WORKING GROUP ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

SRHR POLICY BRIEF 2014

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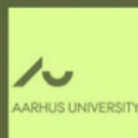

WORKING GROUP ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Sexual and Reproductive Health and Rights: Agreements and Disagreements – A Policy Brief

Purpose

The purpose of this policy brief is to give a short overview of issues related to Sexual and Reproductive Health and Rights (SRHR), especially from a health perspective. It is a companion to a longer Background Paper, 2014 edition.[1]

The two documents are a joint effort by the SRHR Working Group with members from 5 Danish universities teaching SRHR, as well as Danida, UN organizations (e.g. UNFPA) and NGOs (e.g. WoMena, Sex & Samfund).

The documents are being used for teaching/research purposes at the universities involved, as briefing for staff at the organizations involved, as well as in advocacy.

WHAT IS SRHR?

The concept of SRHR has developed over the last three decades. In the 1980s, 'Reproductive health' (RH) was formulated as a broad concept, beyond vertical approaches such as family planning programmes, and as something that was part of overall health for girls and boys, women and men, throughout the life cycle. RH was seen as a sensitive issue, as it is closely related to cultural identity and survival, including the political aspects of population size and gender relationships. Thus, RH has commanded the interest of cultural leaders in a manner that for example heart disease has not.

In 1994, at the International Conference on Population and Development, the concept was expanded to include emphasis on rights and the inclusion of sexuality. The term SRHR was coined. However, RH, even in its most narrow definition, remains a contested area, and the areas of sexuality and rights even more so. Until recently, most UN organizations referred only to parts of the concept, but ongoing discussions regarding the post-2015 Sustainable Development include reference to SRHR as this document went to press, thus, the title of this policy brief.

Nevertheless, much consensus has been achieved, with major progress in many areas.

> **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

POLITICAL CONSENSUS FRAMEWORKS FOR SRHR

The ICPD Programme of Action, which 179 governments adopted by consensus in 1994, committed those governments to a 20 year Programme of Action to deliver *human rights* based development in *reproductive health*. This programme has recently been extended – beyond 2014 – a testimony both to its continuing relevance, and a concern that renegotiation might result in setbacks.

The Millennium Development Goals are some of the most widely used consensus documents used by the international community. In their first formulation, in 2001, the only reference to SRHR was with regard to maternal mortality (Goal 5 Target 5A) as well as HIV/AIDS, and child mortality. After much negotiation, a second reproductive health target 5B was added as binding for the UN System in January 2008.

What will happen post 2015 is not yet known – first drafts of the Sustainable Development Goals include reference to SRHR, but the exact formulation is not assured as this policy brief went to press.

Another major consensus document is the 2004 WHO Reproductive Health Strategy. The World Health Assembly adopted that strategy in May 2004. The US (as the only country) disassociated itself from that consensus, apparently mostly over references to abortion.

These consensus documents go a long way toward defining areas of agreement, providing a basis for joint action. However, many areas remain hotly contested, in particular abortion, services for the unmarried, sexual rights (especially sexual orientation and the definition of the term 'family'), and the concept of 'gender'.

Selected Indicators

MDG Target 4.A: “Reduce by two-thirds, between 1990 and 2015, the under-five mortality ratio”

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

MDG Target 6.A: “Have halted by 2015 and begun to reverse the spread of HIV/AIDS”

6.1 **HIV prevalence among population aged 15-24 years**

6.2 **Condom use at last high-risk sex**

6.3 **Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS**

SITUATION AND RESPONSE - PROGRESS OVER THE LAST DECADES

Priority Area 1: Improving antenatal, delivery, post-partum and newborn care

Definitions

Maternal Mortality Ratio, MMR	The number of pregnancy related deaths per 100,000 live births
Stillbirth	A baby born with no signs of life at or after 28 weeks’ gestation
Neonatal (newborn) deaths	Annual deaths during the first 28 days of life per 1 000 live births in a given year
Skilled birth attendant	An accredited health professional trained in midwifery skills
Adolescents	Persons aged 10-19
Children	Persons aged less than 18
Adolescent birth rate	Number of births occurring to girls aged 15-19 per 1 000 women aged 15-19

Trends

MMR is difficult to estimate. Although different estimates vary, trends are similar. The number of deaths in 2013 was estimated at 289 000 by WHO/UNICEF/UNFPA/World Bank. This represents a reduction by 45% compared to 1990, with reductions accelerating since 2003. The levels of MMR demonstrate higher disparities than almost any other health indicator – 99% of the deaths occur in less developed regions.

As a rough estimate, up to 40% of women may develop complications in child birth, and 15% of those may be life threatening.

Estimates of the causes vary. One general estimate says that that 80% of maternal deaths stem from direct obstetric conditions, such as post partum haemorrhage (35%), hypertension (18%), sepsis (8%), abortion and miscarriage (9%), other direct causes (11%). Indirect causes such as malaria, AIDS and heart disease, which aggravate conditions of pregnancy, have been identified as causes of 18%. However, recent estimates indicate a higher proportion of deaths due to indirect causes, especially in high-income countries. Adolescents have a particular situation. Every year, about 15 million girls are married before the age of 18, a third of them before the age of 15. About 15 million, or close to 10% of all births annually, are to adolescents, 90% of them married. The focus until recently has been on health problems of adolescents under 15, where one estimate puts the MMR for girls under 15 as 5 times higher than for women in their 20s. Recent estimates also emphasize an elevated mortality for women over 40, but unfortunately do not disaggregate for girls aged under 15.

This is only the tip of the iceberg – 10-30 times as many women suffer serious injury or illness or as a result of pregnancy, including obstetric fistula, uterine prolapse or other morbidities and disabilities.

Reproductive health includes the health of the newborn. Estimates are that 2.7 million stillbirths and 2.9 million neonatal deaths occur every year, lending another dimension to the concept of the ‘tip of the iceberg’.

Determinants

Over the last two decades, there is increasing agreement that major determinants of MMR are family planning (to reduce high risk births), skilled birth attendance, and referral to Emergency Obstetric Care whenever needed.

The time factor is central: attention has been drawn to the ‘three delays’ – delay in making the decision to seek care at a clinic which offers EmOC, delay in reaching that clinic, and delay in accessing the care after arrival. There is also recognition that such care may be even more important for the survival of the newborn than for the woman, and some refer to it as EmNOC. Other factors than the availability of medical care are equally important –

including accessibility (e.g. transport, cost), acceptability (e.g. women's status and cultural issues related to services), and quality (and trust in that quality).

Consequences
In addition to the obvious health consequences for the women themselves, 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 5.

Response
Reduction of maternal and neonatal mortality is possibly the RH goal where there is most wide agreement. Recently, it has also been framed as a human rights concern, based on the disparity mentioned above.

However, the strategy to achieve that goal has changed over time. Over the last decades, a consensus has developed that maternal deaths are not as predictable, preventable or easily treatable as previously thought. After the Alma Ata conference in 1978, where Primary Health Care was promoted, much effort was placed on the training of Traditional Birth Attendants (TBAs), which are widely present at community level in less developed regions. In the 1990s, a consensus developed that there was little if any evidence that TBAs could deal with complications such as acute haemorrhage (a woman may die within two hours of the onset of haemorrhage), and training programmes had no discernable impact. As a result, TBA training has been largely abandoned. On the other hand there is also recent recognition that TBAs have a demonstrated role in assuring the survival of the newborn, as well as in many other aspects such as recognizing warning signals and helping transport women to the clinic.

Given the lack of evidence of effectiveness in reducing maternal mortality, the role of antenatal care was also downplayed over the last decade. However, women have embraced the idea of ANC, and over 60% of women in developing countries have at least one ANC consultation (WHO recommends at least 4 visits). There is also ample evidence to show that this affords an opportunity to deliver interventions, which will improve maternal health (e.g. malaria treatment) as well as perinatal health and survival.

Continuity of care, which is a gold standard in health provision, is seen as particularly important in RH in general, and in maternal health in particular. This refers to continuity throughout the life cycle as well as between places of care (e.g. from community to referral hospital). In particular the importance of functioning referral systems is a reason maternal mortality is often referred to as the 'litmus test for health systems'.

Access to EmOC is costly compared to other health services, e.g. measles vaccination. This may be one reason EmOC was not widely available until recently. However, the last 5 years or so have seen increased investment, and associated progress.

Priority area 2: providing high quality services or family planning, including infertility services

Definitions

Contraceptive prevalence rate	Contraceptive use among women aged 15-49, married or in union, percentage
Unmet need for family planning	The proportion of women aged 15-49 years, married or in union, who want no more children or want to wait minimum 2 years, yet are not using contraception
Infertility	Inability to conceive after 1 year of regular, unprotected intercourse. Demographers use the term '*infecundity*'
Traditional/modern means of contraception	Traditional means include methods such as withdrawal, lactational amenorrhoea, whereas modern means include methods available at clinics or pharmacies such as sterilization, hormonal methods

Trends
The contraceptive prevalence rate in developing countries has increased from less than 10% in 1960 to about 60% in 2000. In the same period, the number of births per woman decreased from around 6 to 3. Over the last decade, CPR has increased more slowly and is estimated at 62% for 2012. Some regions are at much lower levels, e.g. in sub-Saharan Africa the CPR is at 26%. Sub-Saharan Africa also has the highest number of births per woman at around 5.1.

Unmet need has also decreased slightly, and is presently estimated at 12% in the world as a whole, but with sub-Saharan Africa at 25%.

Infertility receives little attention in international literature, and there are few estimates. Global estimates generally are in the range of 3-10%, however some areas of Africa at times have experienced up to 30-40% secondary (acquired) infertility.

Determinants
There are two main groups of determinants – factors influencing the number of children which people want, and the means they have to achieve that goal. Numerous studies show that contraceptive prevalence increases when child mortality decreases ('child survival hypothesis'), as well as with higher levels of urbanization and women's

education. Studies also show that availability and knowledge about contraception is not sufficient to increase utilization, for example, fear of medical side effects also play a major role in unmet need.

Although contentious, it is also clear that people's contraceptive utilization is influenced by policy (sometimes referred to as 'political fertility'). This can be both intended to *reduce* or *promote* births, for example, the former revealed in the one- or two child policies in China, Vietnam or India as well as in Iran prior to 2009, and the latter in Japan during the Second World War and Turkey, Palestine and Iran after 2009.

Infertility is influenced by many factors, among them endocrinological, trauma, reproductive tract infections with resultant tubal occlusion, as well as age of the woman

Consequences

From a rights perspective, contraceptive use or non-use can result both in women having more, or fewer, children than they would like. Thus, in Europe, women on average have fewer children than they would like, whereas in sub-Saharan Africa (sSA) they have more than they would like. The disparity in sSA is particularly great for women with lower income and education (up to 2 children for the lowest quintile) whereas in Europe the opposite is the case. From a health perspective, there is ample evidence that bearing 5 children or more, and bearing children spaced less than 2 years apart, before the age of 20 or after the age of 40, has poor health consequences for both mother and child (for children, the longer spacing the better, for women 2 years seems ideal). There are also demographic consequences – at present the population projection for 2050 is 9.6 billion, and for 2100 it is 10.9 billion. On the other hand, if contraceptive use, and thereby birth rates, stay constant for each country, the figure for 2050 would be 11.1 billion in 2050, and 28.6 billion in 2100.

Response

The international consensus is clear with respect to contraception – with the adoption of the Convention on the Elimination of All Forms of Discrimination Against Women in 1979 and further elaborated in the ICPD, *'…right of couples and individual to freely and responsibly decide the timing, number and spacing of their children and to have the education, information and means to do so…'* This was followed up in the ICPD with a recommendation for the widest possible range of safe, effective and acceptable means of family planning. It was included in the MDGs, thereby arguably becoming the health indicator with the clearest rights basis.

At the national level, until a few decades ago, many countries limited access (e.g. France until 1967). However, by 2009, 91% of all governments supported FP directly or indirectly, the remainder allowed it, and only 1 (Holy See) limited access.

It is important to note that contraceptive use is both a positive and a negative right, that is, both the right to have the information and means, but also the right not to use them. Unfortunately, whereas until the 1960, the main effort was to assure the positive right to use contraception, since then a number of programmes have had coercive elements that force people to use contraception. This has sometimes led to reluctance to support contraception, and international financial assistance fell from a high in 1995 down to a much lower rate in 2008. A recent series of events starting with the family planning summit in 2012 have put it back on the agenda.

Priority area 3: eliminating unsafe abortion

Definitions

Abortion	A procedure for terminating pregnancy, where pregnancy is taken to begin with the implantation of the foetus in the uterus
Unsafe abortion	A procedure undertaken by unskilled personnel, or in unsafe conditions
Abortion rate	The number of abortions for every 1000 women aged 15-44 for a given time period

Trends

Statistics on unsafe abortion are particularly difficult to assemble, given that they are often illegal. A number of methodologies have been developed to overcome this.

Globally, the number of abortions is estimated to have declined from 46 million (1995) to 42 million (2003) and then to have increased again to 44 million in 2008. World wide this means that one pregnancy in five ends in abortion. 21.6 million of these abortions are unsafe, and 21.2 of those occur in developing countries. These numbers have not decreased. In 2008, the highest rates were in Eastern Europe (43) eastern Africa (38) and Latin America (32) and the lowest in Western Europe (12) and Southern Africa (15). The greatest decline in abortion rates over the last decades has occurred in Eastern Europe (where it was 90 in 1995).

Determinants

Intuitively, one would expect abortion rates to be lower where it is most restricted by law. However, this is not supported by evidence – the highest rates are in Eastern Africa and Latin America (where it is highly restricted) and in Eastern Europe, where it is freely available, but where access to contraception used to be low. In Eastern

Europe, the rates have dropped dramatically as contraception has become more accessible. Given that in most societies contraception is less available to low income, uneducated and more marginalized groups, they often have higher abortion rates, no matter what the laws or cultures dictate.

Consequences
The health consequences of safe abortion are limited – there is no agreement that it causes additional mental distress (as compared to child birth), and a safe abortion has a lower mortality rate than an injection of penicillin. On the other hand, unsafe abortion until recently was estimated to cause an estimated 47 000 deaths per year, all but 90 of those in developing countries. Out of 5 women who have an unsafe abortion, at least one suffers an infection as a result, constituting a main cause of infertility.

Response
There is no international consensus that access to abortion constitutes a human right. Indeed it would be meaningless to state there is such consensus as long as 6 countries do not allow abortion under any circumstances (even to save the life of the mother) and less than half allow and provide access to abortion on demand, at any period of pregnancy. However, ICPD and ICPD+5 in 1999 affirmed that abortion should be safe where it is legal, and both affirm that women should have access to treatment if their abortion leads to complications.

Priority area 4: combating sexually transmitted infections *– including HIV, RTIs, cervical cancers and other gynaecological morbidities*

Abbreviations

RTI	Reproductive tract infections
STI	Sexually transmitted infections
HIV/AIDS	Human immunodeficient virus/acquired immunodeficiency syndrome
HAART	Highly active retroviral therapy

Trends
Globally, WHO estimates an annual incidence of 499 million new cases of treatable bacterial and protozoal sexually transmitted infections (i.e. syphilis, gonorrhoea, chlamydial genital infections and trichonosomiasis) in men and women aged 15-49 years.

In addition, millions are infected by mostly incurable viral infections. New HIV infections have dropped from a high of 3.1 million in 1999 to 2.3 million in 2012. Deaths to AIDS have dropped from 2.1 million in 2004 to 1.6 million in 2012. Human papillomavirus (HPV) is the most common viral infection of the reproductive tract. Most sexually active women and men will be infected at some point in their lives and some may be repeatedly infected. HPV is estimated to contribute to around 530 000 new cases of cervical cancer every year, and 270 000 deaths.

STI infections often are asymptomatic in early stages, especially for women, leading to less likelihood that those concerned seek care or take precautions to prevent further spread.

Consequences
In addition to mortality and morbidity directly associated with the infections, STIs may lead to infecundity (see priority area 2), and may cause serious conditions in unborn and newborn children. Furthermore, an infection with one STI increases the risk of becoming infected with another, e.g. genital ulcers increase the transmission of HIV. In the 1990s, AIDS caused a decrease in overall life expectancy by up to 20 years in some Southern African countries – an exceptional and devastating impact of one illness.

Response
HIV has received unprecedented attention, including the establishment of a new UN Agency in 1996 (UNAIDS), special sessions of the UN General Assembly (2001/11), establishment of a Global Fund (2001), high attention in the MDGs, and an estimated close to half of all ODA health funding. Over time, the strategy to address HIV/AIDS has gone through several phases. From its first identification in 1981 until 1996, the main strategy was prevention, and some countries had success in applying a broad approach including condom use and education (e.g. Senegal, Uganda, Thailand). In 1996 anti-retroviral drugs became more widely available, but at an annual cost of around 10 000 USD, high level of complexity in distribution and utilization, and major side effects, utilization was still low. Partially as a result of major advocacy campaigns the price was brought down to just over 100 USD per annum in 2001, leading to much greater utilization. With growing evidence that using HAART at an early stage of infection can reduce the viral load to a level where further transmission is negligible, goals for treatment have increased greatly, and the number of users has increased from around half a million users around 2000 to 9.7 million in 2012. This still falls short of the estimated need, which is 14.8 million, but since 2011 the ambition has been: Getting to zero: Zero new HIV infections. Zero discrimination. Zero AIDS-related deaths.

One of the biggest donors has been the US, contributing a major part to the response. However, at times this has included conditionality, such as the separation of services devoted to family planning and HIV/AIDS. This has meant a waste of resources and synergies.

The other STIs and morbidities are close to invisible in consensus documents, including the MDGs. One exception is HPV, where many countries have launched vaccination campaigns.

Priority area 5: promoting sexual health

Definitions

For this complex priority area, part of the task is simply to arrive at a consensus on the concept of sexual health. Here we will merely present a few elements of this vast field.

In 1994, ICPD stated:
'*Reproductive health therefore implies that people are able to have a satisfying and safe sex life…*'

In 2012, WHO stated:
'*Sexual health is a state of physical, mental and social well being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence'.*

These statements imply positive aspects of sexual health (e.g. enjoyable) and the absence of negative aspects (violence, coercion, ill health, discrimination based on sexual orientation). However, whereas the first elements are often simply invisible, the issue of sexual rights in the form of sexual orientation is a visible and contentious issue.

Trends
Between 8% and 33% of the adult population in developed countries are estimated to experience some kind of sexual dysfunction in their lifetime, and some studies suggest that the actual figure may be higher. WHO defines unsafe sex as the second most important risk factor for disability and death in countries with poor health. Violence has been shown to be a key factor in unwanted pregnancy, in the transmission of STIs, and in sexual dysfunction worldwide.

Response
Recently there is much attention to violence against women, including in conflict, and it is reflected in legal frameworks, e.g. being framed as a war crime. The recent tendency is to call it violence against women rather than gender based violence, because some actors do not accept the term 'gender'.

With respect to sexual orientation, given that more than 70 countries have laws against homosexuality, and a handful in principle have the death penalty for it, it is difficult to adopt a consensus document. However, the last few years have seen a great deal of activity – the 2006 Yogyakarta Principles by human rights lawyers, a 2008 IPPF declaration, as well as several reports in the UN Human Rights Council in 2011 and 2012 have made the issue visible, although consensus is still elusive.

Another element would be early marriage (that is, before age 18). Estimates are that up to 1/3 of girls in developing countries are married as children. Although some countries maintain laws, which allow early marriage, major initiatives are underway, for example a campaign launched in 2014 by the African Union, UNICEF and UNFPA, to accelerate change on child marriage across the continent.

OTHER CROSS CUTTING ISSUES

Other cross cutting issues detailed in the background paper include:

1. Co-morbidities including how infections, reproductive and non-communicable disease interact
2. Menstrual hygiene and how its management can impact the lives of girls and women
3. New technologies including mHealth
4. Male and female circumcision – including the inter-relationship with HIV/AIDS
5. Imbalances in the sex ratio at birth – what is the role of the health sector?

Note

[1] To make this policy brief as accessible as possible, definitions are simplified, and only selected references are given. Since several different estimates exist for different metrics, we have chosen to use the WHO as our main source. For more precision and detail, see the background paper.