

# SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR) – AGREEMENTS AND DISAGREEMENTS

## POLICY BRIEF No 2

The purpose of this policy brief is to bring together research based evidence on issues and their progress in the field of Sexual and Reproductive Health and Rights (SRHR) in developing countries. It has been developed in dialogue with Danida and is intended as a contribution by Enreca Health, serving as an introduction for Danida staff, parliamentary members, and others who want to broaden their evidence based knowledge on SRHR for their own work on programme, policy and advocacy.

Evidence evolves over time and its interpretations vary. Therefore, this policy brief refers to 'conventional wisdom,' including academic literature, international consensus documents, but also to uncertainties and divergent views. A background document with references and explanations of terminology is available at <http://www.enrecahealth.dk/rhwg>

### WHAT IS SRHR?

The concept of 'SRHR' has evolved since the 1980s in terms of understanding the problems and goals for sexual and reproductive health and rights, and in particular how to fulfil such goals. However, despite much agreement, many aspects remain politically controversial and contested in many countries as they are closely related to gender, human rights and to the role of those rights in intimate and interpersonal relations.

**Reproductive health** is the complete physical, mental and social well being related to the reproductive system throughout the life cycle.

**Reproductive rights** are those of couples and individuals to freely decide the timing, number and spacing of their children, and to access information and care in all matters related to reproduction and sexuality.

**Sexual health** is a state of physical, mental and social well being in relation to sexuality throughout the life cycle.

**Sexual rights** includes the right to not be subjected to sexual violence and coercion, as well as to a safe and satisfying sex life - including the right to say 'no' to sex.

*Adapted from the ICPD Plan of Action*

'Reproductive health' (RH) is a component of overall health for both men and women, youth and adults, and refers to a life cycle health approach in opposition to vertical programmes only addressing

stand-alone themes such as family planning or HIV. The terms 'sexual and reproductive health' (SRH) and 'reproductive rights' (RR) have a relatively solid base in international consensus, whereas 'sexuality' in general and 'sexual rights' in particular, especially the issue of sexual orientation, remain contested. UNFPA refers to sexual and reproductive *health* and reproductive *rights*, WHO usually refers only to *SR health*. However, a number of countries, including Denmark, use the inclusive health *and rights* term SRHR widely.

### POLITICAL FRAMEWORK FOR SRHR

Since 2008, the Millennium Development Goals (MDGs) have made

#### MDG TARGET 5.A: "REDUCE BY THREE QUARTERS THE MATERNAL MORTALITY RATIO"

5.1 **Maternal mortality ratio:** Number of death per 100 000 live births.

5.2 **Proportion of births attended by skilled health personnel:** Number of deliveries attended by an accredited health professional —such as a midwife, doctor or nurse.

#### MDG TARGET 5.B: "ACHIEVE, BY 2015, UNIVERSAL ACCESS TO REPRODUCTIVE HEALTH"

5.3 **Contraceptive prevalence rate:** Number of women of reproductive age (15-49) married or in union who are using contraception to the total number of women of reproductive age in union.

5.4 **Adolescent birth rate:** The number of live births occurring to all women aged 15-19 per 1000 women in the 15-19 age group.

5.5 **Antenatal care coverage:** Percentage of women who used antenatal care provided by skilled health personnel for reasons related to pregnancy at least once and at least four times during pregnancy, as a percentage of live births in a given time period.

5.6 **Unmet need for family planning:** The proportion of women who are married or in consensual union who are at risk of pregnancy who desire to delay their next birth at least two years or avoid another one who are not using a method of family planning.

direct reference to reproductive health under the goals to reduce child mortality (MDG4) and to improve maternal health (MDG5). SRHR have specifically been included in Danida's 2010 strategy for development cooperation *'Freedom from poverty – Freedom to change'* as a means to achieve social and economic gains in low income countries, and in particular is a central component of gender equity. In the strategy improved SRH is recognized as a precondition for the achievement of gender equity and vice versa. Sexual and reproductive health and rights could be addressed directly through Danida's Health Sector Programme Support, as well as indirectly in countries where Danida does not financially support the health sector, e.g. through gender components and support to women's health movements and other rights based grass root organisations.

The concept of SRHR is grounded in the International Conference on Population and Development in 1994 (ICPD or the 'Cairo Conference') organised by United Nations Population Fund (UNFPA) and the United Nations (UN), where it was adopted by the 179 states in attendance as part of the Programme of Action. A strong emphasis was placed on rights, especially women's rights, throughout that document. At the Beijing Women's Conference of 1995, these rights were further specified to include women's rights to decide on issues related to their own sexuality. However, no country –including Denmark– has achieved perfect implementation of these rights and much remains to be done here and in our partner countries.

## SITUATION AND RESPONSE – PROGRESS OVER THE LAST DECADES

### PRIORITY AREA 1: PROVIDING HIGH QUALITY SERVICES FOR FAMILY PLANNING, INCLUDING INFERTILITY SERVICES

Lack of access to effective, safe, affordable and acceptable methods of contraceptives leads to unwanted pregnancies. Guttmacher Institute and the UNFPA estimate that 215 million women in the world have an 'unmet need' for contraception. About 32% of all maternal deaths and 10% of child deaths could be averted by use of effective contraception.

**Epidemiology:** The contraceptive prevalence rate in developing regions rose from less than 10% in 1960 to about 60% in 2000. In the same period, the average number of births per woman decreased from about six to three. In the last decade, contraceptive prevalence has risen more slowly, and is estimated at around 62%

**'Unmet need' for contraception** is defined as the number of women who are married or in union, do not want to become pregnant for the next two years, yet are not using contraception. Of those, about a third is using less effective (not modern) methods. The reasons for non-use include lack of access to contraception, but also fear of side effects (some well founded in evidence) fear of becoming temporarily infertile (again with some reason) and fear of husband or community disapproval. Therefore, 'unmet need' should not simply be translated as lack of physical access.

(2007). Progress is particularly slow in Sub Saharan Africa with a prevalence rate of 22% (2007). Africa also has the highest desired family size of 4.4 children per woman.

**Determinants of contraceptive use** can be divided into the answer to three questions: are people aware that family planning is possible and in theory acceptable? Do they want to use it themselves? Do they have access to contraception, which they consider adequate?

There is much evidence that contraceptive use is closely related to the quality of family planning programmes, but also that family planning, women's education, income levels, birth rates, and child death rates are closely correlated. Recent evidence shows that, in Africa, many countries experience stagnating birth rates despite declining child mortality –with one explanation being the absence of high quality family planning programmes.

Infertility receives little attention in international literature. WHO estimates that about 3-5% of couples in the developing world experience core (primary) infertility, however, some areas of Africa at times have experienced up to 30-40% acquired (secondary) infertility. One factor determining acquired infertility is that of various untreated reproductive tract infections (RTIs).

**Consequences of lack of effective contraception** can lead to maternal as well as child deaths. It also has an impact on population growth. World population grew from around 1.5 billion in 1900 to 6.5 billion in 2000, and is projected to grow to 9.3 in 2050. Like any projection, this one is based on assumptions, the most important one being that global fertility rates will decline from 2.5 today to 2.1 by 2050, as a result of increased levels of contraceptive use. If instead contraceptive prevalence, and fertility, stay at present levels, then the projection is that population will increase to 11.0 billion. For a discussion of the relationship between reproductive health, gender and climate change, see the background document at [www.enrecahealth.dk/rhwg](http://www.enrecahealth.dk/rhwg)

**Response:** Since the adoption of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1979, family planning is recognized as a human right. This right is reiterated in the ICPD: *'...right of couples and individuals to freely and responsibly decide the timing number and spacing of their children and to have the information and means to do so...'* With the new target MDG5B, and its indicators 'Contraceptive Prevalence Rate' and 'Unmet Need', it is also clearly part of the MDGs. Over the last five decades, family planning programmes have been key in fulfilling this right, increasing contraceptive prevalence rates. However, it is important to recognize that it is both a negative and a positive right – both use, and non-use of contraception. This is not always respected in family planning programmes – at times either access to contraception is restricted, or it is pressed upon reluctant users. This sometimes leads to reluctance to press for family planning. International funding for family planning has actually decreased over the last decade since the ICPD. Donors should increasingly support:

- Sustainable, long term supply programmes of voluntary and effective methods of family planning, which are part of over-all health programmes.

**PRIORITY AREA 2: IMPROVING ANTENATAL, DELIVERY, POSTPARTUM AND NEWBORN CARE.**

Maternal mortality ratios are sometimes called a litmus test for a well functioning health system and the poor progress from 1990 to 2008 of only 34% decline in maternal mortality towards the achievement of MDG5 is not a good result.

**Epidemiology:** It is estimated by UNFPA/UNICEF/WHO/World Bank that the global number of maternal deaths has dropped to about 358 900 in 2008, translating into a maternal mortality ratio of around 260 per 100 000 live births, 99% of those in developing countries. There is great disparity between high and low-income countries, for example it is 5 in Denmark and 880 in Mozambique. This disparity is one reason why maternal mortality has been presented as a human rights concern in the Human Rights Council in 2009.

80% of maternal deaths are estimated to be due to direct obstetric conditions: haemorrhage accounts for 35%, hypertension 18%, sepsis 8%, abortion and miscarriage 9%, other direct causes such as obstructed labour, complications of anaesthesia or Caesarean section, and ectopic pregnancy lead to 11%, and indirect causes such as malaria, AIDS, and heart disease result in 18% of deaths. Estimates are that this is only the tip of the iceberg: 10-30 times as many women suffer serious injury or illness as a result of pregnancy, including obstetric fistula, uterine prolapse and other morbidities and disabilities. Over the last two decades, a consensus has developed that maternal deaths are not as predictable, preventable, or easily treatable as previously thought. Thus, the role of antenatal care (ANC) has been downplayed over the past years as a highly efficient intervention for reducing maternal mortality. However, mothers-to-be have embraced the idea of care during pregnancy and two thirds of all pregnant women in low-income countries receive at least one ANC visit. There is ample evidence that care during the antenatal period represents an opportunity to deliver interventions that will improve maternal health, perinatal health and, more than likely, perinatal survival. WHO recommends at least four antenatal care visits during pregnancy.

Reproductive health also includes the health of the newborn. A significant body of research indicates that a mother's death or disability raises the risk that her newborn or other children will die before age five. 99% of all neonatal deaths (defined as death before 28 days) arise in developing countries and there is general agreement that this is linked to limited progress on ANC and obstetric care. Thus, Emergency Obstetric Care (EmOC), including caesarean section, may be even more important for newborns than for women, and some now refer to it as 'EmNOC.'

**Determinants** of maternal morbidity and mortality can be described by using the so called 'three delays' model: delay in mak-

ing the decision to seek care, delay in reaching care, and delay in medical decision and quality care which all contribute morbidity and mortality. These delays threw light on the central role of the time factor and access to emergency obstetric care.

**Consequences:** Lack of quality antenatal care, delivery and newborn services contribute to the ill health of mothers resulting in 358 900 maternal deaths, 2.65 million still-borns, and 4 million newborn deaths every year.

**Response:** There is a general need for improving 'continuity of care' which is the golden standard in provision of RH services whereby health systems aim to ensure continuity throughout the reproductive life cycle (adolescence, pregnancy, childbirth, the postnatal period) and between places of care (communities, out-patient and clinical-care).

Increased attention is needed for:

- Birth attendance by personnel that has received continued education and refresher courses to deliver quality of care
- Access to Emergency Obstetric Care, including addressing cost and transport issues
- Strengthened health systems by integrating care for mothers and newborns (continuity of care)
- Effective methods of and access to contraception

**PRIORITY AREA 3: ELIMINATING UNSAFE ABORTION**

40% of all women in the world live in countries with no access to safe abortion ranging from countries where it is forbidden under all circumstances, to countries where it is legal but not accessible. Only a few countries totally outlaw abortion for any reason, and in many countries, either the women or the authorities are not aware that there is some flexibility in the existing law.

**Epidemiology:** Globally, the number of abortions is estimated to have declined from 46 million (1995) to 42 million (2003) meaning that worldwide the proportion of pregnancies that ends in abortion is one in five. 21.6 million of abortions are unsafe, and 21.2 of those occurring in developing countries (2008), and these numbers have not decreased. Globally, we find very high rates in for example Eastern Europe and Eastern Africa with limited access to contraception, whereas the lowest rates are in Western Europe, which has had good access to contraception for a long period of time.

**Determinants of abortion levels:** Every method of family planning has failures, but altogether, modern contraception averts 112 million pregnancies in the developing world every year, better where programmes are well established, high quality and accessible to all parts of the population. Given that in most societies family planning is less available to younger, poorer, less educated and more marginalized groups, they often have higher abortion rates. Research has shown that criminalizing abortion does not lead to a long-term decrease in abortion rates, only to poor health outcomes. Increasing use of contraception, on the other hand, does lead to decreased abortion rates.

**Consequences of unsafe abortion** are important in terms of mortality and morbidity: of every 5 women who have an unsafe abortion, at least one suffers a RTI as a result; some of these infections are serious, leading to infertility.

It is estimated that that 47 000 women die from unsafe abortions every year. The large majority of unsafe abortions take place in developing countries.

**Response:** As noted by the ICPD and ICPD+5 in 1999, safe abortion should be accessible in countries where it is legal. Thus, donors should support:

- Access to safe abortion services including post abortion care;
- Promote access to safe abortions in countries where it is legal but in reality inaccessible.

#### **PRIORITY AREA 4: COMBATING SEXUALLY TRANSMITTED INFECTIONS, INCLUDING HIV, RTIS, CERVICAL CANCERS AND OTHER GYNAECOLOGICAL MORBIDITIES**

**Epidemiology:** WHO estimates that every year more than 340 million new cases of the common (and treatable) bacterial and protozoal sexually transmitted infections (i.e. syphilis, gonorrhoea, chlamydial genital infections and trichomoniasis) occur throughout the world in men and women aged 15-49 years. In addition, millions of women are affected by incurable viral infections such as HIV and human papilloma virus (HPV). Not all infected are aware of the diseases, as many of the infections are asymptomatic. Focusing on HIV there are 2.6 million new – incurable – HIV infections, 370 000 of which are mother to child transmissions. The number of women in low and middle-income countries with access to prevention of mother to child transmission of HIV is estimated to have grown from 45 to 53% in just one year (2009).

**Consequences:** WHO estimates that, 60-80 million globally suffer infertility and consequent involuntary childlessness, as a result of untreated or inadequately treated STIs. In unborn and newborn children chlamydial infections, gonorrhoea and syphilis can produce serious and often life-threatening conditions including congenital disease, pneumonia and low birth weight. Part of the viral STIs are deadly and annually approximately 800.000 women die from HIV and another 240 000 women from cervical cancers caused by HPV infection. Finally, infection with one STI increases the risk of becoming infected with some other STIs, e.g. genital herpes specifically, and genital ulcers in general, increase the transmission of HIV.

**Response:** This is clearly an area, which has received very little attention. STIs, RTIs and cancers are not visible in the MDGs, despite their considerable share of the disease and death burden, with the notable exception of HIV, which is overwhelmingly sexually transmitted.

- Increase support to sexual health programs which focus on controlling STIs, RTIs and cancers as integrated parts of health system efforts;
- Improve access to prevention of mother to child transmission of HIV

#### **PRIORITY AREA 5: PROMOTING SEXUAL HEALTH**

As noted above, sexual health is part of international consensus documents, yet it is close to invisible in guidelines and programmes, and sexual rights are even more so. Neither is clearly defined, agreed, nor monitored through the MDG framework. Furthermore, sexuality outside of marriage is often seen as unacceptable. Many countries see early marriage as a protection of the family as well as the girl, rather than acknowledging that it may have adverse health effects (e.g. girls aged under 15 years have 5 times the MMR of women over 20, and their children also have higher mortality rates. Married girls e.g. in Kenya have higher risk of contracting HIV from their partner, than girls who are not married).

**Epidemiology:** WHO identifies 'unsafe sex' as the second most important risk factor for disability and death in the world's poorest communities, yet promoting sexual health is close to invisible in international consensus documents. Sexual rights have mostly been approached by combating gender-based violence, with little attention to other issues such as the issue of under-age marriage, where under-age is generally taken to mean children under 18.

**Consequences:** Lack of open discussion about issues related to sexuality and pleasure makes it difficult to address issues compromising sexual health in an efficient manner, e.g. in relation to unmarried youth, people living with HIV and gay, bisexual and transgender people.

**Response:** Donors should note the health risks of early marriage, and, with care, address the issues of healthy sexuality, both for its own sake, but also because it may have a great impact on the impact of family planning programmes.

#### **SOME CROSS CUTTING, CRITICAL ISSUES**

**Linkage HIV and Family planning:** one of the most unfortunate aspects of the political sensitivity surrounding SRHR is the delinking between different components – in particular vertical programmes for HIV and AIDS, reproductive health including family planning, and other STIs which sometimes get lost between the cracks.

Many efforts have been made to reconnect based on the assumption that this would actually imply cost savings or efficiencies, rather than additional costs. Recent studies point to cost benefit for both maternal health and HIV programs by linking, for example, general management of sexually transmitted infections, screening for HIV status, promoting safer sex including condom use, integrating HIV with maternal and infant health care (e.g. for the prevention of mother to child transmission), integrating STI into FP including discussion of counselling regarding sexuality outreach to men, and counselling and information regarding sexuality.

**Other linkages and co-morbidities:** Although it yet appears with quite low visibility, Danish researchers amongst others are addressing the issues of co-morbidities and other linkages, e.g.

between malaria and maternal health, low birth weight and non-communicable diseases, etc.

**Cost of investing in SRHR, and of not investing:** Altogether, Official Development Assistance (ODA) for health has increased dramatically over the last decades, from 5.59 billion USD p.a. in 1990 to 10.69 in 2000 to 21.79 billion in 2007. However, HIV/AIDS has received the biggest share and about half the total has been targeting HIV/AIDS, tuberculosis and malaria (MDG6). Between 1995 and 2003, donor support for family-planning commodities and service delivery fell from US\$560 million to \$460 million. Overall, the investment in reproductive health remains 12 billion a year.

What would be needed? The estimated cost of providing access to both family planning and maternal and newborn care to all women in developing countries who need them is estimated to cost \$24 billion per year by 2015, or the double of today's investment. Providing each pregnant woman in the developing world with quality care would cost an average of \$123 (\$43 for antenatal care; \$75 for delivery, newborn, and postpartum care; and \$5 for post-abortion care, or 4.50 per capita).

What would be the result of such investment? The estimate is that such additional investment would prevent 70% of the current levels of maternal deaths and 44% of neonatal deaths.

**Consequences of conditionality:** Failure to invest enough is not the only reason why progress toward enhancing sexual and reproductive health has been poor. Another important factor are policies of structural adjustment which have placed demands on Third World governments to reform and liberalize their health care systems with widening health divides between rich and poor (and a strengthening of vertical programs) as a result. ■

**Non-exhaustive list of researchers** - with expertise in Sexual and Reproductive Health from ENRECA Health's Working Group

<b>NAME</b>	<b>INSTITUTIONAL AFFILIATION(S)</b>	<b>FIELDS OF EXPERTISE</b> <i>One sentence. Five key words (themes, countries)</i>
Birgitte Bruun Nielsen	AU, AUH	Antenatal care, female infanticide, maternal mortality: India, Nepal, Tanzania and Guinea Bissau. Keywords: Maternal mortality, pregnancy and chronic diseases, female infanticide
Birgitte Folmann	AU, DAE	Reproduction and HIV/AIDS – experiences from Uganda Keywords: reproductive strategies, respectability, moralities, HIV/AIDS, qualitative research, Uganda
Birgitte Jyding Vennerwald	UC, LIFE	MD, Human parasitologist, Msc Med. Anth. Experience from Uganda, Kenya Rep. of South Africa, Mali, Madagascar Keywords: Schistosomiasis pathology, diagnosis and treatment, female urogenital schistosomiasis, schistosomiasis and cancer
Bjarke Lund Sørensen	UC, ISIM	Quality assurance of emergency obstetric and neonatal care. Keywords: Maternal mortality, skills training, criterion based audit, maternal death audit, confidential enquiry into maternal deaths.
Britt Pinkowski Tersbøl	UC, ISIM	Anthropology, Public Health, Field research experience from Namibia, India, Tanzania, Zanzibar and Ghana Keywords: Health systems research, child health, gender, reproductive health & sexuality, qualitative research, ethics in qualitative research
Christian Groes-Green		Condom use, gender and HIV prevention in Mozambique Keywords: Safe sex, gender notions, social inequality, youth, peer education, sexual strategies, sexual capital
Christentze Schmiegelow	UC, ISIM	Malaria in pregnancy - experiences from Tanzania Keywords: Fetal growth, malaria and birth outcomes, maternal health, malaria and hypertensive disorders
Henrik Friis	UC, LIFE	International nutrition and health, pregnancy/lactation, childhood, infections and chronic diseases Keywords: Nutrition, infections, HIV/TB, diabetes, SAM
Ib Bygbjerg	UC, ISIM	Non-communicable diseases and Communicable diseases – experiences from Ghana, Tanzania and India Keywords: Diabetes mellitus, TB, Malaria, HIV and double burden of diseases
Myassa Arkam Dartell	UC, ISIM, DCS	HPV infection, cervical cancer risk factors and screening – experiences from Tanzania Keywords: Women health, HPV testing, Pap smear, HIV, Sexually transmitted diseases
Pascal Magnusson	UC, LIFE, SPHD	Tropical Medicine and Infectious diseases- experiences from Eastern Southern and Western Africa Keywords: Malaria in Pregnancy, ANC, IPTp, HIV in pregnancy, Female genital schistosomiasis
Sarah Fredsted Vil-ladsen	UC, DPIN	Improving antenatal care – experiences from Ethiopia Keywords: Antenatal care, health systems, intervention, maternal and infant health, Ethiopia
Siri Tellier	UC	Population, climate change and SRHR Keywords: disaster and gender demography
Stine Lund	UC, ISIM	Safe motherhood – experiences from Tanzania and Ghana' Keywords: Maternal health, child health, health systems, mHealth
Tine Gammeltoft	UC	Sexual and reproductive health and rights in anthropological perspective – experiences from Vietnam Keywords: sexuality, abortion, pregnancy, gender, HIV
Vibeke Rasch	USD, OUH	Experiences from Tanzania, Vietnam and Ethiopia Keywords: unsafe abortion, contraceptive use, cervical cancer, HPV, HIV

**AU:** Aarhus University

**AU, DAE:** Aarhus University, Department of Anthropology and Ethnography

**AUH:** Aarhus University Hospital

**DCS:** Danish Cancer Society

**OUH:** Odense University Hospital

**UC:** University of Copenhagen

**UC, DPIN:** University of Copenhagen, Department of Paediatric and International Nutrition

**UC, ISIM:** University of Copenhagen, Department of International Health, Immunology and Microbiology

**USD:** University of Southern Denmark

**RUC:** Roskilde University