

BRINGING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN FROM THE MARGINS

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The links between sexual and reproductive health and rights and development

Reproductive rights were importantly clarified by the International Conference on Population and Development in Cairo in 1994. They were defined as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity... Reproductive health therefore implies that people are able to have a 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’ (ICPD, 1994). Sexual rights are recognized in national laws, international human rights documents and other consensus documents. They include the right to health and access to health services, education and information, respect for bodily integrity, to seek and to receive and impart information in relation to sexuality.

There are bi-directional links between sexual and reproductive health and rights and development. These include freedom from unwanted pregnancies that hold back women’s capacity to participate in broader social and economic affairs, and macro-economic benefits from reducing the significant burden of poor health and often associated stigma resulting from neglect of sexual and reproductive health.

At their creation the Millennium Development Goals (MDGs) did not include a goal or target that explicitly dealt with sexual and reproductive health and rights. Of course they are intimately related to all of the health goals. Unsafe sex is a major route for HIV transmission. The prevention of HIV infection is, to a large degree, reliant on the availability of programmes to provide sex education, condoms, screening, diagnosis and treatment of some sexually transmitted infections and the prevention of mother to child transmission. An estimated 15% of maternal deaths are attributable to unsafe abortion and more could be averted through the provision of family planning. It is widely acknowledged that the health of mothers has profound effects on their children.

Slow progress on MDG 5 in particular led to calls for urgent action on sexual and reproductive health to achieve the MDGs. The World Summit in 2005 recommended the integration of the ICPD goal into the MDG monitoring framework. As a result MDG5 now includes the target of universal access to reproductive health by 2015. This is underpinned by indicators that cover:

- Contraceptive prevalence rate
- Adolescent birth rate
- Antenatal care coverage
- Unmet need for family planning

Whilst this amendment offers promise for increased action on sexual and reproductive health and rights the impact of their initial omission from

MDGs has been profound. The lack of international visibility led to further marginalisation of what is almost universally a politically unpalatable issue.

Global influences on sexual and reproductive health and rights

The period since the creation of the MDGs has been one of increasing conservatism in some parts of the world in terms of sexual and reproductive health and rights. President GW Bush's US Administration oversaw some of the most regressive policy and law in this area - leading to actions that were often contrary to public health, human rights and national laws. The Mexico City Policy, or the Global Gag Rule, prevented organisations that offered or promoted safe abortion from accessing US family planning assistance regardless of their own national laws - augmenting the earlier Helms Amendment that prevents US development assistance being channelled to safe abortion. HIV and AIDS policy took a turn for the worse through restrictions on work with people who inject drugs, sex workers and the provision of comprehensive sex education to young people. This was often well received by aid recipients who are not exempt from conservatism themselves where this issue is concerned particularly in contexts of religious and cultural fundamentalism. President Obama has overturned the Mexico City Policy by Executive Order and reinstated funding to UNFPA but it remains to be seen how this affects an environment shaped by years of risk aversion.

As many development donors, the United States aside, looked to the MDGs to guide their bilateral and multi lateral funding sexual and reproductive health and rights suffered. Financing levels overall appear quite robust largely due to a ramping up of funding for HIV and AIDS. However other areas of sexual and reproductive health have not received the necessary levels of investment (UNFPA, 2006). Whilst many regard the increases in financing for HIV impressive it is worth noting that based on the country-defined targets it is estimated that an investment of US\$ 25.1 billion will be required just for the global AIDS response in 2010 for low- and middle-income countries. An estimated US\$ 13.7 billion was invested in the AIDS response in 2008 (UNAIDS, 2009).

We have experienced a time where health targets and initiatives have mushroomed, underpinned by a desire to 'roll out' and 'scale up' programmes. In HIV the '3X5 Campaign' was superseded by UN targets to attain universal access to comprehensive HIV and AIDS services by 2010 - leading to increases in the number of people accessing lifesaving antiretroviral therapy. As people with HIV live longer and healthier lives, ensuring their right to a safe and satisfying sex life and the health of their children is an area that takes on increased importance. It is a situation which has also prompted fearful, repressive policy making in many settings through laws that criminalise the transmission of HIV. The enforcement of these laws is often abusive, underlining the importance of clear commitments to human rights in the context of sexual and reproductive health

Lately efforts to improve maternal health have coincided with a focus on strengthening health systems. Initiatives like the International Health Partnership and the High Level Taskforce for Innovative Financing for Health are attempting to fund and implement the Paris Principles on Aid Effectiveness. New programmes to harmonise old initiatives are a response to the implementation of vertical financing instruments like the Global Alliance on Vaccines and Immunisation and the Global Fund to fight AIDS, TB and Malaria. This has led to an increasingly crowded and complicated global architecture for health within which it is difficult for sexual and reproductive health and rights to find their home.

Population growth and demographic change have altered the scope and nature of the challenge. According to the UN population estimates and projections the numbers of children and young people in developing countries are at an all time high (1.7 billion children and 1.1 billion young people). Population numbers are set to increase and yet our ability to provide comprehensive sex education - even in the richest countries of the world - is hampered by squeamishness and moralistic attitudes. How do we prepare young people for their lives in mega cities and peri urban areas where traditional systems of initiation and education no longer apply and new risks are legion?

As we approach 2015 we are facing a future where the old concerns of sexual and reproductive health and rights - family planning, combating sexually transmitted infections, access to safe abortion, gender equity and the rest - have lost none of their relevance to development. Added to this portfolio are a whole host of new challenges. How will we ensure the poor benefit from new sexual and reproductive health technologies like HIV post exposure prophylaxis, HPV vaccination, or circumcision for HIV prevention without overstating the relevance of these 'magic bullets'? How will we build health systems that are responsive to chronic illnesses like AIDS or cervical cancer? In the context of an increasing focus on rights based approaches how do we operationalise sexual and reproductive health and rights beyond the right to access clinical services - particularly for sexual minorities in poor countries? How do we move from an approach characterised by a focus on death, disease and desperation to one that capitalises on the pleasurable and life enhancing aspects of sexuality and reproduction?

Moving forward

As with many areas of development when we look beyond the MDGs to what might replace them it may make sense to argue for more contextually specific, locally owned goals and targets. However, an analysis of many national policies and laws does not inspire confidence that it is an area that will produce widespread political leadership any time soon - despite pockets of good practice. So global goals will continue to be important to sexual and reproductive health and rights. But global goals rarely capture the personal, the particular and the often peculiar nor do they encourage learning from local innovation.

One way forward is to consider more nuanced goals and targets that reflect a more holistic view of 'good outcomes' For instance, a gender wellbeing goal could incorporate cross cutting indicators such as a reduction in gender based violence. Or a target such as improved adolescent sexual and reproductive health, could be made up of one each of nutritional, sexual health, service access, knowledge access and rights indicators. More generally, the next generation of goals, targets and indicators needs to reflect the linkages between these critical areas of human wellbeing and the apparently unconnected 'large' themes of poverty, environment and human development. A focus on equity could also ensure that overlooked and stigmatised issues and groups that rarely win elections or find space within political processes could be brought in from the margins to the mainstream of development discourse and programming.

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