

Sexual and reproductive health and rights

A position paper



Cover photo: Two women harvest vegetables from their plot in Kenya. Two babies sleep peacefully. (Charlotte Thege/Still Pictures)

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by the Rt Hon Hilary Benn MP Secretary of State for International Development

Sexual and reproductive health is important to us all, at all stages of our lives. Yet far too many people are denied their right to sexual and reproductive health. The vast majority are poor women, men and young people in developing countries.

Millions of women and men lack access to contraception and to the sexual and reproductive health information and services they need to choose their family size and improve their own and their children's life chances. Millions more people are living with HIV and sexually transmitted infections that could have been prevented or treated. Every minute a woman dies from a complication of pregnancy or childbirth. Some 80 million women each year have unintended or unwanted pregnancies. For too many their only option is abortion in unsafe conditions. Women, especially, need more choice and control over their sexual and reproductive lives.

There have been some gains. But not enough progress has been made since the 1994 International Conference on Population and Development agreed the goal of reproductive health for all by 2015. This will make attaining the Millennium Development Goals much harder.

We intend to keep at the forefront of the international debate on controversial issues and to support country governments and partners to uphold everyone's right to sexual and reproductive health. These rights have their opponents who feel threatened by them and we must therefore continue to explain why they are important and relevant to everyone.

This paper complements the UK's Call for Action on HIV and AIDS, DFID's strategy on maternal mortality and our Target Strategy Papers on 'Better Health for Poor People' and 'Realising Human Rights for Poor People'. We will use it as the basis for action and work with our partners, and I hope you will find it useful.



Hilary Benn
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Sexual and reproductive health is a human right, essential to human development and to achievement of the Millennium Development Goals. DFID is firmly committed to the Programme of Action of the International Conference on Population and Development and will continue to support governments and partners to achieve reproductive health for all by 2015.

Poor people, especially women and young people, face huge social and economic barriers to sexual and reproductive health. 120 million couples do not have access to the family planning services and contraception they need. Every year, 529,000 women die from complications of pregnancy and childbirth and 3 million children die in the first week of life. 38 million people are currently living with HIV and 340 million people contract sexually transmitted infections each year. Most are preventable.

This paper sets out DFID's position on Sexual and Reproductive Health and Rights and our view of the future. It forms the basis for planning our investment and activities and our work with partners.

We have seen considerable achievements since the 1994 International Conference on Population and Development set goals and targets on reproductive health and rights for all by 2015. Countries have turned ICPD commitments into policies and action, increased access to a range of family planning options, and in some countries cut maternal deaths. But faster progress is needed. We face new challenges, in particular the devastating impact of HIV and AIDS and the biggest ever population of young people entering their reproductive years. Demand for sexual and reproductive health services and commodities will continue to grow. Health systems remain weak in many countries, and are deteriorating in some. There are too few health workers particularly in the poorest areas. We could make more use of opportunities to integrate HIV and sexual and reproductive health services in ways that respond better to people's needs.

DFID will work with country governments and partners to:

- **advocate** internationally and nationally for policies and resources that address people's rights to sexual and reproductive health, and continue to address controversial issues such as safe abortion and harmful and coercive practices;
- **improve access to comprehensive services**, that are responsive to the rights and needs of poor people and other vulnerable groups;
- **address social cultural and economic barriers**, using a rights-based approach, and tackling issues outside the health sector; and
- support research, monitoring and evaluation and **apply knowledge and lessons learnt** in policy and planning.

Our aim is to achieve the following outcomes:

- Improved maternal and newborn health.
- Accessible, high quality family planning choices.
- Elimination of unsafe abortion.
- Reduced incidence of HIV and sexually transmitted infections.
- Greater awareness of sexual health and reduced risky behaviour.
- Gender equality, rights, accountability and equity realised everywhere.

1. The goals of the International Conference on Population and Development (ICPD) of 1994^{1,2} provide the foundation for many of the Millennium Development Goals. We have seen real progress towards the target it set of universal access to reproductive health services by 2015. Important gains have been made over the last decade in sexual and reproductive health and rights, with a renewed focus on women's needs. But there are threats to these gains and much more work to be done to meet the goals and targets.

2. This paper reviews and updates DFID's position on sexual and reproductive health and rights. The following sections review the current situation, describe challenges ahead, and set out DFID's view of the future. We will use the paper as the basis for planning our continued contribution to achieving the ICPD goals. It also communicates to our partners our continuing commitment and approach to achieving those goals.

Why are sexual and reproductive health and rights important?

3. Sexual and reproductive health is an essential element of good health and human development. But we need more progress on sexual and reproductive health to meet many of the Millennium Development Goals (MDGs), particularly those concerned with child and maternal health, HIV and AIDS and other communicable diseases, and gender equality. Better sexual and reproductive health will also accelerate progress towards the MDGs on eradicating extreme poverty and hunger, and achieving universal primary education.

4. Upholding people's rights to sexual and reproductive health would help meet the MDGs in many ways. Most maternal and newborn deaths could be prevented by improved access to well-integrated reproductive health services, including antenatal care, skilled attendance during childbirth and immediately after birth, and emergency obstetric care for complications. Family planning and modern contraception offer choice and opportunity for women to make informed decisions and have more control over their lives. Enabling young women to avoid pregnancy too early in life, when they are at much greater risk of complications, reduces maternal and child deaths. Better spacing of births reduces child mortality and improves maternal health. Sexual and reproductive health information and services are essential to efforts to prevent HIV and AIDS.

5. Sexual and reproductive health is also important as an issue in itself. People have the right to make their own choices and decisions, based on sound information. Improving sexual and reproductive health is among the most cost-effective of all development investments, reaping personal, social and economic benefits. It will save and improve lives, slow the spread of HIV and AIDS and encourage gender equality. It will help to stabilise population growth and reduce poverty. Reducing high fertility can create opportunities for economic growth if the right kinds of social policies are in place.³

6. Reproductive rights must be protected, promoted and fulfilled if sexual and reproductive health outcomes are to be improved, particularly for the poor and vulnerable. A rights perspective highlights the importance of empowering people to take their own decisions about their sexual and reproductive lives. It strengthens the ability of poor and vulnerable people to demand and use services and information and to be heard. It also puts emphasis on equitable access to services and women's empowerment.

7. Experience shows that, given the choice, people want the benefits that sexual and reproductive health offers. The increased choices and opportunities, especially for women, that come from better and more accessible sexual and reproductive health services and education, have led millions of people in many countries to opt for smaller families. But huge inequities remain. The poorest people have the most to gain from improved access but are least able to use and benefit from available services. Priority, clear goals and resources for sexual and reproductive health are needed within Poverty Reduction Strategies and other development plans.

What do we mean by sexual and reproductive health and rights?

8. ICPD defined **reproductive health** as:

"a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes". Men and women should be able to enjoy a satisfying and safe sex life, have the capability to reproduce and the freedom to decide if, when and how often to do so. This requires informed choice and access to safe, effective, affordable and acceptable health-care services.

9. And **reproductive health care** as:

"the constellation of methods, techniques and services that contribute to reproductive and sexual health and wellbeing by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations and not merely counselling and care related to reproduction and sexually transmitted diseases".

10. **Reproductive rights** are defined in the ICPD Programme of Action paragraph 7.3, and are based upon rights recognised in international human rights treaties, declarations and other instruments, including the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the UN Convention on the Rights of the Child,

and the International Convention on the Elimination of all Forms of Racial Discrimination. The 2004 UN Commission on Human Rights explicitly recognised women's sexual rights as essential to combating violence and promoting gender equity. ICPD and ICPD+5 underlined the importance and contribution of rights to population, reproductive health and gender equality issues. The 2001 UN General Assembly's Declaration of Commitment on HIV and AIDS reinforced the ICPD commitments on sexual and reproductive health needs and placed a strong emphasis on women's empowerment. ICPD recognised that people's sexual and reproductive health needs are rights that they are entitled to demand. Box 1 lists specific rights relevant to sexual and reproductive health.

Box 1: Specific rights relevant to sexual and reproductive health^{4,5}

- Right to the highest attainable standard of health.
- Right to life and survival.
- Right to liberty and security of person.
- Right to be free from torture, cruel, inhuman or degrading treatment.
- Right to decide freely and responsibly the number and spacing of one's children and to have the information and means to do so.
- Right of women to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.
- The same right of men and women to marry only with their free and full consent.
- Right to enjoy the benefits of scientific progress and its applications, and to consent to experimentation.
- Right to privacy.
- Right to participation.
- Right to freedom from discrimination (on the basis of sex, gender, marital status, age, race and ethnicity, health status/disability).
- Right of access to information.
- Right to education.
- Right to freedom from violence against women.

What is the scale of the problem?

11. Sexual and reproductive ill health includes death and disability related to pregnancy and childbirth, sexually-transmitted infections, HIV and AIDS, and reproductive tract cancers. Sexual and reproductive ill health accounts for at least 20 per cent of the burden of global ill health for women of reproductive age (15-44 years) and some 14 per cent for men.⁶ These figures may underestimate the full burden as they exclude menstrual disorders and some respiratory tract infections. Of all human development indicators, those for sexual and reproductive health reveal the largest gaps between low income and developed countries and the starkest inequities between rich and poor people within countries.

12. Each year, an estimated 210 million women become pregnant.⁷ Of these, 8 million experience life-threatening complications related to pregnancy and many more develop long-term physical and psychological ill health and disabilities. More than half a million women die every year during pregnancy and childbirth from complications that can almost all be treated effectively. A woman's lifetime risk of dying due to maternal causes is one in 16 in sub-Saharan Africa, one in 94 in Asia, and one in 160 in Latin America, compared to one in 2,800 in developed countries.⁸ Despite some success stories, the global maternal mortality ratio has changed little over the past decade. DFID's strategy on reducing maternal deaths describes the problem and what can be done to improve maternal health in more detail.⁹

13. Some 80 million women face an unwanted or unplanned pregnancy each year.¹⁰ Larger than desired family sizes can make it harder for households to escape poverty and jeopardise the nutrition, health and education of children. Reproductive health and family planning offer a way to improve life chances, yet in developing and transition countries, more than 120 million couples are not using any contraception despite their expressed desire to avoid or to space future pregnancies. About 45 million women seek abortion,¹¹ 19 million of them in unsafe circumstances. Unsafe abortion kills 68,000 women every year, accounting for 13 per cent of all pregnancy-related deaths. Unsafe abortion is also associated with considerable ill health, including infection and infertility. Forty per cent of all unsafe abortions are performed on young women aged 15 to 24 years. Almost all these deaths and illness could be prevented through improved access to and choice in sexual and reproductive health services, particularly family planning and contraception to enable planned pregnancy. Safe comprehensive abortion services can also help eliminate deaths among women who do seek abortion because of lack of choice or control over the circumstances in which they become pregnant. In all settings, effective post-abortion care should be a part of routine services.

14. Many of the 3 million deaths each year of babies in the first week of life¹² and 2.7 million stillbirths are related to poor health of the mother and to inadequate care during pregnancy, childbirth and the period immediately after birth. These statistics have not changed in developing countries in the past 20 years. Short birth intervals risk the lives of children and mothers. Survey data from 18 countries suggest that, compared with children born less than 2 years after a previous birth, children born 3 to 4 years after a previous birth are 1.5 times more likely to survive the first week of

life and 2.4 times more likely to survive to age five.¹³ Postponing first births until the mother is at least 18 years old is another important factor in reducing child deaths. There is also evidence that short birth intervals increase the risk of death for the mother.¹⁴

15. 340 million new cases of largely treatable sexually transmitted bacterial infections occur annually,¹⁵ 100 million of them among young people. Many go untreated due to difficulties in diagnosis and lack of access to competent, affordable services. Many of these infections increase the risk of HIV transmission.

16. The terrible toll of HIV and AIDS is clear: 38 million people living with HIV of which 25 million are in sub-Saharan Africa.¹⁶ In the worst affected countries 1 in 4 people may be infected, with rates of infection still rising. Of these 38 million people 17 million are women, and 2 million are children infected through mother-to-child transmission. Fifteen million children have already lost one or both parents to HIV and AIDS, and it is estimated that there will be 18 million orphans in Africa by 2010. Fewer than 1 in 5 people at risk have access to prevention information and services. The UK Government Strategy on HIV and AIDS¹⁷ describes the problem and response in more detail. More could be done through better integration of services for HIV and AIDS and sexual and reproductive health so that they are complementary and not competitive.

17. Failure to uphold various rights in law, policy and practice adds to the barriers that poor women and men face in accessing services and information and adopting healthy behaviours. For example, sometimes women may not be offered contraception without their husband's consent. Millions of women have no power to challenge violations of their rights. Mechanisms for redress are rare. There is strong evidence from work on HIV and AIDS that fulfilling the rights to freedom from discrimination and to privacy leads to markedly better prevention and treatment.¹⁸ The challenge remains of how better to apply the human rights principles of participation, inclusion, non-discrimination, fulfilling obligation, accountability, and entitlement in and beyond the health sector, in ways that make a real difference to people's lives.

18. Gender discrimination and other forms of social exclusion have very direct effects on sexual and reproductive health. They increase vulnerability to HIV and other sexually-transmitted infections, particularly amongst younger girls and women. Social restrictions, lack of financial security and decision-making power in the household, lack of inheritance and property rights, and inequitable access to education earlier in life, all limit women's use of services and ability to adopt healthy sexual and reproductive behaviour. Programmes often lack components that address such issues.

19. Violence against women exists across all socio-economic groups throughout the world, and includes a wide range of violations of women's rights, including forced prostitution and trafficking, child marriage, rape, wife abuse, sexual abuse of children, intimidation in the workplace, and harmful practices and traditions (including female genital mutilation) that damage sexual and reproductive health. It also includes coercive family planning (e.g. forced sterilisation). Violence is a major cause of long-term gynaecological and psychological problems, unsafe sex, unintended pregnancies, resort to unsafe abortion, maternal deaths, miscarriages, still births and low birth weight babies.

20. Young people are particularly vulnerable to problems of sexual and reproductive health. This is widely recognised but too rarely translated into accessible services for young people. The poorest women start their childbearing youngest, between the ages of 15 and 19 in many developing countries. Half of new HIV infections are among young people aged 15-24, many of whom remain ignorant of the epidemic or ill prepared to respond. In some African countries more than half of young people do not believe they are at risk.¹⁹ Prevalence is highest among young women and girls. The 15 million children so far orphaned by HIV and AIDS will be particularly vulnerable and less likely to complete schooling.

21. The focus on women and young people should not neglect the role of men and their own health needs. The damaging effect of sexually transmitted infections, unplanned pregnancies and other sexual and reproductive health problems on the lives of women and men cannot be fully addressed without men. Men often lack access to the information and services they need to protect their partners' and their own sexual and reproductive health, including education and counselling, diagnosis and treatment of sexually-transmitted infections, and contraceptive services. Men may play a damaging role in controlling women's and young people's sexual and reproductive behaviour and their access to services and information.

22. Demand for reproductive health commodities is increasing as populations grow, and as people become more knowledgeable and actively seek out family planning, and condoms for protection against sexually transmitted infections as well as for contraception. Yet millions of women and men are unable to access the contraceptives and related services they need to plan when and if to have children. Meeting the current gap and future increases in demand will make a huge difference to people's lives. It will lower reliance on abortion, which for many women is the sole means of regulating fertility. The number of couples wanting contraceptives is predicted to rise from 525 million couples in 2000 to 742 million in 2015. UNFPA also predict that the need for condoms for prevention of HIV and other sexually-transmitted infections will rise from 8 billion in 2000 to 12.8 billion in 2005 and 18.6 billion in 2015.²⁰ Improving the supply of commodities will require better coordinated systems nationally and internationally for needs assessment, financing, procurement, regulation and distribution.

23. Poor sexual and reproductive health and huge unmet need for family planning is threatening wider development, especially in Africa. Here, while average family size is falling in many places, populations are still growing and so the effect of individual women having fewer children is offset by increasing numbers of women of reproductive age. Three quarters of women in sub-Saharan Africa need but do not have access to family planning and the opportunity it offers to take more control of their lives. UN projections show an increase in Africa's population from 794 million in 2000 to 2,000 million in 2050.²¹ This huge increase is almost bound to check progress towards poverty reduction goals and achievement of the MDGs.

24. Health service coverage in many high burden countries is currently far short of meeting needs for services for sexual and reproductive health. This is particularly so for poor people and other underserved groups, including displaced people and refugees. In many countries, institutions are often weak and financing inadequate to cope with even the most basic needs, let alone increasing demand for reproductive health services. Shortages of human resources for health are being made worse in countries hard hit by the HIV epidemic.

25. Accessible, comprehensive sexual and reproductive health services are the cornerstone of efforts to enable people to make informed, safe and healthy choices. They need to be addressed within national and local development plans. Services need to be:

- responsive and **accountable** to poor and vulnerable people;
- **appropriate** to local needs;
- **acceptable** to poor women, men, young people and specific vulnerable groups (such as sex workers);
- **affordable**;
- **physically accessible** (location and opening times);
- of **high quality** (client-focused, well-managed with the skilled staff, equipment and supplies needed to offer best practice); and
- **non-discriminatory and non-stigmatising** (attitudes of health providers to poor and vulnerable people).

26. As for so many other aspects of basic health, improving reproductive health depends on strengthening health systems. Increasing access to sexual and reproductive health services requires adequate resources (both financial and human), accountability between policy makers, providers and citizens, and strengthened public institutions. The critical shortage of service providers and other human resources for health calls for both short and longer-term responses to problems such as low pay and poor incentives, migration, deployment and retention – as part of wider strengthening of service delivery systems. Building effective demand for sexual and reproductive health services means commitment to giving poor people more say and improving their ability to hold providers accountable for the delivery and quality of services. Community-based and community-led action also provides an important and essential part of the response and drive to promoting better sexual and reproductive health.

27. There are significant barriers to behaviour change experienced by young people. Abstinence messages have been promoted as a way to promote behaviour change. However, evidence seems to suggest that simply telling young people to abstain is not the answer.²² WHO studies show that sex education delays the onset of sexual activity and increases safer sexual practice.²³ They need the knowledge, skills and assertiveness to make safe decisions and have them respected, including to say no and to delay sex. Research shows that sex education does not increase the number of sexual partners among young people.²⁴ They need access to comprehensive and confidential services that

respond to the realities of their lives. And if they do have sex – and eventually most of them will – they need access to the information and means to protect themselves.

28. Services should incorporate policies and activities that promote gender equality and reduce social exclusion. Comprehensive sexual and reproductive services aim to provide (though not necessarily all from one site):

- **Education and information** on all aspects of sexual and reproductive health.
- Counselling on and access to a broad choice of **family planning** and modern contraception for all who want to prevent or space pregnancies.
- Care during pregnancy and childbirth for **mothers and newborn children** including a continuum of skilled attendance before during and in the period immediately after birth, and emergency obstetric care for complications, with effective referral systems.
- Care for **longer-term psychological and physical problems** arising from pregnancy complications and pregnancy loss.
- Comprehensive care for **women who seek abortions**: safe abortion services where legal and post-abortion care everywhere, including counselling on family planning to help avoid repeat abortion.
- Diagnosis, counselling, treatment, and promoting prevention of **sexually transmitted infections, including HIV**. Services for prevention of mother-to-child transmission of HIV. Sexual and reproductive health services for people with HIV to enable informed choices, and where feasible the inclusion of family planning within HIV services such as voluntary counselling and testing.
- **Supply of commodities** (contraceptives, condoms, medicines, etc.) to meet demand. A broad range of commodities must reach those who are most in need but can least afford them. (When used correctly and consistently, **condoms** are highly effective in preventing sexually-transmitted infections and HIV infection and are an important choice in preventing pregnancy.)
- Care and counselling for women and others who have suffered **violence** that threatens their sexual and reproductive health, and generating community and political recognition and support to address the causes of violence.

- Adolescent friendly services that provide an approachable, responsive environment and offer young people the information, skills and means to make safe choices.
- Care, counselling and prevention promotion for aspects of sexual and reproductive health including menstrual problems, cancers, fertility and sexual dysfunction.

29. The sexual and reproductive health and HIV and AIDS communities need to work together on policy-making and service delivery.²⁵ Given that HIV is predominantly sexually transmitted, sexual and reproductive health services are an integral component of HIV prevention, building on the lessons of family planning promotion and behaviour change. Similarly HIV and AIDS services offer an important opportunity for increasing access to sexual and reproductive health services, including for women and men affected by HIV. Initiatives to reduce stigma and discrimination associated with HIV, and targeted HIV and AIDS interventions for vulnerable groups can also improve marginalised people's access to sexual and reproductive health services. Improved access to family planning enables increased condom use for HIV prevention, and reduction of mother-to-child transmission. Integrated services can harness resources more effectively. Integration is not straightforward: the arrangement of services needs to recognise the stage of the HIV and AIDS epidemic and the needs of specific groups. For example, integrating antenatal and other services may reduce accessibility of those services for men; integrated clinics for sexually transmitted infections and HIV and AIDS may not meet the harm reduction needs of injecting drug users.

30. Improving services is not enough. Sexual and reproductive ill health has major social, cultural, political and legal determinants and consequences that also need to be addressed in other ways. Taboos and norms about sexuality and reproduction (including practices such as child marriage, female genital mutilation, early sexual initiation) present strong barriers to providing information, services and other forms of support that people need to be healthy. Sex, pregnancy and young people are sensitive issues, but must be addressed if young people are to fulfil their potential. Social policies and action are needed to support communities to develop healthy and supportive social norms and to confront practices that damage sexual and reproductive health. These efforts need to be backed up by rights-based legal and policy frameworks.

31. A rights-based approach to sexual and reproductive health can add momentum to policy-making and improvement of services. DFID identifies three key operational principles of a rights-based approach: inclusion, participation and fulfilling obligation.²⁶ Components are contained in Box 2.

Box 2: Components of a rights-based approach

Participation:

- increasing access to information on reproductive rights, to give people choices and a sense of entitlement to quality services;
- ensuring that poor and vulnerable people participate actively in setting priorities and standards for policies and programmes;
- supporting civil society organisations to monitor government policies and performance on sexual and reproductive health issues;
- supporting women's groups and other vulnerable groups, including people with HIV and AIDS, to participate in the provision and monitoring of quality sexual and reproductive health care; and
- working with community leaders to protect reproductive rights.

Inclusion:

- targeting poor, vulnerable and excluded groups in countries with the largest burden of reproductive and sexual ill health;
- disaggregating data to monitor disparities in access to services and in health outcomes;
- promoting equality for women and men, to empower women to control their sexual and reproductive lives;
- working with men and boys to tackle harmful behaviour and increase their understanding of women's rights; and
- tackling discrimination in service provider attitudes and practices by supporting health workers' understanding of reproductive rights, whilst upholding the rights of service providers themselves.

(continued)

Box 2: Components of a rights-based approach (continued)**Obligation:**

- reforming legislation and policies that contribute to poor sexual and reproductive health;
- implementing laws and policies that protect women's health, such as prohibitions against child marriage and female genital mutilation;
- implementing anti-discrimination laws that enable vulnerable groups to access services;
- building in-country capacity to advocate for sexual and reproductive health and rights in reform processes;
- guaranteeing a means of redress for the violations of rights, linking up individual action with national advocacy processes;
- building capacity of policy-makers and service providers to respond to the voices and demands of poor and vulnerable groups;
- supporting governments to put in place rights-based monitoring tools, such as equity audits; and
- harnessing in-country capacity to monitor action on commitments to promote reproductive rights, through treaty-based monitoring bodies such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and through civil society organisations.

32. Investment in reproductive health is cost-effective. As well as direct health gains, better access to services can enable completion of education, especially for young women, higher productivity, greater involvement in the community and workforce and better family care. But more analysis is needed to quantify the economic, social, gender and governance benefits.²⁷

What progress has been made?

33. ICPD shifted the debate about reproductive health from demography to human development. It established consensus on, and commitment to, reproductive health and rights with a renewed focus on women's needs. ICPD set a new standard for what people are entitled to expect and what policies and plans should address. Countries have made much progress since 1994 in turning ICPD commitments into policies and action, demonstrating their ownership of the Programme of Action. Many countries include reproductive health within their national reporting on progress towards poverty reduction and attainment of the MDGs. There is also an emerging agenda to promote culturally-sensitive human rights-based approaches, and to translate rhetoric on rights into action.

34. At the same time, some still seek to undermine the ICPD consensus and reverse the gains made in countries striving to implement the ICPD Programme of Action.

35. Countries that have achieved better sexual and reproductive health have done so by using existing resources more effectively, and by building increased political and grassroots support for reproductive rights. This is well illustrated by gains during the 1990s in family planning and maternal health. The availability and quality of family planning has improved in many countries with the result that people in many countries are able to achieve their wish to have smaller families. Maternal mortality ratios in several middle-income countries fell by 30-50 per cent in the 1990s, to below 100 deaths per 100,000 live births (for example in Egypt and Honduras).²⁸

36. The downward trend in fertility globally is projected to continue with consequent potential wider benefits for improved health, poverty reduction and other development indicators. However those benefits are still some way off in countries where the impact of previous high fertility is still being felt. And recent apparent declines in use of contraception in some countries suggest that many people still have little choice in family size. In these countries, there are growing numbers of people of reproductive age. Need and demand for sexual and reproductive health services, especially for poor people, will continue to grow. Support for effective policy-making, resource allocation and action is needed in countries at this challenging stage of demographic transition. Lessons from programmes that have successfully met such demand will be important here.

37. In many respects, the direction of health sector development in the last decade accords well with the ICPD consensus: for example, the emphasis on integrated services to cover the health problems most affecting poor people. But problems remain in providing and maintaining sexual and reproductive health services in the face of broader changes such as decentralisation and privatisation of services, and finding the best way to involve, coordinate and regulate multiple service providers, including the private sector, which are playing an increasingly important role. The poorest still often remain excluded by social, geographic and economic barriers. It is the richest people in many countries who benefit most from public subsidies for health care. Laws, policies and regulations, as well as custom and practice of officials and health workers, may hinder access to services. Greater delegation to enable health workers to work closer to communities would save and improve many lives.

38. The way development assistance is given has been changing. This includes a shift by many donors away from targeted project investments into support to overall health sector strategies or to comprehensive government poverty reduction strategies. There has been little change in investment in basic sexual and reproductive health services and family planning, and a continuing neglect of maternal and newborn health, services for adolescents and action to reduce violence against women. Often reproductive health is a low priority in sector plans and budgets. Potential implementers, including non-governmental organisations (NGOs) and civil society organisations, cannot easily secure the funds that are available. The benefits of integrated services for sexual and reproductive health are not being realised as envisaged by ICPD. Delivery of HIV and AIDS prevention, treatment and care requires strong sexual and reproductive health services and offers an opportunity for increasing access to them. Increased resources could be used more effectively to strengthen health systems and support other actions that contribute to sexual and reproductive health.

39. The major barrier to the expansion of comprehensive services in many countries is too few trained staff, in health generally and sexual and reproductive health specifically. Increasing difficulties in retaining skilled staff, particularly in poorly served areas, and the tragic loss of staff to HIV and AIDS in countries with high HIV prevalence, is heightening the problem. It calls for commitment to find and deliver long-term solutions locally and internationally. Better-integrated services would make better use of existing skilled staff but integration is not enough on its own to meet growing needs.

40. There is now a large and growing body of knowledge on what works to improve sexual and reproductive health. Continued investment is needed in research, monitoring and evaluation, and lesson learning to address remaining barriers to access, and to generate new more effective approaches. There needs to be more rapid translation of emerging knowledge and technology into policy and practice. Likely areas where new evidence over the next decade will require new policy and practice include microbicides for prevention of HIV and other sexually transmitted infections in women, medical abortion and emergency contraception. Research on contraceptives has increased the options available and must continue, for example to develop methods that better meet women's dual needs for contraception and protection against infection. New knowledge and policy analysis is needed on the cost and effectiveness of different approaches to integrating services for sexual and reproductive health, promoting culturally-sensitive human rights-based approaches, and on ways to reach the poorest and most vulnerable, including internally displaced people and refugees.

What is DFID's position?

41. DFID remains firmly committed to realising international targets on sexual and reproductive health and rights. Without progress on sexual and reproductive health, the MDGs will not be achieved.

42. DFID is also firmly committed to the principle of progressive realisation of human rights. We recognise the challenge of implementing human rights approaches in different cultural and political contexts, and will support countries' own efforts to address violations of reproductive rights. We will continue to mainstream a rights-based approach and use it to shape and prioritise the practical action outlined below.

43. We will continue to work to accelerate progress towards the ICPD goals, focusing on:

- advocacy and partnership;
- support to strengthen sexual and reproductive health services;
- support to address social, cultural and economic barriers to access; and
- generation and application of knowledge.

We will do more to get those working on HIV and AIDS and sexual and reproductive health to cooperate with each other, to ensure coherence in policy and planning and address reproductive health within HIV and AIDS responses and vice versa.

44. DFID has recently increased the number of staff working on sexual and reproductive health and several central policy teams are working together to provide policy and advisory support to country, regional and international programmes.

Advocacy and partnership

45. DFID aims to be at the forefront of the debate on sexual and reproductive health and rights, ensuring that sound knowledge and analysis is applied. We will lobby hard to maintain the international consensus, and argue the case for comprehensive reproductive health services that enable people to make responsible choices. Our advocacy and partnership building with governments, international organisations and civil society will emphasise a rights-based approach.

46. We will continue to address controversial issues, including access to safe abortion services and coercive policies and practices, and will support measures to counter gender-based violence. We support the line of the ICPD Programme of Action that abortion should not be promoted as a form of family planning. However, we believe that when any woman does seek an abortion, it should be safe and they should have access to post-abortion care and counselling on and access to a wide range of family planning.

47. We will continue to support and work with agencies and partnerships involved in sexual and reproductive health and rights and in health systems strengthening at country and international level. We currently support the World Health Organisation, United Nations Population Fund, UNICEF, UNAIDS, the World Bank and the European Community, and the International Planned Parenthood Federation, and support NGOs through the Civil Society Challenge Fund and tendered contracts. Specific examples are in Box 3. We will continue to support and work with international agencies and partnerships where this adds value to country-led efforts.

Box 3: Examples of DFID support to international agencies

UNFPA: support for their role in providing the widest achievable range of safe and effective family planning, and condoms to prevent HIV and AIDS, and in promoting reproductive rights in international fora and at country level.

WHO: budget support for programmes including those of the Department of Reproductive Health and Research. These provide research evidence and technical support for policy and practice on reproductive health to high-burden countries.

UNAIDS: support to intensify and strengthen the coherence of responses to HIV and AIDS including work to emphasise the continued importance of HIV prevention and the role of sexual and reproductive health and rights.

IPAS: a major source of support to this international NGO, which has had considerable success working with governments and civil society to increase women's access to safe abortion care and related reproductive health information and services.

International Planned Parenthood Federation: increased funding. The world's largest voluntary reproductive health organisation, IPPF has a network of civil society organisations in 164 countries. Its five priorities are: adolescent sexual health, HIV and AIDS prevention, unsafe abortion, access to information and services, and advocacy.

48. The Government launched the UK's Call for Action on HIV and AIDS²⁹ in December 2003. The Call for Action was the first stage of a campaign to step up efforts bilaterally and internationally to tackle the devastating burden of the epidemic. The UK Government Strategy on HIV and AIDS lays out steps to implement the Call for Action. The international community must work better together to achieve real progress towards the international targets for HIV and AIDS. We will ensure that DFID's international and national responses to HIV and AIDS promote sexual and reproductive health and rights.

Improving access to sexual and reproductive health services

49. The vast majority of our support will continue to be at country level. We will seek to ensure that reproductive and sexual health is adequately reflected in national planning processes, including poverty reduction strategies and other development frameworks, sector plans and budgets. Through our support to and involvement in the UN, we will encourage UNFPA to play a lead role here. We will argue for adequate priority and accountability for sexual and reproductive health in health sector strategies and essential health care packages, and promote the translation of such commitments into resources, action and outcomes.

50. We will continue to participate in and support health sector development processes that address underlying issues such as ways to reach the poorest and most vulnerable, human resources, sustainable finance, commodity security, non-state service provision, building accountability, and rights-based regulatory frameworks. Civil society organisations, non-state providers and UN agencies are vital to this work.

51. We will support national government stewardship of inclusive processes that harness in-country knowledge and expertise and ensure follow-through and accountability. Where these processes are weak, particularly in places affected by conflict, we will work with partners to help build accountability and capacity, assess needs and design and implement coordinated responses.

52. We will continue to invest in comprehensive services for sexual and reproductive health through our country programmes and partnerships and through support to international agencies. Our annual bilateral investment in HIV and AIDS and sexual and reproductive health (which also serves to reduce maternal mortality) increased from £56 million in 1997/8 to over £370 million in 2002/3. While the majority of new programme commitments have focused on HIV and AIDS, these offer benefits for reproductive health, improving access to and quality of services generally. Support will include improving family planning choice and access to services, ensuring supply of reproductive health commodities with an effective mix of public, private and social marketing provision, and improving access to services for sexually-transmitted infections, HIV and AIDS, adolescent and maternal and newborn health (see paragraph 28). The particular mix will be based on local analyses of need, current provision and the likely impact of improving services. Some examples of DFID support are given in Box 4.

Addressing social, cultural and economic barriers to reproductive health

53. Improvements to sexual and reproductive health will also result from investments in other sectors including education, governance, gender, and social and economic development. Communities need a social environment that fosters sustained behaviour change. We will work with country partners on recognising these non-health sector elements in development plans, and on building them into sector plans and allocations. We will carry out new policy analysis on how rights-based approaches can contribute in a practical way to improving access. In particular, we will examine what contribution rights can make to (a) strengthening legal/policy frameworks (b) strengthening health systems in ways that improve sexual and reproductive health (c) broader strategies that address the wider social, cultural and economic issues. We will continue to work with WHO, UNFPA, UNAIDS and UNICEF in implementing a human rights approach to programming.

Box 4: Examples of DFID support to countries

Safer motherhood in Nepal

This is one of several ways in which DFID is supporting the Government of Nepal to improve sexual and reproductive health. Nepal has one of the highest maternal mortality rates in South Asia. A recent study suggested that 20 per cent of maternal deaths in health facilities are due to unsafe abortion. In 2002, Parliament amended the constitution to legalise abortion under any conditions up to 3 months gestation, and at any stage where the life or health of the mother is at risk if the pregnancy continues.

The DFID project and partners have provided financial and technical support to Nepal's Department of Health in implementing this change in law, developing policies, implementation strategies, protocols and curricula for safe abortion services and post-abortion care, and adapting communication and monitoring and evaluation strategies. Policy analysis has been an essential component and has included international lesson learning, particularly from India, and a rights-based approach has underpinned the work.

Box 4: Examples of DFID support to countries (continued)

Sexual and reproductive health through a sector-wide approach in Ghana

In Ghana, support for a sector-wide approach to health has seen benefits for sexual and reproductive health and rights in several ways, including: improved staff and financing for the poorest districts, better collaboration between the centre and districts on performance monitoring, and fee exemptions for maternal health services in the poorest regions in the North. A new National Health Insurance Programme will have a benefits package that includes maternal health services and family planning.

The SWAp has helped increase the profile and effectiveness of UNFPA. UNFPA and WHO have, with the Ghana Health Service, initiated the development of a national plan for improved reproductive, maternal and newborn health in Ghana.

Generating and applying knowledge

54. DFID funds a broad research programme in sexual and reproductive health including knowledge programmes and development of new technologies, including contributions to HIV vaccine, microbicide and contraceptive development partnerships. We fund research that aims to extend the evidence base for policy and practice, and we promote the use of this evidence by policy makers and practitioners. There are gains to be made from drawing together research communities working on sexual and reproductive health and on HIV and AIDS. The new DFID research strategy highlights the importance of strategies for improving sexual and reproductive health and HIV prevention and their implications for gender equality.

55. We also contribute to international work to monitor and evaluate progress against the international targets. We will continue to work across DFID and with partners to translate new evidence and lessons from practical experience – including lessons from other health programmes and other sectors – into innovative rights-based approaches to sexual and reproductive health.

Conclusion: Where do we go from here?

56. We should not be complacent about gains of the past decade. Increasing demand for services, threats to the international consensus, and the HIV and AIDS pandemic, all bring extra challenges. We will work to develop a fresh approach that recognises sexual and reproductive health and rights as central to human development and to achieving the MDGs.

57. We must do more to achieve the following outcomes:

- Effective integration of services for sexual and reproductive health built on a strong health system – including greater lesson learning between, and integration of services for, HIV and AIDS and sexual and reproductive health – resulting in:
 - improved maternal and newborn health;
 - accessible, high-quality family planning and contraceptive choices;
 - elimination of unsafe abortion;
 - reduced incidence of sexually transmitted infections including HIV and reproductive tract infections, cervical cancer and other gynaecological illness and disability; and
 - greater awareness of sexual health and reduced risky behaviour.
- Gender equality, rights, equity and accountability addressed across the board, with highest priority for the poor and most vulnerable, including young people.
- Sustained financial and human resource investment in comprehensive sexual and reproductive health and in health systems development.
- More effective research, policy analysis and advocacy work to promote all these outcomes.

58. The different but connected aspects of sexual and reproductive health need to be addressed coherently through the 'sexual and reproductive health approach' agreed at ICPD. We will work with countries to strengthen and build on existing services and to introduce new more effective approaches. Our challenge is to scale up proven approaches, targeting people in greatest need such as adolescents and the poor and making health systems more responsive to the needs of poor women and men. We will work with partners to help countries produce better information for planning and priority setting, monitoring, evaluation and accountability and will promote sexual and reproductive health rights at all levels of our development effort.

59. Strategies are in place for DFID action on maternal health and UK action on HIV and AIDS. We are working with partners to develop new knowledge and policy in other areas, including rights-based approaches, and reproductive health and poverty. We will use this position paper as a basis for planning the contribution of all parts of the organisation to improving sexual and reproductive health and for our work with partners.

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Department for International Development

The Department for International Development (DFID) is the UK Government department responsible for promoting sustainable development and reducing poverty. The central focus of the Government's policy, based on the 1997 and 2000 White Papers on International Development, is a commitment to the internationally agreed Millennium Development Goals, to be achieved by 2015. These seek to:

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- Achieve universal primary education
- Promote gender equality and empower women
- Reduce child mortality
- Improve maternal health
- Combat HIV/AIDS, malaria and other diseases
- Ensure environmental sustainability
- Develop a global partnership for development

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