination Against Women, the Committee on the Rights of the Child, the International Conference on Population and Development and the 4th World Conference On Women.

The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) (1979)
There are numerous articles in CEDAW which pertain to the right to family planning [7]. Article 10 specifies that women's right to education includes "access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning." Article 12 states parties shall take all appropriate measures to eliminate discrimination against women in health-care, including in services related to family planning. Article 16 guarantees women equal rights in deciding "freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights." The Committee also recommends that States prioritise the "prevention of unwanted pregnancy through family planning and sex education" [7].

Convention on the Rights of the Child (1989)

Article 24.2 (f) States "parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: To develop preventive health care, guidance for parents and family planning education and services" [8].



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International Conference on Population and Development (1994)

ICPD is a conference coordinated by the United Nations. The Program of Action (PoA) adapted during ICPD in Cairo in 1994 guided the work of the United Nations Population Fund (UNFPA) over its 20 year agenda. [2] The PoA not only defined reproductive health for the first time, as a “state of complete physical mental and social well-being...relating to the reproductive system” but also promoted sustainable population development through the realization of human rights, especially women’s rights and including the right to comprehensive, patient-centred family planning services. The PoA also promotes the right to a “safe and satisfying sex life,” adopting a sex-positive approach to family planning strategy. [9]

The 4th World Conference on Women (1995)

The 4th World Conference on Women, held in Beijing, strengthened language on reproductive health and rights introduced in the ICPD PoA. It called for governments to protect women and girls from violence including forced marriage and reproductive coercion and affirmed women’s right to “have control over and decide freely and responsibly on matters related to their sexuality including sexual and reproductive health, free of coercion, discrimination and violence.” [10].

Sustainable Development Goals (2016)

The UN Sustainable Development Goals (SDGs) build upon the work of the Millennium Development Goals and aim to guide sustainable development of populations until 2030. Consisting of 17 goals and 169 targets, the SDGs make specific references to family planning in Goal 3 on Health and Goal 5 on Gender Equality [5].

Goal 3: Ensure healthy lives and promote well-being for all at all ages.

Targets:

3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Goal 5: Achieve gender equality and empower all women and girls.

Targets:

5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

However, there are many more goals that are related to family planning. Ending poverty and hunger, ensuring quality education for all and promoting sustainable economic growth all rely on people’s, especially women’s access to family planning services [11].

Importance of family planning

Family planning enables people to make informed choices about their sexual and reproductive health. Family planning represents an opportunity for women to pursue additional education and participate in public life, including paid employment in non-family organizations. Additionally, having smaller families



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allows parents to invest more in each child. Children with fewer siblings tend to stay in school longer than those with many siblings [3]. Access to contraceptive information is central to achieving gender equality. When women and couples are empowered to plan whether and when to have children, women are better enabled to complete their education; women's autonomy within their households is increased; and their earning power is improved. This strengthens their economic security and well-being and that of their families. Cumulatively, these benefits contribute to poverty reduction and development [12].

Family planning also benefits maternal health and is one of the most powerful ways to reduce maternal mortality. In 2008, 44% of the world's maternal deaths were prevented because of contraceptive use. Contraceptives decrease maternal mortality through reducing the number of high-risk and high-parity births and reducing the number of unwanted pregnancies which will result in unsafe abortion [13]. Contraception is essential to prevent ill-spaced and timed pregnancies and births, which contribute to high infant mortality rates. Infant mortality and morbidity is also increased in infants whose mothers have died during birth [3]. Use of contraception also reduces vertical transmission of HIV from mothers to infants through the prevention of unwanted and unplanned pregnancies in people living with HIV or AIDS. Additionally, barrier method contraceptives provide protection against HIV and other STIs [3].

Current unmet need for contraception

Unmet need for family planning is defined as the percentage of women who are married or partnered, do not want any more children at all or within the next two years but are not using any contraceptive or method to prevent pregnancy. This definition can be divided into unmet need for limiting and unmet need for spacing of children [14].

However, both married and unmarried people have a need for contraception and family planning services [15]. Globally, 214 million women of reproductive age living in lower and middle income countries have an unmet need for contraception [16]. Unmet need for contraception is especially high among adolescents, migrants, refugees, urban slum dwellers and women in the postpartum period [17].

The global prevalence of use of contraceptives was 64% in 2015 from 55% in 1990. The prevalence of modern contraceptive use was 57.4% in 2015. However there are large regional discrepancies in unmet need for contraceptives [18]. In Africa only 28.5% of people reported use of a modern contraceptive in 2015. Men account for only a small subset of these prevalence rates with contraceptive options limited to condoms and sterilization [3].

In all regions except sub-saharan africa, the need for limiting contraception is higher than spacing. This is due to an overall trend of a smaller desired family size. Countries or areas with a rapidly decreasing desired family size may have increasing unmet need for contraception, without the supply and service systems to meet demand [14]. More rigorous research is required to understand regional and population discrepancies in unmet need for family planning [19].

Overview of contraceptive and family planning methods

Contraception delivery should be affordable for everyone, provided with dignity, autonomy and confidentiality and the decision should be made by a fully-informed patient, meeting their needs and perspectives [20].

Types of Contraceptives

Currently, contraceptives can be reversible or permanent (sterilization). The reversible methods are divided into three types based on their mode of action: barrier, hormonal and chemical.



Within barrier methods, we differentiate male and female condoms, contraceptive sponges, diaphragms and cervical caps. Their purpose is to prevent sperm from entering the uterus. It is worth mentioning that apart from preventing pregnancy, both male and female condoms, play a key role in preventing sexually transmitted infections.

Hormonal methods are the combined oral contraception, progestogen-only pill, implants, intrauterine devices (IUDs), injections (progestogen only or combined), patches and vaginal rings. Their main goal is to suppress ovulation and to thicken cervical mucus [3]. Apart from the hormonal influence, the copper intrauterine devices operate through damaging sperm due to a sterile inflammatory reaction [21].

Chemical methods are preparations with spermicides such as foams, creams and jellies, but also are contained in contraceptive sponges. They should not be used as an only contraceptive on account of their inefficient effectiveness, so they need to be always used along with another birth control method [22].

For new mothers whose menstruation has not returned it is possible to use a temporary contraceptive method called lactational amenorrhea method, which is exclusive breastfeeding of an infant less than 6 months old. There are also methods which are based on observation of the menstrual cycle and avoiding vaginal sex on 'fertile' days, however, these methods may not be as effective as barrier or hormonal methods [3].

Emergency contraception

Emergency contraception (EC) is colloquially called the "morning-after pill". It can prevent pregnancy if taken up to 72-120h of unprotected intercourse or contraceptive failure by blocking ovulation and thickening of cervical mucus or, if fertilization occurred, preventing an egg from implantation [23]. It should not be mistaken with abortion pills, because implantation has not yet occurred. Emergency contraception is not effective after implantation, thus cannot cause abortion of an embryo, nor a foetus [24]. There are no absolute medical contraindications and age limits for emergency contraception use and it can be used to prevent any unwanted pregnancy. In addition to different kinds of oral medication, copper-bearing intrauterine devices may be used as EC [25].

Emergency contraception was available in 148 countries in 2014. In 73 of these, it could be accessed without a prescription [26]. There is a strong correlation between EC being available, affordable and recognized as a contraceptive method increases the likelihood of its use. Only 15% of women who present for induced abortion had used emergency contraception to prevent the pregnancy, meaning that with greater availability and awareness of its EC, the number of abortions could be reduced [26].

Abortion

Abortion is not a contraception method and should be considered only as a family planning method. Annually, 227 million women get pregnant, 44% of these pregnancies are unplanned [27]. 56% of these unplanned pregnancies are terminated by abortion, 32% in unwanted childbirth, 12% in miscarriages. Each year there are approximately 56 million abortions performed worldwide, with 50 million in developing countries, most of which take place in the context of restrictive abortion laws. The lowest abortion rate is in Switzerland, 5/1000 women a year, and the largest in Pakistan, 50/1000 women a year [28].

Only 55% of abortions worldwide were safe, meaning 45% were unsafe (least safe and less safe combined) [29]. Three out of 4 abortions performed in Latin America and Africa were recognized as dangerous. Every year, around 4.7-13.2% of maternal deaths were associated with dangerous abortions and this is one of the most common mortality factors for pregnant women (8-11%). The annual cost of treatment of serious complications is 553 million dollars a year, an additional 375 million costs for comprehensive care after complications of dangerous abortions [30]. In countries where abortion is illegal or allowed only in special cases, a quarter of abortions were safe, while in countries with a liberal abortion law, nine in ten treatments are safe [28]. Aside from legal restrictions, access to safe abortion



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is limited by stigmatization, low availability of treatment facilities, high costs and lack of trained providers. Expanding access to safe abortion is an integral part of achieving the Sustainable Development Goals and protecting reproductive rights [31].

Infertility treatment

Infertility is defined by the World Health Organization as follows: “a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse”. It is divided into primary and secondary infertility. Primary infertility is when a couple have not previously conceived and birthed a live child, compared to secondary infertility, when a couple are unable to have a child but have had previous successful pregnancies [32].

In 2010, the prevalence of primary infertility was approximately 2% of child-seeking women globally, whereas secondary infertility in child-seeking women is estimated at approximately 11% prevalence, with 7.2% in the North Africa and Middle East region and 18.0% in the Central and Eastern Europe and Central Asia regions. The percentage of infertile men varies from 2.5% to 12% with the highest rate in Africa and Central and Eastern Europe [33]. It is estimated that nowadays one in every four couples in developing countries struggle with infertility [34].

Infertility being a significant problem worldwide should be treated in those who wish to have biological children. The treatment depends on the condition of partners' reproductive system. To improve sperm delivery and quality, hormonal treatment, surgery and management of delayed ejaculation can be offered. If there are ovulatory disorders, changes in lifestyle, hormonal and pharmacological therapy or surgery can be offered. Surgery can also be offered for tubal and structural uterine disease. Other methods that could be considered in infertility treatment are intrauterine insemination, in vitro fertilization (IVF), intracytoplasmic sperm injections, donor insemination and oocyte donation [35].

The most marked disparity in access to infertility care between developing and developed countries is the availability of IVF and intracytoplasmic sperm injections. In 2006 only 48 member states of WHO out of 191 had medical facilities offering IVF. In addition to the fact that the majority of couples affected by infertility live in developing countries, where timely diagnoses and treatment facilities may be lacking, the management in these countries may be unaffordable, while in some developed countries it is possible for IVF to be publicly funded [36].

In some cases, infertility can be prevented through early detection and treatment of STIs, promoting healthy diets and exercise, avoiding smoking, as well as regulation of environmental and occupational exposure to chemicals that may decrease sperm quality [37].

Barriers to access

Gender equality

Addressing gender when monitoring and evaluating family planning and reproductive health projects and interventions helps to ensure equity in access and benefits all. Gender discrimination and inequities limit access to good-quality reproductive health services. They also hinder women's ability to negotiate family planning and use contraception effectively. Though traditional gender roles generally place greater constraints on women's access to reproductive health programming, men face gender-related barriers too. Men may not feel comfortable accessing family planning services that are offered in primarily women-only spaces or may view family planning as a woman's issue. These norms contribute to a lack of use and development of male contraceptive methods [38]. Global frameworks have traditionally failed to adequately address the ways in which inequitable gender dynamics and masculinities play a role in perpetuating poor SRH (sexual and reproductive health) outcomes, a paradigm that ensures women continue to bear the responsibility of family planning, exacerbates gender inequalities, and leads to suboptimal health outcomes for men, women, and children [39]. Gender-based violence is an important factor regarding barriers to access to contraception and family



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planning - for women in violent relationships, not being able to control their own fertility may lead to bringing children into a violent home, while increasing dependence on the abuser, who will often control all finances. Reproductive coercion is also a form of gender-based violence which violates the right to self-determination over family planning decisions. If women are to fulfill their potential and break cycles of poverty and abuse, access to modern, female-controlled contraceptives is key [40].

Education

Lack of knowledge, misperceptions and exaggerated concerns about the safety of contraceptive methods are major barriers to contraceptive use. The emphasis on abstinence only education in many schools worldwide may have in part led to widespread miscomprehension of contraceptive effectiveness, mechanisms of action, and safety that can have an effect on contraceptive use and method selection. For example, many individuals have unfounded concerns that oral contraceptives are linked to major health problems or that IUDs carry a high risk of infection [41]. Many individuals also incorrectly believe certain types of contraception to be abortifacients [42]. WHO studies have shown that women in many underdeveloped countries do not have enough knowledge about contraception. Hence, women in Tanzania have little awareness about contraception and in Nigeria only 34% women have ever heard about contraception, while only 21% know about modern methods of contraception – the best known is a condom, then oral pills and an intrauterine device [43]. A systematic review of qualitative research demonstrates that young women's use of modern contraceptive methods in five developing countries is limited by a range of factors, which centre on lack of knowledge, obstacles to access, and lack of control. Use of hormonal methods was limited because of lack of knowledge and access and concern over side effects, especially fear of infertility. Although often more accessible, and sometimes more attractive than hormonal methods, use of condoms was limited by their association with disease and promiscuity and greater male control of this method. As a result young women often relied on traditional methods or abortion [44]. European countries face issues as well - according to recent studies, young people receive their information on sexual education from various sources, most notably role models' channels on YouTube followed by Wikipedia and social media platforms. Yet, only 11 countries in Europe have very good or excellent government supported websites providing thorough, evidence-based and practical information on contraception [45].

Affordability

Poverty and large socioeconomic disparities within a country are correlated with rapid population growth. Those living in poverty are the least likely to be using a modern contraceptive method and also have the higher total fertility rates compared to those of higher socioeconomic status. Unmet need for family planning is therefore strongly associated with an inability to afford modern contraceptives [46]. Donors and aid cover half of the costs of sexual and reproductive health services including maternal and child health services worldwide. In developing regions, US\$6.3 billion is spent on modern contraceptive services annually. These include direct costs such as contraceptives, other supplies and salaries of healthcare providers. It also includes indirect costs such as construction of clinics and maintenance of supply chains [47].

Affordability is also a barrier in high-income countries, affecting the choice of contraceptive method used and the compliance of use. The cost of seeing a health care provider, paying for the contraceptive and in some cases paying for the insertion or delivery of the contraceptive (medium or long acting contraceptives) can be considerable and varies widely [48]. Of the 37 million women in the U.S. who were in need of modern contraceptive services, more than half rely on publicly funded services. The number of women in need of publicly funded services has also increased by three million million between 2000 and 2010 [49]. Some of the most effective methods are also the most expensive. For example an IUD is more efficacious and effective (percentage of pregnancies avoided with perfect and typical use) than condoms, but the cost may be much higher, depending on government subsidization and cost of seeing a healthcare provider. The total cost of receiving a long-acting method such as an IUD may exceed US\$1,000 [50].



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All forms of contraceptives are cost-saving to governments, even when the total costs of the contraceptive is publicly funded [51]. Despite this, there are still many places where affordable access to contraceptives is a major barrier towards use [52]. In many countries that do offer a reimbursement scheme or publicly funded access to contraceptives, these schemes often do not include newer, more effective contraceptives such as implants and IUDs [44].

Sociocultural norm

In low to middle-income countries worldwide, particularly in the Pacific, Africa, South America, and East Asia, sociocultural norms greatly influence a woman's decision to access family planning services. Men are usually the providers of monetary income in low- to middle-income countries within these regions, and are usually the head of the family. This means that the men play a predominant role in making decisions for the family, including childbearing [53–55]. Few men believe that the number of children in a family should be a collective decision made by a couple. Moreover, women in these communities usually have low societal status, and are not allowed to make their own choices or formulate their own opinions. Therefore, whilst a lot of women desire to plan their reproduction, their partner's opinions and decisions take precedence, thereby, acting as a barrier for them to access family planning services.

Furthermore, various studies show a consensus that a woman's identity is defined by the number of children provided to her husband. Societal stigma is a common barrier to access to family planning services and is more prevalent in regional and rural areas [55–57]. A study in lowest socioeconomic regions of Chiapas, Mexico, showed that most women support family planning, however, opposing community members due to cultural and religious opposition acted as a strong barrier preventing these women from accessing family planning services [58]. Stigma, therefore, prevents a woman from feeling empowered to take a stand for planning their own reproduction.

Additionally, in communities where traditional medicine takes precedence, culture trumps medical advice due to lack of familiarity towards the health service itself. Fear of the unknown is very rarely discussed, but is a critical factor that influences a woman's decision to access family planning and contraceptive services [57]. This calls for better integration of family planning services with local health practices to boost cultural familiarity towards family planning services.

Health Workforce

The health workforce plays an integral role in providing family planning services to various communities. Issues with the health workforce can act as a barrier to accessing these services. Studies in areas with high unmet needs, such as Africa and the Pacific, show that common health workforce-related issues include lack of government funding, poor training of healthcare workers, judgemental responses by healthcare workers towards women accessing family planning services, lack of privacy and confidentiality, and poor integration with other women's health services, such as gynaecological clinics and postnatal care checks. With subjective opinions and misinformation regarding family planning and various forms of contraception, many women are hindered from accessing contraceptive services [56].

Guidelines for providing and improving access to family planning

The World Health Organization's "Family Planning: a global handbook for providers" provides a comprehensive overview of contraceptive methods. It compiles chapters aimed at different demographics seeking family planning methods (adults, adolescents, women in menopause, patients with disabilities), includes discussion on protecting against STIs and HIV, and also discusses reproductive rights, the understanding of which is fundamental to providing high quality and effective family planning care. The third and latest edition of the handbook was published in February 2018 [16].

The World Health Organization has also published the Medical Eligibility Criteria for Use of Contraceptive Methods, the last revision being dated 2008. This document, used by health providers



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all over the world in a wide range of settings, has offered guidance on safe and effective provision of contraceptives, including to people with medical conditions [59].

The international planned parenthood federation also has a number of guidelines for health providers who may provide family planning services and information. These include the Medical and Service Delivery Guidelines and the Right to Care: Guidelines on Sexual and Reproductive Healthcare for Youth [60,61].

These guidelines give on-the-ground workers and health service managers information on how to implement best-practice family planning and contraceptive care. In addition to these, the UNFPA's Framework of Actions for the follow-up to the Programme for Action of the International Conference on Population and Development Beyond 2014 highlights the current challenge of growing inequity and inequality in access to sexual and reproductive healthcare. The beyond 2014 framework for action affirms governmental responsibility and accountability in ensuring the realisation of human rights and sustainable development through family planning and urges for comprehensive and equitable action to ensure these rights for all in a time of growing planetary instability. The framework provides global guidance and goals, especially for governments, in achieving what the Cairo Programme for Action set out, building in the progress that has been made and addressing the gaps and inequities that remain [62].



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