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## Reproductive health and rights

# Reproductive health and human rights

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One of the greatest disparities between rich and poor countries and, often, rich and poor people, is in maternal mortality. The risk of dying from maternal causes in sub-Saharan Africa is 1 in 16. In western Europe it is 1 in 4000. 70% of maternal deaths occur in only 13 countries.<sup>1</sup>

Why do more than 500 000 girls and women die every year—99% in developing countries—from preventable conditions and injuries related to pregnancy and childbirth? Why do 3·9 million newborns die every year in their first 28 days of life?<sup>2</sup> Why are more women than men, at younger ages, living with HIV/AIDS? 62% of all young people (aged 15–24 years) infected with HIV-1 are female; in sub-Saharan Africa this proportion is 67%.<sup>3</sup>

Generally, countries with a poor record in reproductive health have weak health systems or constraining social environments, or both, often exacerbated by poverty. Thus, the underlying causes of maternal morbidity and mortality are complex: sex discrimination in employment, education, and access to food and health care; low status of girls and young women in marriage; and poor (or non-existent) pregnancy, delivery, and post-partum care. Prevention is correspondingly complex, involving not only expansion of preventive and clinical care, but also realignment of public health and funding priorities, protection of women's rights, and behavioural changes by individuals, families, and communities. The world has prioritised and responded to communicable diseases such as severe acute respiratory syndrome (SARS) and poliomyelitis. The record on combating diseases related to sexuality and reproductive health, including HIV/AIDS, remains woefully inadequate in many parts of the world.

Political and ideological roadblocks have obstructed progress on the non-disease elements of reproductive health: contraception, safe abortion, and comprehensive sexuality education. Although the reproductive health programme agreed at the 1994 International Conference on Population and Development (ICPD) included these interventions, conservative states prevented their explicit inclusion in the Millennium Development Declaration.

In this essay, I outline what is and is not being done in research and practice in four areas: respecting women's reproductive autonomy and right to life, generating political will and resources, building health system capacity, and creating effective demand for reproductive health services.

### Rights to life, health, and reproductive autonomy

Despite longstanding global agreements, notably the 1987 Safe Motherhood Initiative—an international effort to reduce maternal mortality—and the ICPD Programme of Action, the rights to life, health, and reproductive autonomy are not a reality for most girls and women. In fact, many governments have instead tried to control childbearing, at

times through coercive programmes: China's one-child policy; sterilisation abuses in India during the 1975 "emergency"; re-emergence in India of provider targets and disincentive schemes; and the case of Peru (see page 68).

Until recently, many nations largely ignored a woman's right to health, and did little to make pregnancy and delivery safe. This climate is now changing. Between 1998 and 2001, efforts by the government and non-governmental organisations in Brazil, for example, reduced maternal deaths from 34·3 to 28·6 per 100 000 hospital admissions.<sup>4</sup> Research is needed to enable other countries to follow the lead of nations such as Brazil (see page 73) and Colombia, which have implemented comprehensive and effective sexual and reproductive health policies.

Endemic violence against girls and women, especially domestic violence, rape, and sexual coercion, threatens women's reproductive autonomy and right to life. The UN estimated in 2003, that one in three girls will be raped, beaten, coerced into sex, or otherwise abused in her lifetime.<sup>5</sup> Addressing the problem from a public-health perspective, WHO led a research effort, using rigorous and uniform methodology, to assess the prevalence and effect of such violence in Bangladesh, Brazil, Japan, Namibia, Peru, Tanzania, and Thailand. WHO has received requests from other countries interested in doing similar studies, but such work is contingent on the availability of funds.<sup>6</sup> What is also needed is documentation of what works in prevention, follow-up care, and support. Factors contributing to violence, such as crossgenerational sex and child marriage, also require basic and applied research.<sup>7</sup>

Another step towards addressing violence against women is the US government's \$15 billion US Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003, which calls for programmes to encourage men and boys "to be responsible in their sexual behavior . . . and to respect women, including the reduction of sexual violence and coercion". Research on how to encourage responsible behaviour is just beginning, and should be a priority.<sup>8</sup>

### Political will and leadership

Good reproductive health and autonomy for women will be achieved only through concerted popular and political effort. But building political support requires a strong evidence base, especially when making the case that full financing of reproductive health services should be a high global priority—that it is a benefit to society as a whole, worthy of investment at a time of intense competition for human and financial resources (see page 70).

Paradoxically, the shortage of resources for reproductive health services itself results in inadequate data collection. Maternal mortality, morbidity, and suffering are currently underestimated (see pages 67 and 71). Little progress has been made in measurement techniques that compensate for missing data. A study of maternal morbidity, which showed 17 cases of severe morbidity for each maternal death in rural India, was the only example cited for nearly two decades.<sup>9</sup> In 1998, WHO estimated that ten cases of serious morbidity, some with lifelong effects, occur for each maternal death.

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Strong data on unsafe abortion, estimated to cause 13% of maternal deaths and substantial morbidity, are also lacking. Much remains to be learned about how best to support effective use of contraception, reduce unwanted pregnancies, improve access to safe abortions, and treat women with complications after unsafe procedures.<sup>10</sup>

To build the case for priority investment in reproductive health, research is needed in several areas.

- Effects of women's reproductive ill-health on infant survival, especially during the neonatal period. A 1974 study showed that 95% of infants whose mothers died giving birth, died within 1 year, but more research is vital.<sup>11</sup>

- Productivity losses due to pregnancy, unsafe abortion, delivery complications, and sexual coercion and violence.

- The cost-effectiveness of reproductive health interventions. The effectiveness of family planning services has been well estimated, but there is little hard cost-benefit evidence from poor countries for other non-disease reproductive health efforts.<sup>12</sup>

- The extent to which public and private reproductive health services are foundations for HIV/AIDS prevention, treatment, and care. In south Asia, with soaring HIV/AIDS rates, reproductive health services are often the only way to reach the majority of girls and women living in rural areas.

### Health system capacity

The ICPD Programme of Action set out a comprehensive approach to delivering sexual and reproductive health information, education, and services. It recognised that vertical interventions, based largely on certain technologies or drugs, cannot address the social and behavioural determinants of sexual and reproductive health, nor are they suited for some core elements of health care, especially obstetric care. Health system capacity varies enormously, thus solutions must be tailored accordingly. For example:

- Research on what interventions work best in reducing maternal mortality is needed to establish what to scale up, and how, in different settings.<sup>13</sup> Work is also needed on how best to address widespread but neglected maternal health problems, such as obstetric fistula (see page 71).

- Systematic needs assessments and operations research are required to establish which less-than-gold-standard interventions are safe and effective and under what conditions. A good example is work that shows the effectiveness of nevirapine to prevent parent-to-child transmission of HIV/AIDS.<sup>14</sup> Likewise, for cervical dysplasia, which kills more women than breast cancer in poor countries, further research is needed on how to do early detection, treatment, and follow-up in these settings.<sup>15</sup>

### Generating demand

Social, educational, and economic inequalities underlie the reasons why girls and women often do not use health services: they don't know about them, are not allowed by their families to use them, or do not have money to pay for them. We need better data to understand why they cannot access information and services, and what interventions can successfully correct these "market failures".

Similarly, understanding the changing demands of the world's 1.2 billion adolescents is essential. Their access to accurate, comprehensive information and education, as well as to health services, will determine their children's health as well as their own.<sup>3</sup> Programme and policy decisions must be based on solid evidence, rather than ideology. Evidence clearly shows that comprehensive sexuality education works in developed countries.<sup>16</sup> Similar evaluations are needed in Asia, Africa, and Latin America, in part to counter US government policies to promote and fund unproven abstinence-only approaches.

### Conclusion

The ICPD reproductive health agenda is not a utopian vision. Many governments, especially European ones, and bodies such as the World Bank have implemented ICPD sexual and reproductive health and rights commitments. A good example is a Bangladesh national programme designed by the government, civil society (especially women's health and rights advocates), and development partners. Together, these stakeholders reviewed the evidence on reproductive health and made hard choices about which services to prioritise, given the scarce funding available. They debated the importance of, and strategies for, outreach to adolescents, and the challenges of learning about sexuality, addressing violence against women, establishing a charter of patients' rights, and making obstetric services accessible. They made a difference. Between 1998 and 2002, the percentage of women in Bangladesh receiving antenatal care went from 26% to 47%, female life expectancy increased from 58 to 60 years, and female infant and under-five mortality rates fell. The most significant decline was in maternal mortality, which dropped from 410 per 100 000 livebirths to 320.<sup>17</sup> The Bangladesh programme is not perfect, nor is its implementation, but by engaging all sectors of society, progress has been made.

2004 marks the 10th anniversary of ICPD, when the world's nations recognised reproductive health and rights, women's empowerment, and gender equality as important global goals. We hope that this series of articles highlights some of the challenges that remain, and serves as a reminder that these issues underlie many of the world's most pressing problems.

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