

# Good choice: the right to sexual and reproductive health

Access to sexual and reproductive health services is vital in preventing unnecessary deaths of men and women. Yet around the world, governments and health organisations do not prioritise spending on these services.



The right to health is a universal human right and this includes sexual and reproductive health. To guarantee these rights, people must be treated according to their needs and work against prejudices which limit access to healthcare. While married people need access to good sexual and reproductive health services, so too do teenagers, gay men, disabled people, sex workers, drug users and people having sex outside marriage.

Good sexual and reproductive health services enhance public health and improve quality of life. They can reduce the risk of disability, disease or death from sexually transmitted infections (STIs), harmful traditional practices and HIV and AIDS.

Thousands of women die from complications associated with pregnancy and childbirth. The provision of midwives at birth plus community-based antenatal work with mothers and traditional birth attendants can hugely reduce maternal mortality rates.

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And having a choice about how many children a woman has, and when, makes pregnancy, childbirth and abortion safer. Despite the obvious gains, improving access to these health services is often contentious. Medical developments such as female condoms, abortion pills, screening for STIs and making antiretroviral drugs available can bring public health policy into conflict with religious ideologies and traditional practices. Lack of funding, changes in legislation or simple government inaction can create barriers to universal access to services.

Journalists can play a key role in getting important sexual and reproductive issues debated publicly. They can examine critically the claims made by traditional healers and health researchers alike. Investigating whether research reflects the reality on the ground and interviewing researchers about key trends should all result in information to enrich a story.

## Media toolkit on communicating research

This is the fourth in a series of briefing documents for the media from the RELAY programme. RELAY works with Southern print and broadcast journalists to communicate the findings of academic research in an accessible way. The briefings set out the main issues around a topic, prompting journalists to pursue ideas and do further story research themselves. If you wish to receive future media briefings by email, please contact [media@panos.org.uk](mailto:media@panos.org.uk)

To find out more about Panos London and the RELAY programme go to [www.panos.org.uk/relay](http://www.panos.org.uk/relay)

## Getting started

In 2006 a key article in the UK-based medical journal, *The Lancet*, written by Anna Glasier and colleagues, stated that in developing countries unsafe sex is second only to malnutrition in leading to disability, disease or death. Every year 80 million women worldwide have unintended pregnancies, 45 million of which end in abortion. Because abortion is legally restricted in many of the poorest countries, some 5 million women are estimated to be hospitalised each year for complications as a result of unsafe abortions. Over half a million women die from complications associated with pregnancy and childbirth, with almost half of these deaths occurring in South and South East Asia. Every year 340 million people acquire STIs, including 5 million new cases of HIV – more than half of which are in sub-Saharan Africa, where two thirds of all people living with HIV and AIDS live.

The recognition of individual rights as the principle underpinning sexual and reproductive health policy and services is relatively new. But there are many more factors – political, cultural and economic – which influence how policies are implemented and how easily people can access sexual and reproductive health services.

The imbalance of power between men and women in many societies, for example, can influence the sexual and reproductive health of women and men. In 2005 an Amnesty International report explained that men often behave in ways that incur risks for themselves and their partners. Men are rarely offered sexual and reproductive healthcare and women often find that they cannot insist on safe sex.

There is evidence that sexual and reproductive health services work best when they are linked to other health services. But research conducted in 2005 in Malawi by Brian Mtonya and colleagues of the Global HIV/AIDS Initiative Network shows that a diversity of funding sources makes this difficult to achieve. The arrival of significant new funds from outside sources, earmarked for combating HIV and AIDS, can attract scarce staff towards the new services, hindering the development of the healthcare system as a whole and other sexual and reproductive healthcare services, such as family planning and antenatal care in particular.



## Hitting the target

In 2000 the United Nations (UN) agreed eight Millennium Development Goals (MDGs), or targets, to be achieved by 2015. These included halving global poverty and tackling illiteracy. Due mainly to pressure from social conservatives (said Margaret Greene and Thomas Merrick in a paper for the World Bank in 2005), universal access to sexual and reproductive health was excluded as a target. It took until 2006 for the UN to rectify this.

It is now recognised that the MDGs cannot be achieved without improving access to sexual and reproductive health services and rights. Cheap and effective interventions are available for many sexual and reproductive health problems but they are not reaching the people who need them most.

### Rights: not a simple story

There can be tension between an approach to healthcare based on the concept of individual sexual and reproductive rights and one which responds to a person's medical needs.

One example of this is contraception. Family planning programmes have sometimes been coercive, as with sterilisation in India in the 1970s. Individual rights to make choices about reproduction have been abused.

However, rights and medical needs are not necessarily at odds. Work by John Cleland at the UK-based Centre for Population Studies in 2006, based on surveys in 18 African countries, has shown that single women want to prevent pregnancies and that condoms have an important part to play in this – not only in reducing the risk of HIV infection. In seeking to fulfil their personal sexual and reproductive rights, individuals are contributing to the wider social aims of improving maternal and child health.

Addressing sexual rights and sexuality through the provision of relevant health programmes may have other public benefits, argued Roger Ingham of Southampton University, UK, in 2005, giving people confidence to insist on safer sex. Anupam Hazra's 2006 report from Solidarity and Action Against the HIV Infection in India (SAATHI) supports this idea for men who have sex with men.

Negative views of sexuality and reproductive rights in general as well as explicit cultural, religious and political opposition pose a major barrier to providing universal access to such services. In Pakistan, Zeba Sathar, writing in 2005 for the Population Council, shows how training staff to respect patients' rights can make services more effective.

In 2005 Scott Long of Human Rights Watch (HRW) described a backlash against these rights where homosexuality is condemned and those who do not sexually conform are harassed or worse. Policies based on religious principles have been allowed to override public health arguments for legalising abortion and making it safe. Through its foreign aid policies the United States (US) and the Vatican are leading the opposition to sexual and reproductive rights.

Homosexual men can face discrimination in some countries when trying to access sexual health services.  
DIETER TELEMANS | PANOS PICTURES





## Ideological barriers

By accepting US Government funding for family planning health services, organisations must agree not to provide abortion services, inform women about such services or advocate for safe abortion, even if abortion is legal in that country. Organisations in this position cannot use funds from other sources to set up abortion services. An alliance of fundamentalist Christians and the Roman Catholic church in the US have influenced this policy.

Similar influences have resulted in the US promoting total sexual abstinence as the main way to prevent HIV infection. The US is the world's biggest bilateral donor of direct funding for HIV prevention through the US President's Emergency Plan for AIDS Relief (PEPFAR). One third of these funds must be used to promote abstinence.

Uganda is often cited as a success story because new cases of HIV infection have fallen over 10 years. But in 2006 Gary Slutkin, senior adviser to the World Health Organization, showed that this was not due to a strictly abstinence-only policy.

## The case of Nepal

Maternal mortality rates in Nepal are among the highest in the world. Half of the country's maternal deaths are due to unsafe abortion and in 2002 Nepal liberalised its abortion law to address this crisis.

In response, US government agencies withdrew funding to Nepal's health sector, resulting in the curtailment of a wide range of Nepal's primary and reproductive healthcare, including contraceptive and legal abortion services. Services ceased and staff lost their jobs.

In the long term, however, alternative funding has arrived and safe abortion services have begun to be set up again.

Sex workers interviewed in Bangladesh said that they had suffered discrimination and violence and as a result were distanced from HIV prevention services. SHEHZAD NOORANI | PANOS PICTURES

What caused the reduction was coordinated leadership, openness, de-stigmatisation, compassionate care and, most importantly, cheap condoms. President Museveni of Uganda was the first African leader to promote condom use. Research conducted by Ozge Tuncalp at Yale University in 2005 argues that since Uganda's policy switched to abstinence, the rate of new infections is on the rise. In 2004 The Lancet argued that abstinence is no protection for women who are forced to have sex or who want to have sex.

## Extra barriers for some

Stigma, discrimination and legislation can create barriers to providing sexual and reproductive health services for everyone in society.

In 2003 HRW interviewed Bangladeshi sex workers, drug users and men who have sex with men. They had suffered discrimination and violence – people who could play a part in preventing HIV transmission were being abused. HRW predicted an HIV epidemic if the government did not act.

In 2005 Washington Onyango-Ouma and colleagues at the Population Council in Kenya documented discrimination against men who have sex with men in Kenya, where homosexuality is illegal.

In 2006 Vaishali Mahendra and colleagues of the Population Council in India showed that with training, health workers' attitudes towards patients with HIV and AIDS became less stigmatising.

Sexual activity in teenage years is often unsafe because it is unplanned. The result is that in Africa, teenagers account for one in four of all unsafe abortions and STIs disproportionately affect the young. They will suffer the effects of STIs the longest, and may even lose their fertility.

A 2006 attitude survey in Kenya by Linnea Warenus of the Karolinska Institute, Sweden, showed how healthcare workers disapproved of teenage sexual activity, implying that teenagers face difficulties in accessing health services which could protect them. The University of Malawi's Adamson Muula revealed in a survey in 2006 that Malawian Members of Parliament were prejudiced against condom use.

### Fundamental difficulties

With enough political will, difficulties associated with discrimination can be overcome. But chronic underinvestment – for all types of healthcare – and inadequate aid hamper the development of health services, and in some cases threaten their very existence. There is a lack of health infrastructure including buildings, equipment, medical supplies and especially money for training staff to run services. In 2005 Sevene and colleagues at Eduardo Mondlane University, Mozambique, showed how a cheap drug that prevents eclampsia (high blood pressure) is unavailable in Zimbabwe and Mozambique, causing unnecessary deaths of women and their babies in late pregnancy. Both governments wrongly believed other drugs were as effective and drug companies had no financial incentive to push for take-up of the drug.

### New technologies

New technologies can help people control their fertility and protect themselves against STIs. They do not take away the need, of course, for an equitable relationship between partners and will be most effectively applied in this kind of situation.

- *Female condoms* protect against pregnancy and STIs. They have been introduced across Southern Africa but in a limited way with patchy uptake except for in Zimbabwe. In South Asia they have been better received and there is evidence that listening to potential users and improving products may overcome issues around uptake.
- *New condom brands* in different flavours and colours encourage young people to use them.
- *Microbicides* (creams and gels which can be applied to prevent the sexual transmission of infection) are still being tested and not yet available. Microbicides would especially benefit women, allowing them to control the risk of infection without having to negotiate condom use with their partners. Trials of the microbicide cellulose sulphate in Benin, India, South Africa and Uganda were halted due to safety concerns but three other types are still being tested and scientists expect a safe microbicide to be available for use by 2010.

Other new technologies under development include an *AIDS vaccine* and simpler and less expensive *screening for STIs* like chlamydia.

The link between poverty and poor sexual and reproductive health is not hard to grasp. Poorer people lack information, money and transport. Lack of education makes it difficult for men and women living in poverty to confidently claim their rights to sexual and reproductive healthcare. In societies in conflict, internally displaced people (IDP) are particularly at risk. Without access to health services or family planning measures in IDP camps, unwanted pregnancies and malnutrition in newborns are common.

Sexual and reproductive health services need to be linked in with other health services, not run separately. Women, for example, could benefit from HIV services being integrated with those offering family planning and antenatal or postnatal care.

In reality, say Nel Druce and colleagues from the UK Department for International Development, writing in 2006, one result of the billions of dollars now going into fighting HIV and AIDS has been that these services are becoming fragmented. There may sometimes be a case for services targeted at particular groups, such as men, teenagers or other groups, but this should be planned for. Delius Asimwe and colleagues' 2005 study from the Makerere Institute of Social Research in Uganda found that people living with HIV wanted contraceptive advice but HIV and AIDS and contraceptive services were being run separately. Druce found evidence that HIV services were expanding at the expense not only of reproductive health services but also other general health services. Some efforts are being made to link up services and she points out that in September 2006 health ministers from Kenya, Zambia and Zimbabwe adopted a plan to promote sexual and reproductive health and rights, thereby integrating HIV and AIDS into wider sexual and reproductive health services.

### Highlighting neglected issues

In 2006 Neelofar Sami and Tazeen Saeed Ali from the Aga Khan University, Pakistan, writing in *The Lancet* showed how infertility can lead to stress among women and even violence against them. Abuse and sexual violence are often widespread, yet women remain largely silent about it. Mental health problems such as postnatal depression receive little attention. And research into unsafe abortion has not been taken into account in policy discussions around improving sexual and reproductive health services.

Some women suffer chronic illness and disability as a result of pregnancy and childbirth and without access to treatment can experience painful and debilitating pelvic pain, reproductive and urinary tract infections, a prolapsed uterus and incontinence. Maternal health research currently focuses on preventing deaths during pregnancy and there is less research done on post-pregnancy problems.





Poorer people may lack money for transport so it makes sense to situate sexual and reproductive health services within the community.  
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## Lessons learned

- **Take-up of new technologies**  
Improved female condoms and microbicides are being developed but making them accessible and affordable requires investment and marketing. Research conducted by the UK Department for International Development showed that in Zimbabwe female condoms have been a huge success with 900,000 sold in 2005 alone, the highest sales per capita in the world. Half of these sales were made via a network of 1,000 women's hairdressers trained to promote the condoms to their clients. Hair salons provide the friendly, supportive and safe environment that young women need to be able to discuss personal and sexual issues.
- **Bringing services together**  
Due to fragmented health service planning, scarce skilled health workers and funds are attracted away from sexual and reproductive healthcare to those areas considered higher priority. In addition, the decentralisation of services means that sexual and reproductive healthcare has to compete for funding at the local government level. Tayla Colton, of Columbia University, showed in 2005 how this is being addressed in Kenya: nearly 200 'multipurpose' clinics successfully offer basic healthcare to pregnant women alongside measures to prevent the transmission of HIV from mothers to babies.
- **Community participation**  
Research from the UK-based Institute of Child Health argues against focusing purely on ensuring a skilled midwife is present at every birth and instead presents evidence that community-based strategies, including distribution of vitamin A supplements, work with women's groups and support to traditional birth attendants can hugely reduce maternal mortality rates.

## Using researchers as a journalistic source

Journalists should think clearly about what they want to know so that they make the best use of the researcher's time, and their own.

Apparent medical breakthroughs or scare stories about risks need to be thoroughly examined. For instance, conclusions may have been drawn using a very small research sample. Ask how representative researchers think their work is and consider whether they might have a hidden agenda based on their own prejudices or interests. It is very important to grasp the significance of statistics and not draw general conclusions which may not be valid.

There may be a story around research that doesn't get carried out due to funds being unavailable, perhaps because of political or cultural influences, so be alert to a researcher speaking of other important questions which need to be answered but for which there is little or no research.

When researchers use jargon they should be asked to clarify what they are saying in everyday words. Journalists do not need to be expert in the science but they must understand enough to write their story accurately.

If a researcher indicates that a particular solution – such as cheaper medical supplies, better staff training or more education – might solve a specific problem, get them to expand on what needs to be done to achieve that. A journalist can then follow this up by asking the relevant authorities what they are doing to help.

## Reporting on sensitive issues

Most people's experience of sexual and reproductive health is very personal and private. In producing stories on this topic journalists need to consider similar ethical issues to those that health researchers face when interviewing potentially vulnerable people:

- **Confidentiality** – people may suffer violence at the hands of their sexual partners or be abandoned by their community if their identity is revealed in a story. If people are ostracised as a result of talking to a journalist this can affect their ability to earn a living.
- **Stigma** – people may feel guilty or ashamed about their past actions or experiences (eg – having an abortion or contracting an STI) and journalists should be sensitive to this and always treat the people they talk to with dignity.
- **Legality** – journalists need to make sure they aren't putting people at risk of arrest or imprisonment by asking them to talk about their sexual behaviour.
- **Checking facts** – all the facts in a story should be double checked to avoid putting the people or community involved at risk.

## Research organisations

**African Population and Health Research Centre (APHRC) Kenya:** conducts research on urban health, adolescent sexual and reproductive health, health and social inequities in sub-Saharan Africa  
Tel: +254 (0)20 272 0400/1/2  
Email: info@aphrc.org  
www.aphrc.org

**Bangladesh Rural Advancement Committee (BRAC) and BRAC University**  
Pushpita Alam – BRAC Public Affairs and Communications  
Tel: +880 2 9881265/8824180 ext 2155 and 2158  
pushpita.qa@brac.net  
www.brac.net

**Centre for Health Policy, South Africa:** conducts research on health systems, health financing and economics, HIV and AIDS and STIs  
Tel: +27 (11) 489 9936  
Email: dudu.mlambo@nhls.ac.za  
www.wits.ac.za/chp/

**Centre for Operations Research and Training (CORT), India:** researches reproductive health, contraceptive use, abortion and sexual violence in South Asia  
Tel: +91 265 2341253/2336875  
Email: cort10@satyam.net.in or cortresearch@cortindia.com  
www.cortindia.com

**Centre for Population Studies – London School of Hygiene and Tropical Medicine**  
Tel: +44 (0)207 636 8636  
Email: john.cleland@lsh.ac.uk (family planning)  
www.lsh.ac.uk

**Guttmacher Institute, US:** focused on sexual and reproductive health and the impact of US aid  
Tel: +1 212 248 1111  
Email: info@agi-usa.org or policyinfo@agi-usa.org  
www.guttmacher.org

**Health Economics and HIV/AIDS Research Division, South Africa:** conducts research on public health, especially HIV and AIDS, based in South Africa, but international in scope  
Tel: +27 (31) 260 2592  
Email: heard@ukzn.ac.za  
www.ukzn.ac.za/heard/

**Institute of Child Health, UK**  
Tel: +44 (0)207 242 9789  
Email: Anthony Costello (community-based interventions to improve maternal and neonatal health)  
a.costello@ich.ucl.ac.uk  
www.ich.ucl.ac.uk/ich

**Institute of Development Studies (IDS) UK:** research on health, gender, sexuality and development, including HIV  
Tel: +44 (0)1273 621202/691647  
Email: Hilary Standing  
h.standing@ids.ac.uk (reproductive health)  
www.ids.ac.uk

**Opportunities and Choices research programme, Centre for Sexual Health Research, at University of Southampton, UK:** research into reproductive health services, with focus on equal access  
Tel: +44 (0)2380 597770  
Email: Roger Ingham  
ri@soton.ac.uk  
www.socstats.soton.ac.uk/choices/

**Population Council**  
**India**  
Tel: +91 11 2 464 2901/2, 464 4008/9, 465 2502/3, 465 6119  
Email: mbhalla@popcouncil.org or frontiers@pcindia.org  
www.popcouncil.org/asia/india.html

**Kenya**  
Tel: +254 (0)20 271 3480/1/2/3  
Email: info@pcnairobi.org  
www.popcouncil.org/africa/kenya.html

**Pakistan**  
Tel: +92 051 227 7439  
Email: imran@pcpak.org  
www.popcouncil.org/asia/pakistan.html

**Zambia**  
Tel: +260 1 255 035  
Email: pcouncil@zamnet.zm  
www.popcouncil.org/africa/zambia.html

**University of Malawi, College of Medicine**  
www.medcol.mw

**World Health Organization (WHO), Switzerland:** WHO Department of Reproductive Health and Research promotes a positive view of sexuality for women, men and young people  
Tel: +41 (22) 791 3372  
Email: Iqbal Shah shahi@who.int  
www.who.int/reproductive-health/gender/index.html

## Useful websites

**Eldis:** gateway to development information including sexual and reproductive health and maternal health [www.eldis.org/health/sexrepro/index.htm](http://www.eldis.org/health/sexrepro/index.htm) and [www.eldis.org/health/maternal/index.htm](http://www.eldis.org/health/maternal/index.htm)

**DFID Health Resource Centre:** case studies and background research [www.dfidhealthrc.org](http://www.dfidhealthrc.org)

**The Lancet:** independent UK-based medical journal [www.thelancet.org](http://www.thelancet.org)

**Realising rights:** research to address the persistent low priority given to sexual and reproductive health and rights [www.realising-rights.org](http://www.realising-rights.org)

**Reproductive Health Matters:** in-depth coverage of sexual and reproductive health and rights issues for an international audience [www.rhmjournal.org.uk](http://www.rhmjournal.org.uk) and [www.rhm-elsevier.com](http://www.rhm-elsevier.com)

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**Margaret Greene and Thomas Merrick (2005)** – ‘Poverty reduction: does reproductive health matter?’ – [www.worldbank.org](http://www.worldbank.org)

**Anupam Hazra (2006)** – [www.siyanda.org](http://www.siyanda.org)

**Zeba Sathar (2005)** – [www.popcouncil.org/pdfs/councilarticles/sfp/SFP363Sathar.pdf](http://www.popcouncil.org/pdfs/councilarticles/sfp/SFP363Sathar.pdf)

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**Gary Slutkin (2006)** – [www.springerlink.com](http://www.springerlink.com)

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**Human Rights Watch (2003)** – [www.hrw.org/reports/2003/bangladesh0803](http://www.hrw.org/reports/2003/bangladesh0803)

**Washington Onyango-Ouma et al (2005)**  
[www.popcouncil.org/pdfs/horizons/msmkenya.pdf](http://www.popcouncil.org/pdfs/horizons/msmkenya.pdf)

**Vaishali Mahendra et al (2006)** – [www.popcouncil.org/pdfs/horizons/inphafriendly.pdf](http://www.popcouncil.org/pdfs/horizons/inphafriendly.pdf)

**Linnea Wärenius (2006)** – [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=916733](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=916733)

**Adamson Muula (2006)** – [www.ajol.info/viewarticle.php?id=25669](http://www.ajol.info/viewarticle.php?id=25669)

**Sevene et al (2005)** – [www.id21.org/id21ext/h8es2g1.html](http://www.id21.org/id21ext/h8es2g1.html)

**Nel Druce et al (2006)** – [www.dfidhealthrc.org](http://www.dfidhealthrc.org)

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