Sexual and reproductive health: A right of women and men

Every minute one woman dies of pregnancy-related causes, while 125 to 200 million people would like to be able to control their fertility, but are not using contraceptives. If contraceptives were sufficiently available, 1.5 million lives would be saved per year. Although in 1994 the heads of state adopted the International Conference on Population and Development Programme of Action, funding for sexual and reproductive health and rights still lags behind at both the national and international level. Different policies have been adopted around the world but many governments still need to be convinced of the important economic impact that a good sexual and reproductive health care system can have.

Joyce Haarbrink
Marie Stopes International

The conception of social security is not limited to pensions, but also encompasses education, health, employment, and other spheres of life. There is serious concern over the dramatic situation created by the HIV/AIDS pandemic in Africa. Sexual and reproductive health and rights form part of the conception of social security from a rights-based perspective.

In accordance with the Global Policy Committee of the World Health Organization (WHO), reproductive health "implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this is the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."[1]

Each man and woman is entitled to a whole range of fundamental human rights including the rights to life and health, the right to equality and non-discrimination, the right to be free from torture and cruel, degrading treatment, the right to dignity and the right to information. However, women in many parts of the world are not granted these rights. They are maltreated, raped, stigmatized, left to their own devices and politically ignored. Their sexual and reproductive health rights are often not recognized, let alone acted upon at the governmental, regional or community level. Yet, if women have the freedom to decide the number and spacing of their children and have access to the means of living a healthy and satisfying sex life, a country's economy and social structure will only benefit.

From population control to the right to sexual and reproductive health

In the 1980s and early 1990s sexual and reproductive health were closely related to the impact of population growth. This changed in 1994 when 179 heads of state and government came together in Cairo for the International Conference on Population and Development (ICPD) and adopted the ICPD Programme of Action (PoA). The signatories agreed that governments should "meet the family planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family planning methods…"[2] They also acknowledged that men and women have the right to be informed and to have access to safe, effective, affordable and acceptable comprehensive methods of family planning of their choice, as long as they are not against the law.[3]

This decision was a watershed for population issues, as the policy evolved from 'population control' to recognizing the *right* of men and women to a healthy and satisfying sex life.[4]

In 1999 the 21st special session of the UN General Assembly revisited the ICPD PoA and adopted the Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development, stressing the linkages between sexual and reproductive health and rights and economic growth, the environment, education, equity and equality. Governments were invited to urgently accelerate the implementation of the ICPD PoA and mobilize the agreed estimated financial resources for its implementation.

In 2007, 13 years after the 1994 ICPD PoA granted women the right to be informed on sexual and reproductive health and rights (SRHR) and to have access to safe, effective, affordable and acceptable comprehensive methods of family planning of their choice, women in many parts of the world can still not exercise these rights and suffer from the consequences:

- Every minute one woman dies of pregnancy-related causes; this means 529,000 deaths every year, of which 68,000 are the result of unsafe abortions.
- 300 million women in the developing world currently suffer from short- or long-term illness brought about by pregnancies and childbirth.[5]
- 125 to 200 million people would like to be able to control their fertility, but are not using contraceptives[6] ('unmet needs'). If contraceptives were sufficiently available, 1.5 million lives would be saved per year.[7]
- More than half of women in the developing world aged 15 to 49 – around 705 million women in all – are at risk of unintended pregnancy.
- One third of women give birth by the age of 20; their babies are 1.5 times more likely to die within the first year of life compared to babies born to older mothers.
- Each year an estimated 2.2 million pregnant women infected with HIV/AIDS give birth. Around 700,000 neonates contract HIV/AIDS from their mothers either during pregnancy, labour, delivery or breastfeeding.[8]

In addition, one of the reasons for this situation is that there is hardly any funding available to support SRHR. In 1999 the ICPD PoA calculated that the implementation of the PoA would cost USD 17.0 billion in 2000, USD 18.5 billion in 2005 and USD 21.7 billion in 2015. Donors were invited to contribute one third of this amount, while the developing countries would allocate the remaining two thirds from domestic sources.[9] However, the funding targets indicated by the PoA have so far not been reached and funding for SRHR has actually gone down. In the late 1990s the HIV/AIDS pandemic captured the world's attention, with funding streams being diverted from SRHR to the response against HIV/AIDS.[10]

In 2000 189 heads of state and government committed themselves to the Millennium Development Goals (MDGs). Although the MDGs include promoting gender equality and empowering women, reducing child mortality, improving maternal health

1 Global Policy Committee of the WHO, 2 May 1994.

2 ICPD PoA, para. 7.16.

3 *Ibid*, Chapter VII.

4 *Ibid*, para. 13.15.

5 WHO (2005). *The World Health Report 2005. Make every Mother and Child Count.*

6 Report of hearings by the All Party Parliamentary Group on Population, Development and Reproductive Health: "Return of the Population Growth Factor: Its Impact upon the Millennium Development Goals". London, January 2007.

7 UNFPA and Alan Guttmacher Institute (2003). "Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care".

8 WHO (2004). *The World Health Report 2004. HIV/AIDS: Changing History.*

9 ICPD PoA, Chapter XIII, para. 13.15.

10 Report of hearings by the All Party Parliamentary Group, *op. cit.*

and combating HIV/AIDS, malaria and other diseases, sexual and reproductive health and rights were not mentioned at all. Yet sexual and reproductive health and rights have an impact on practically all the MDGs.[11]

It is therefore clear that sexual and reproductive health and rights have an important role to play in achieving the ultimate goal of the MDGs: eradicating poverty. This was recognized at the World Summit in 2005, when the participants committed themselves to achieve universal access to reproductive health by 2015. They proposed a new target on reproductive health under MDG 5. However, this new target has not yet been finalized, due to the ongoing discussions around identifying appropriate indicators. This suggests that sexual and reproductive health and rights are still a controversial issue.

The African Union: a continental effort for sexual and reproductive health and rights

In view of the above it is heartening to see that countries of the African Union have recognized the need to move forward and take steps on guaranteeing their citizens' access to sexual and reproductive health care, a tacit acknowledgement that the African Union understands that poverty cannot be eradicated if sexual and reproductive health and rights are not addressed.

In September 2006 the ministers coming together in Maputo for a special session of the African Union adopted the Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007-2010. In the Programme of Action the ministers agreed to take the continent forward to the goal of universal access to comprehensive sexual and reproductive health services in Africa by 2015. As key strategies they identified:

- Repositioning family planning as an essential part of the attainment of health MDGs.
- Addressing the sexual and reproductive health needs of adolescents and youth as a key sexual and reproductive health component.
- Addressing unsafe abortion.
- Delivering quality and affordable services in order to promote safe motherhood, child survival, and maternal, newborn and child health.
- Promoting African and South-South cooperation for the attainment of ICPD and MDG goals in Africa.[12]

For the financing of this ambitious Programme of Action the health ministers stated that the initiatives involved will be mainly financed through domestic resources.[13] These resources will be needed to strengthen health systems and improve basic public health functions, including community action and other necessary support functions.[14] Health workers need to be trained and the links between sexual and reproductive health care, the response to HIV/AIDS, malaria and other diseases need to be integrated in all health services. Gender-based violence, including sexual abuse, emergency contraception, HIV/AIDS post-exposure prophylaxis and STI treatment also need to be addressed in an integrated and coordinated manner. The ministers recognized the need to pay extra attention to youth, who are extremely vulnerable to HIV/AIDS infection and unwanted pregnancies, by putting youth-friendly services in place. The total amount of funding needed to implement this Programme of Action would be USD 3.5 billion by 2007 and USD 16 billion by 2010. So even though the ministers of health in the African Union acknowledge the importance of SRHR for their citizens, the ministers of finance still need to be convinced that investing in SRHR will have a beneficial impact on their economy.

Donors and governments: resources and political will

Donors, too, have not recognized the importance of funding for SRHR. The US still maintains the Mexico City Policy, also known as the Global Gag Rule.[15]

MILLENNIUM DEVELOPMENT GOALS

- MDG 1: **Eradicate extreme poverty and hunger:** High fertility levels contribute directly to poverty, reducing women's capacity to contribute to a household's income, diluting expenditure on children's education (and girls' in particular) and health, and increasing malnutrition as there are more mouths to feed.
- MDG 2: **Achieve universal primary education:** Families with fewer children and further spaced apart can invest more in their children's education.
- MDG 3: **Promote gender equality and empower women:** Women who plan the timing and number of their children have more opportunities to develop themselves socially, find job opportunities, get education and training and contribute to the economy.
- MDG 4: **Reduce child mortality:** Where modern contraception is below 10%, the average infant mortality rate is 100 deaths per 1000 live births. However where it is over 30%, the rate is 52 per 1000 live births. Moreover, children born too closely together have an increased risk of ill health.
- MDG 5: **Improve maternal health:** Preventing unplanned and high-risk pregnancies and providing care in pregnancy, childbirth and the postpartum period saves women's lives. Preventing unplanned pregnancies also prevents the need for (often unsafe) abortions.
- MDG 6: **Combat HIV/AIDS, malaria and other diseases:** Ensuring universal access to sexual and reproductive health would help combat HIV and AIDS. Preventing mother-to-child transmission can save the lives of thousands of children.
- MDG 7: **Ensure environmental sustainability:** reducing population growth will ensure less pressure on natural resources, including safe water.
- MDG 8: **Develop a global partnership for development.**

11 See also UN website on MDGs "Key Facts and Figures on Sexual and Reproductive Health" and UNFPA, "Reducing Poverty and Achieving the Millennium Development Goals".

12 African Union Conference of Ministers of Health (2006). Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007-2010. Maputo, 18–22 September, art. 17.

13 *Ibid*, art. 19.

14 *Ibid*, art. 25.

15 In 2001, US President George W. Bush re-imposed restrictions known as the 'Global Gag Rule' (or the 'Mexico City Policy'). This policy mandates that no US family planning assistance can be provided to foreign NGOs that use funding from any other source to perform abortions in cases other than a threat to the woman's life, rape or incest; provide counselling and referral for abortion; or lobby to make abortion legal or more available in their country. This policy forces a cruel choice on foreign NGOs: accept US assistance to provide essential health services – but with restrictions that may jeopardize the health of many patients – or reject the policy and lose vital US funds, contraceptive supplies and technical assistance. For more information visit: <www.globalgagrule.org>.

The challenge of quality health care

The availability and quality of essential health services represent major challenges for many countries of the South. Throughout this report there are countless examples similar to Kenya: health care providers in Kenya encounter a number of serious challenges to providing quality care. These obstacles include understaffing, lack of institutional support, and inadequate supplies and equipment, which invariably lead to lower-quality services for women and their babies. Hospitals often lack the most basic supplies, such as anaesthesia, gloves, syringes, surgical blades, soap and disinfectant, speculums and bed linens.

While, for instance, the European Union (EU), the biggest donor of development aid, had a separate budget line for Aid for Policies and Actions on Reproductive and Sexual Health and Rights in Developing Countries with a financial envelope of EUR 73.95 million for the period 2003-2006,[16] it has now, in 2007, incorporated this budget line in the health sector of a newly created financial instrument for the period 2007-2013 called 'Investing in People', meant to fund thematic programmes in the developing world. However, funding for SRHR will have to compete with many other issues which are to be funded through this thematic programme.

The EU also funds the developing countries through geographic programmes which are based on the so-called Country Strategy Papers, jointly drawn up with the recipient countries. However, here too SRHR are not identified as a separate focal area which means that funding will be very uncertain. It is ironic that this is happening in 2007, the halfway point of the MDGs, particularly since at the global level the introduction of a new target on MDG 5 acknowledges the pivotal role of SRHR in achieving MDG 1 on poverty eradication.

Conclusion

Although the ICPD Programme of Action was a first major step to raise awareness of the importance of sexual and reproductive health and rights and recognize them as a basic human right, the MDGs still need to fully incorporate universal access to sexual and reproductive health as a target under MDG 5. Funding for sexual and reproductive health and rights still lags behind at both the national and international level, although policies have been adopted. Many governments still need to be convinced of the important economic impact that a good sexual and reproductive health care system can have, as has been proven by examples from Mexico, Thailand and Egypt, for instance, where investing in family planning has meant extensive savings in public expenditure.[17]

It needs to be made clear that not only is universal access to sexual and reproductive health care services one of the most cost-effective ways of reducing infant and maternal mortality (medical gains), but it also has a huge impact on a woman's personal life and her social and economic empowerment. Ultimately it also benefits a country's economy, but most importantly, it is a human being's fundamental right to live a healthy and satisfying sexual and reproductive life. ■

16 European Commission (2003). Regulation (EC) No. 1567/2003, 15 July.

17 Mexico: MXN 1 spent saved MXN 9; Thailand: USD 1 saved USD 16; Egypt: USD 1 saved USD 31. From: UNFPA and Alan Guttmacher Institute, *op. cit.*