Sexual and reproductive health and rights in the post 2015 development agenda[i]

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Abstract
Women's health is currently shaped by the confluence of two important policy trends - the evolution of health system reform policies, and, from the early 1990s on, a strong articulation of a human rights based approach to health that has emphasised laws and policies to advance gender equality and sexual and reproductive health and rights (SRHR). The drive for sexual and reproductive rights represents an inclusive trend toward human rights to health that goes beyond the right to health services, directing attention to girls' and women's rights to bodily autonomy, integrity and choice in relation to sexuality and reproduction. Such an expanded concept of the right to health is essential if laws, policies and programmes are to respect, protect and fulfil the health of girls and women. However, this expanded understanding has been ghettoised from the more mainstream debates on the right to health, and was only partially included in the Millennium Development Goals (MDGs). The paper argues in favour of a two-fold approach to placing SRHR effectively in the context of the Post-2015 Development Agenda: *first*, firmly ground it in an inclusive approach to the right to health; and *second*, drawing on two decades of national level implementation, propose a forward looking agenda focusing on quality, equality and accountability in policies and programmes. This can build on good practice while addressing critical challenges central to the development framework itself.

Keywords

Sexual and reproductive health and rights; post 2015 development agenda; right to health; MDGs

Background

Women's health is currently shaped by the confluence of two important policy trends. On the one side, the evolution and transformation of health system reform policies has shaped and continues

to influence the amount and type of health funding, policies towards human resources for health, the definition of health service priorities, pharmaceutical and technology policies, and management and regulatory frameworks. This has been complemented by macroeconomic policies that affect budgets and policies for key social determinants of health outside health service provision such as nutrition, water and sanitation. On the other side, from the early 1990s on, a strong articulation of a human rights based approach to health has emphasised laws and policies to advance gender equality and sexual and reproductive health and rights (SRHR). While women's health and the problem of gender inequity in health are broader than SRHR (Sen and Ostlin 2010), the latter raise a set of core human rights challenges for development, which this paper addresses.

The two trends identified above have overlapped at times but have more often than not been contradictory in recent decades. Under the aegis of neoliberal economic reforms and structural adjustment since the 1980s, health systems and health sector reforms have tended in many countries to constrain availability of and access to health services while raising their cost through user fees and price decontrol of key inputs such as drugs (Homedes and Ugalde 2005; Leive 2008; van Doorslaer et al. 2007). Such reforms have been challenged by many as violating the fundamental right to health that is a key element of the human development agenda, and of the normative framework for human rights. However, as enunciated until the early 1990s (and by many actors even up to the present time), the right to health was understood to refer mainly to health services and other actions such as the provision of potable water and sanitation that were to be undertaken directly or indirectly by states on behalf of their citizens. From the vantage point of SRHR, this traditional approach to the right to health is certainly preferable to neoliberal health reforms, but it doesn't go far enough.

The drive for sexual and reproductive rights represents an inclusive trend toward human rights to health that goes beyond the right to health services. It was in the United Nations conferences of the 1990s (especially the ones held in Vienna in 1993 on human rights, in Cairo in 1994 on population and development, and in Beijing in 1995 on women) that women's organisations transformed the traditional understanding of the right to health by directing attention to girls' and women's rights to bodily autonomy, integrity and choice in relation to sexuality and reproduction.

The International Conference on Human Rights in Vienna recognised violence against women (VAW) as a violation of women's human rights in both public and private life, noting that, barring conflict situations, most of VAW is perpetrated not by the state but by intimate partners and through harmful customs and practices (Zulficar 1995). It thus brought the violation of women's human rights down to families and communities, and recognised that VAW is embedded in gender power relations that are experienced and reinforced in the life of the community. Because of its serious consequences for the lives and health of women and girls, VAW requires recognition that the right to health goes beyond the right to health services or narrowly defined social determinants of health. It includes a right to be protected from the harmful consequences of gender power relations on health. These consequences are experienced both directly on health, and indirectly through other elements such as education, freedom of mobility, income earning, or others that affect women's ability to be free of violence. This more gender-responsive concept of the right to health requires the state to respect this right in its own laws, policies and institutions; and to take active measures to fulfil them in homes, communities, markets and other institutions.

The above more inclusive understanding of the right to health was deepened further at the International Conference on Population and Development (ICPD) whose consensus outcome

spelled out sexual and reproductive health and rights as part of daily life even in the absence of violence. SRHR was understood to include other elements affected by gender power relations such as women's rights to exercise choice in sex and reproduction within or outside marriage; to bodily autonomy and integrity; to decision-making and control by women over their own bodies *vis a vis* not only states and religious hierarchies, but also in relation to families, partners, and communities. The ICPD also spelled out many of the harmful community and family level practices that violate girls' and women's human rights including their right to health, and identified positive steps that would need to be taken. The Fourth World Conference on Women held in Beijing in 1995 reinforced the outcomes of Vienna and Cairo in a number of ways, most importantly by specifying women's equal right to sexuality "free of coercion, discrimination and violence" (United Nations 1996, paragraph 96).

Vienna, Cairo and Beijing (as these conferences are colloquially called) thus affirmed a more inclusive meaning for the right to health: for women and girls in particular, the right to health is not only about obtaining health services, or providing nutrition, clean water and sanitation. The right to health includes the right to decision-making, control, autonomy, choice, bodily integrity, and freedom from violence and fear of violence. States have a responsibility not only to provide access to health services but also to respect, protect and fulfil the above aspects of women's and girls' human rights vis a vis states' own actions as well as those of families, communities and the private sector.

The emergence of this more inclusive agenda of women's human rights to health has been contentious, but arguably no more so than other human rights. An expanded concept of the right to health to include sexual and reproductive health and rights is essential if laws, policies and programmes are to respect, protect and fulfil the health of girls and women. However, this expanded understanding has been ghettoised from the more mainstream debates on the right to

health, and was only partially included in the Millennium Development Goals (MDGs) as is well known. Barring HIV/AIDS, SRHR and, in particular, ICPD's transformation of the meaning of rights has tended to be marginalised from health sector reforms discussions including the debates on universal health coverage for instance (Ravindran and de Pinho 2005). And it has faced opposition from conservative religious and other forces opposed to gender equality and women's human rights.

Concerns about how to position SRHR in relation to the Post 2015 Development Agenda have, in consequence, ranged from concerns that it may be ignored or set aside as unimportant, to fears of aggressive negative politics against SRHR. This paper argues in favour of a two-fold approach to placing SRHR effectively in the context of the Post-2015 Development Agenda: *first*, firmly ground it in an inclusive approach to the right to health; and *second*, drawing on two decades of national level implementation, propose a forward looking agenda that builds on good practice while addressing critical challenges central to the development framework itself. The next sections of the paper address these two aspects.

An inclusive concept of the right to health

Paragraph 7.3 of the ICPD Programme of Action (POA) states: "Bearing in mind the above definition,[ii] reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents…." The paragraph goes on to clarify what this means: the right of individuals and couples to choose whether and when to have children, and how many children to have, and to have the information and means to do so in the form of family planning and other programmes and services; as well as the right to make these decisions free of coercion, discrimination and violence, and to attain the highest standard of reproductive and sexual health. Government- and community-supported policies have a duty to promote these rights, including the promotion of respectful and equitable

gender relations, and especially to meet the educational and service needs of adolescents “to enable them to deal in a positive and responsible way with their sexuality”.

The rights and duties referred to in this paragraph of the POA were clearly seen as part of existing human rights. Further delineation and refinement have taken place by intergovernmental consensus, global and regional agreements, and General Comments of human rights treaty bodies since then, *inter alia*:

- In paragraph 96 (on the human right of women to control and decide on matters related to their sexuality free of coercion, discrimination and violence) of the *Beijing Platform for Action* (United Nations 1996);
- in paragraph 63 (iii) (where abortion is not against the law, health systems should train and equip health-service providers and take other measures to ensure that abortion is safe and accessible) of the *Key Actions for the Further Implementation of the POA of the ICPD* adopted at the five-year review (United Nations Population Fund 2004);
- in a number of paragraphs (11, 14, 16, 18, 21, 22, 23, 34, 35, 36, 44, 51,52) covering a range of issues including among others SRH information, education, services, harmful traditional and other practices, non-discrimination and equal treatment on the basis of sexual orientation, the right of adolescents to youth-friendly services) of *General Comment Number 14* (on the right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights (ESCR)) of the *UN Committee on ESCR* adopted in 2000 (United Nations Committee on Economic, Social and Cultural Rights 2000);
- in the *UNGASS on HIV* in 2006 (United Nations General Assembly 2006, paragraph 30) and 2011 (United Nations Human Rights Council 2011, para 53) on the rights of women and adolescent girls;
- in the *Human Rights Council Resolution on HIV* in 2011 (United Nations 2011, *passim*) that recognises the need to protect and promote human rights as understood in previous international commitments;
- in the Agreed Conclusions of the *45th Session of the UN Commission on Population and Development* (on adolescents and young people) (United Nations 2012, *passim*);
- in the Agreed Conclusions of the *57th Session of the UN Commission on the Status of Women* (on violence against women) (UN Women 2013, *passim*); and

- in the *Maputo Protocol* (2003) to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Article 14 on Health and Reproductive Rights including inter alia the right to medical abortion) adopted in 2003.

Many of these clarifications and refinements, among others, refer to legal, policy, programme, and budgetary actions that governments and other duty-bearers should take in order to ensure that these human rights are respected, protected and fulfilled.

They also point in the direction of a comprehensive, inter-sectoral and integrated approach so that SRHR is placed firmly within the broad development framework. Despite this, for funding and other reasons, there has been a tendency in the last two decades to split off particular parts of the SRHR agenda for separate treatment as has happened with both HIV/Aids (Germain, Dixon-Mueller and Sen, 2009) and more recently in the discussions on a new thrust for family planning (Sen, 2010); and also to separate SRHR from the broader development agenda.

From a human rights perspective, such splitting off is deeply problematic since it downgrades critical elements of the SRHR agenda, and makes it more difficult for duty-bearers to respect, protect or fulfil those elements. This means, in the context of the Post 2015 Development Framework, that particular attention is needed to ensure the inclusion of all the critical elements of the SRHR agenda, without cherry-picking only the easy or uncontroversial parts. This should ensure inclusion of such elements as prevention of harmful practices such as early and forced marriage, FGM, and a number of other violent practices, supporting girls' and women's right to choice and availability of multiple methods of contraception without implicit or explicit coercion, access to safe abortion services and post-abortion care, the right of adolescents to comprehensive sexuality education and to SRH services with confidentiality and privacy, to name some of the most important ones.

Positioning SRHR in the post 2015 development framework—quality, equality, accountability

Two decades of implementing SRHR at the national level have provided considerable experience and understanding of good practices as well as ongoing challenges. It is important in this regard to view the coincidence in time of the Post 2015 and the ICPD 20 processes not as a problem but as an advantage. The potential advantage is that SRHR has the possibility of being elaborated and debated in the public eye and can therefore actively influence the Post 2015 agenda. But to do this, a fresh approach and vision are needed that can capture the public imagination anew while at the same time addressing the unfulfilled parts of the Cairo agenda. Repositioning SRHR in relation to human development and human rights must be done through attention to the main gaps in the last two decades of implementation.

There is considerable evidence to suggest that the three main gaps in both SRHR and MDGs implementation at present are the absence of quality[iii] in service provision; the fact of large and growing inequality; and the need for accountability[iv]. Globally, and in many countries, the quality of services is poor and services are inaccessible, unaffordable or unacceptable (Germain 2013). Health services quality, especially in low and middle income countries, has been adversely affected by the funding and personnel shortages that followed from neoliberal approaches to health sector reforms. Family planning was one of the earliest health agendas to develop simple and doable approaches to the problem of quality (Bruce 1990). Despite this, and despite the existence of WHO technical guidance, the absence of a culture of quality and insufficient attention to it by funders and governments alike has meant that SRH service quality failures are widespread and often border on human rights violations.

This particularly hurts the poorest women and girls, as well as those living in rural and remote areas, or belonging to oppressed or marginalised groups, and makes thereby for high inequalities in service provision and use (UNFPA 2013b). While poor women generally suffer the most from

these gaps in services, adolescents and especially young adolescents in the age range 10-14 years often do not even have their sexual and reproductive health needs or rights acknowledged as such[v]. Inequality thus has multiple dimensions, not only of poor versus rich, but also on the basis of age, rural versus urban residence, ethnicity or caste, sexual orientation and gender identity, or disability, to name some of the major dimensions. At least one reason for weak attention to inequality is that the paradigm shift from top down population control (pre-ICPD) to more human rights responsive policies needed considerable attention to accountability if policies and programmes were not to slide back into old ways. But this has also been one of the most difficult things to build, as entrenched beliefs, practices and institutions have militated against acknowledging the accountability deficit in relation to human rights.

An approach based on criteria of quality, equality and accountability would advance SRHR laws, policies and programmes towards respecting, protecting and fulfilling the human rights of the most disadvantaged women and young people, especially adolescent girls. Such an approach would also provide new energy and needed momentum in national policies and programmes including those linked to new funding for family planning under FP2020[vi]. It could also generate valuable synergies between multiple global institutions: between UNFPA and WHO on how to move towards universal health care; between UNFPA and UN Women on empowering women (particularly but not only by addressing violence against women), and between UNFPA and OHCHR on addressing the challenge of realising SRHR as human rights in practice.

As discussed earlier, the lessons from the MDGs review process suggest strongly that the setting of goals, targets and indicators is both a technical and a political exercise. *First*, it is essential not to over-quantify, over-simplify or create overly closed systems impervious to lessons from below or experimentation. A mix of quantitative and qualitative metrics is needed in order to place quality, equality and accountability front and centre. *Second*, it will be crucially important to

create and maintain space for effective engagement by civil society whose mobilisation will be essential in order to retain public attention, and to ensure country level focus and follow through. *Third*, and not least of all, the human development and human rights implications of choices (both what is included and what is left out) and the organisational and individual incentives they generate must be clearly spelled out and addressed.

It is generally agreed that the post-2015 development goals should be fairly broad ones that can be benchmarked as global standards. Targets and indicators should be both more specific and clearly linked to each other and to the goals, but should also allow for more flexibility and appropriateness to the country context. The criteria of quality, equality and accountability need to be applied at both global and country levels.

The usefulness of focusing on quality, equality and accountability is that it brings human rights very naturally to the development of targets and indicators. Targets and indicators can include a focus on specific programmatic aspects and can also be focused particularly on improving the SRHR of women and adolescents as specific target groups. In doing this, SRHR can be linked (especially for adolescents) with the prevention of non-communicable diseases (NCDs) through healthier living including the prevention of smoking and alcohol abuse, and actions to protect adolescent girls from a range of practices and risks such as violence, or early and forced marriage.

Conclusion

This is a critical time when both the SRHR and MDG reviews are running in parallel, and when the Post 2015 Development Agenda is being negotiated. It is important for the advocates of SRHR at multiple levels—countries, agencies, funders, and civil society—not to retreat in the face of a vocal minority opposition. The human development and human rights basis of the SRHR agenda are profound and must be spelled out with clarity and vigour.

At the same time, it is important to be clear about the likely scenarios for the setting of goals and to maximise the potential therein. This can be very valuable for the SRHR agenda provided it is done with care and pragmatism, and with a clear sense of direction.

This is the time for the SRHR community to show leadership for the Post 2015 Development Agenda by putting forward a creative and fresh vision backed up by strong technical work and supported by an energised civil society. Placing quality, equality and accountability at the centre of this approach can generate considerable momentum. It will show how SRHR can lead the way to translating rights from rhetoric to actual practice.

Such an approach meets multiple objectives:

- It is rooted in human development and human rights;
- it allows strong synergies with the larger health, gender equality, education and other agendas;
- it builds on key civil society strengths in the organisations of women, young people, and those concerned with family planning; and
- it would solidify the support of many countries for SRHR as part of the larger Post 2015 Development agenda.

Notes

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i A version of this paper was prepared as a background document and presented at ICPD *Beyond 2014—International conference on human rights, Nordwijk, Netherlands, 8-10 July, 2013.*

ii Definition of reproductive health including sexual health in paragraph 7.2 of the POA.

iii I use "quality" here as short-hand for the AAAQ - Availability, Access, Acceptability and Quality.

iv The most recent evidence of this is the Global Report on ICPD implementation (UNFPA 2013b) which was published after the first version of this paper was written.

v UNFPA has recently come out in support of a goal for adolescents (UNFPA 2013a) that is cogent and well argued; how much momentum it is able to pick up in the post 2015 discussions remains to be seen. Although there was a full track on Inequalities in these discussions culminating in a multi-stakeholder consultation in Copenhagen in early 2013, inequality has not picked up much momentum so far in the larger discussion except among civil society.

vi Family Planning 2020 (FP2020) is an initiative of the Bill and Melinda Gates Foundation launched in 2011 with multiple donors to provide new funding and momentum to family planning.