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Historical development of the global political agenda around sexual and reproductive health and rights: A literature review

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ABSTRACT

Introduction

Sexual and Reproductive Health (SRH), which is identified by Amnesty International as an important human rights issue [1–4] not only comprises pregnancy/antenatal, childbirth and post delivery/natal but also refers to: "*A state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so*". [5]

This paper reviews the growing universal significance of Sexual and Reproductive Health Rights (SRHRs), policies and the global political agenda over the past 24 years. In addition, it explores what the SRHRs agenda means for fragile states, drawing upon relevant lessons learnt from other countries.

This paper begins by exploring the historical development of WHO (World Health Organisation) and other organisations' political agenda for advocating SRHRs improvement. Implication and implementation of these policies will be discussed. It will also address initiations for sexual and reproductive health system improvement in the low-income countries, especially conflict-affected states. This paper concludes with an outline of how universal access to SRHRs evolved through the years. Even though the concept of SRHRs was developed in Western countries what resistance did they face, which elements were contested and why were they contentious?

Historical development of the global political agenda around SRHR

Over the past sixty years, many international and governmental entities undertook initiatives to address universal health issues [6,7]. However, SRHRs were not particularly addressed in the global health agenda until more recently and therefore it has taken a longer period of time for them to be recognised in the global health agenda as a significant universal health issue.

In the 1950s, there was a conspicuous focus on the issue of population dynamics and disease treatment, while Sexual and Reproductive Health (SRH) related issues were overlooked [7–9]. Indeed, throughout the 1950s, global health systems were curative oriented and any specific health issues such as SRH were not adopted in the political agenda.

In the 1960s, interconnectedness between poverty and numerous health issues was acknowledged. Emphases were made on the social determinants of health, such as sustainable social and economic development, jobs and an increase in labour income, to decrease the prevalence of diseases and poverty [10]. Subsequently, in 1987, the Alma-Ata declaration was adopted at the International Conference on Primary Health Care in Kazakhstan, which underlined the health system-strengthening plan through primary health care services. This declaration emphasised multisectoral commitments to achieve sustainable economic and social goals, which could help promote human rights through healthier nations [6,7,11].

The Alma-Ata declaration demonstrated a bottom-up approach and represented a shift from curative to preventative health care. The WHO enunciated the Alma-Ata declaration as the fundamental framework for civil societies' capacity building and health system-strengthening. Likewise, people's awareness of their rights to access higher quality health care services were considered crucial [6,7,11].

To outline specific strategies and interventions for the reduction of maternal death ratio and pregnancy and childbirth complications, a call for action was issued at the Nairobi Conference (1987) as the Safe Motherhood Initiatives (SMI) and was introduced to improve maternal health at both national and international levels [12–14]. The SMI programme [15,16], underscored social and family support for women during pregnancy and childbirth. The WHO and other UN agencies sought international

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commitments and funded SMI awareness meetings with policy makers from around 90 countries during the period 1987–1994 [17].

Implementation and/or implications

The confluence of two policy trends (the Alma-Ata declaration and SMI) has shaped maternal health care services [18]. First, reforms were made to health system policies and funding following a 'Neoliberal' approach [19], which means addressing higher quality health service provision and social determinants of health such as access to safe water and sanitation, employment, nutrition and poverty reduction [20]. Second, after many years of debate and negotiations, universal access to SRH without any discrimination and violence was addressed. It was first recognised and included in the agenda of the Vienna 1993 World Conference on Human Rights, followed by the Cairo 1994 International Conference on Population and Development (ICPD) [18,21–23]. However, it has been argued that the adoption of a Neoliberal approach or focus on SRH system-strengthening, does not cover all elements of SRHRs, because SRHRs also presupposes legislation against abortion; young age marriage and female genital mutilation (FGM), which are not included [18,21–23].

In 1994, the ICPD Conference established a new benchmark for global and national population and health policies for SRHRs. This conference facilitated 179 governments to adopt the Programme of Action (POA) and to implement three main goals, which were the reduction of maternal and child mortality, the provision of universal access to education and access to reproductive health services. These POA goals were translated into the Millennium Development Goals (MDGs) in the year 2000 [14,24]. It has been suggested that as part of health system-strengthening, male involvement and understanding of religious beliefs, social acceptability and cultural practices can be added to political agendas to improve gender equality and access to SRH services [21,23]. These initiatives were further backed up in the 1995 Beijing 'Platform For Action' programme [25–28].

During the ICPD and Beijing conferences [25–27], important SRHRs issues were debated. For instance, topics around sexual rights, improving policies and guidelines for higher quality SRH service uptake and provision, emergency obstetric services, access to safe abortion, sexual education and SRH system-strengthening were part of the discussions.

Implementation and/or implications

This was a great achievement for the SRHRs activists because policy-makers and funders formerly considered general health issues but did not recognize the universal significance of SRHRs. Sexual and Reproductive Health and Rights advocates faced many objections and challenges because sexual rights did not have clarity in terms of sexuality, sexual health services uptake and education, safe abortion, FGM and gender violence [18,26–28,4]. Indeed, one of the most sensitive issues that created controversy was SRH education. Later, the language was changed through stressing the importance of the parental guidance during the life of adolescents, although issues related to parents, and in particular, men's SRH awareness remained blurred.

Some groups reasoned that none of the governments would consider women's rights and provide broader access to safe abortion. Sexual and reproductive health and rights advocates ensured that the SRHRs issues were incorporated into the ICPD conference agenda. However, the outcomes of their efforts were not satisfactory, and the SRHRs topic still remains controversial [26–28].

Subsequent to the ICPD (1994) and the Fourth World Conference on Women (1995) many global policies emphasised the significance of male involvement as a key aspect for reduction of unintended pregnancy, STIs, interpersonal violence, maternal mortality and morbidity and, more importantly, access to SRH services. Overlooking men's SRH awareness and service needs that are similar to those of women, contribute to wider gaps in SRH service uptake and improvement [29–31].

Following the acknowledgement of the SRHRs' broad concept in the Cairo ICPD in 1994 and the Beijing 1995 'platform for action for equality development and peace' programme [18,24–27,32], in the year 2000, the United Nations' 191 members agreed on a declaration of eight MDGs and agreed to pursue and accomplish these goals by 2015 [7,18,33,34].

The eight MDGs comprised reduction of poverty and hunger (MDG1), provision of primary education and eradication of illiteracy (MDG2), upholding gender equity and empowerment (MDG3), reduction of child death (MDG4), maternal health improvement by reduction in maternal death ratio (MDG5), fighting against prevalence of HIV/AIDS, Malaria and other diseases (MDG6), preserving clean environment (MDG7), and fostering global development partnership (MDG8) [35–37].

Implementation and/or implications

Some scholars argue that many aspects of SRHRs sat apart from the MDGs agenda. The MDGs demonstrate that only non-sensitive issues are picked and some significant issues of women's health rights are excluded. Prevention of sexual violence and safe abortion faced resistance from some conservative groups and therefore such issues were not included in the MDGs [18,26,27]. On the one hand, a number of civil society organisations shared their concerns about overlooking SRHRs, gender-based violence and young age forced marriage in the MDGs [18,32,34]. On the other hand, many of the organisations involved acknowledged the significant impact of MDGs specifically on countries where governments set targets and put efforts into achieving these goals [32,38].

The MDG5, which consisted of two targets (A and B) was regarded as a 'Person-centred' approach. However the focus was only made on maternal health improvements and there was no mention of SRHRs [32,34,39]. Millennium Development Goal (5A) aimed to reduce death by three folds by the end of 2015. Although maternal death is only one of many SRH elements other SRH elements such as family planning, safe abortion, higher quality sexual and reproductive health service uptake, SRH education, STIs and STDs were not included in the MDG 5A [40].

It took a further two years for the UN General Assembly to recognize the need for MDG5 target B. In 2006 UNFPA urged the UN General Assembly to include target B to MDG5 and the target B indicators were finally added in the year 2007 [34]. Target B comprised of universal access to reproductive health such as; increase in the contraceptive prevalence rate, unmet needs for family planning and four Antenatal Care (ANC) visits. However, the extended elements of SRH and rights such as abortion, marital age and sexuality education, remained too sensitive and a constricted issue to be fully acknowledged by policy-makers and funders [8,18,40].

Since MDG5 only addressed reductions to maternal death ratio and did not fully cover SRHRs, some argued that the funding system and projects shifted to specific, selective and vertical programs, which detracted from health system-strengthening and multi sectoral approaches [6,32,33]. It is debated in some papers that in order to support countries for understanding and complying the commitments for women's health and well-being, the health organisations and funders either focused on a few cost-effective vertical interventions to target some specific diseases with higher prevalence and maternal death ratio statistics or a horizontal intervention to scaling-up balanced, curative and preventative primary health care services [6,32].