# Preface

Sexual and reproductive health and rights have by tradition been important in Swedish development cooperation. It accounts for about forty percent of Sida's health sector support and four percent of Sweden's total development cooperation budget.

In 1994, SIDA adopted an *Action Plan for Improving Sexual and Reproductive Health.* Since then the UN Conferences on Population and Development in Cairo and the Women's Conference in Beijing have taken place.

Sida has also recently adopted several policy documents relevant to sexual and reproductive health and rights. These include the *Policy for Development Cooperation in the Health Sector,* 1997, which constitutes the overall framework for health sector programmes, and the *Position Paper on Population, Development and Cooperation,* 1997, which places sexual and reproductive health and rights in the perspective of population dynamics. The publication *Sexual and Reproductive Health: The Challenge for Research,* 1996, was published jointly by the Sida Departement for Research Cooperation, SAREC and the WHO programme for Research and Training in Human Reproduction, HRP.

In addition it should be noted that Sida has launched four overarching development strategies that all have a strong bearing on sexual and reproductive health and rights, namely the strategies for poverty alleviation, gender equality, democracy and human rights and sustainable development.

In the light of all these developments, Sida has now updated the abovementioned 1994 Action Plan into this *Strategy to Promote Sexual and Reproductive Health and Rights.*

By its very nature, the process of formulating a strategy involves many people. The Health Division within the Department for Democracy and Social Development has been responsible for the development of the document, with contributions from many other Sida departments and divisions.

Sida has also relied on Sweden's own experiences in the area. Therefore a large number of Swedish institutions and individuals have contributed to this document.

The strategy is intended primarily for Sida staff and consultants, but it may also serve as a reference document in the policy dialogue with partner countries and with international actors.

A list of relevant Sida publications is found in Annex 1.

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# Contents

# Executive Summary

New perspectives on sexuality and reproduction building on strong ethical and human rights foundations emerged at several UN conferences during the 1990s. This **Sida Strategy to promote Sexual and Reproductive Health and Rights** in the development cooperation is based on recommendations from these conferences, on Sweden's experience nationally as well as from international development cooperation, and on Sidas's four overarching development strategies.

The aims of Sida's cooperation for improved sexual and reproductive health and rights are manifold. Women and men, irrespective of marital status, should have the right to enjoy a safe and satisfying sexual life. People should be able to avoid illness and disability in their reproductive lives, and be able to have the number of children they wish, at the time they wish to have them. In order to achieve these goals, Sida has selected a number of strategic areas within the development cooperation. Programmes and services for improved sexual and reproductive health and rights must be developed in partnership with countries and communities, and be gender sensitive, culturally acceptable, affordable and cost-effective.

There is growing international recognition that *human rights* have a gender dimension and that gender inequality is a major obstacle to sexual and reproductive health and rights. Priority will therefore be given to efforts that enhance increased awareness (in the development cooperation) of international human rights treaties and conventions with relevance for *gender equality* and sexual and reproductive rights. Changes in national legislation are necessary to protect sexual and reproductive rights and to enhance women's empowerment. But gender equality implies changed roles also for men. Men's involvement in defining their own roles in society and as partners in family life needs to be encouraged. Mutual respect, love and tenderness is a basis for positive human development.



Women are exposed to considerable health risks as a consequence of their reproductive role and *maternal health* is therefore a priority. Women need access to good health services during pregnancy, at delivery and for newborn children. Many of these services can and should be provided by a trained midwife, who can provide counselling and qualified care. But if complications occur, women urgently need emergency obstetric care, which should be available through functioning referral systems. Initiation of breastfeeding is part of post-partum care, but breastfeeding also needs promotion, e.g. through appropriate hospital routines and labour market adjustments and protection from commercial marketing of breast-milk substitutes.

All sexually mature people have the right to decide if and when they want to have children. Services for *fertility regulation* should be easily accessible and have a wide range of affordable contraceptive methods. People have the right to personal counselling, and health workers capacity to provide this should be enhanced. Unfortunately, there are programmes for fertility regulation that have been known to use pressure and even coercion. Such practises and other unethical methods should be strongly discouraged. Therefore there is a need for training of service providers about the ethical implications of sexual and reproductive rights.

*Abortion* exists in all societies, whether it is legal or not. When abortions are performed under unhygienic and unsafe conditions they become a public health problem. The best way to make abortions safe is to legalize them. Contrary to common belief, legalized abortion does not imply an increased abortion rate. Women should always have the right to good care for abortion complications, and all efforts should be made to decriminalize women who have undergone abortion.

*HIV/AIDS* is a world-wide growing epidemic and needs to be tackled by all sectors of society. Since there is as yet no cure to HIV/AIDS, preventive strategies are of paramount importance. These include prevention and treatment of all sexually transmitted diseases. Information, education and counselling is necessary to influence and change behaviour.

All people, irrespective of age and marital status, should have the right to know about sexuality and reproduction. In order to protect themselves from disease and unwanted pregnancy, *adolescents* in particular need knowledge about sexuality and reproduction. Sex education should be provided in schools, through the health system, youth organizations and through the media. Special efforts must be made not only to reach, but also to involve young people. There is also a need to promote the idea that young people have the right to services related to their sexual and reproductive lives. The Swedish experience has shown that sex education does not lead to an earlier entry into sexlife.

*Female genital mutilation* is performed in many countries particularly in Africa among groups with different religious beliefs. However, in spite of the many traumatic effects, including during pregnancy and delivery, it may not be perceived as a problem by the communities. Therefore, increased knowledge about the harmful effects is needed among health workers, policy-makers, elders, teachers, and not least among those who perform the excision. Legal changes and monitoring of adherence to existing laws prohibiting the practise is also important. The harmful practice of female genital mutilation is increasingly seen as a human rights issue.

*Gender-based discrimination and violence* are the causes of many sexual and reproductive health problems. Most health workers are untrained to detect and unwilling to react to signs of sexual harassment, abuse and rape.

Obviously the health sector alone cannot combat these grave problems, but health workers have an important role to play, since they often meet those affected. It is the duty of all sectors of society to cooperate in fighting discrimination of women, to provide protection to women in distress, and to prevent sexual abuse and exploitation of children.

# 1. Framework

## *1.1 A New International Agenda*

A new and holistic view of sexuality and reproduction, based on strong ethical and human rights foundations, has emerged during the 1990s. A series of international conferences have addressed health as well as rights related to women's and men's reproduction and sexuality.

### *UN Conferences*

The *International Conference on Human Rights* in Vienna, in 1993 discussed the gender perspectives of human rights as well as controversial issues related to sexual and reproductive rights. The conclusions in the Vienna Declaration and Platform for Action are that "the human rights of women and of the girl-child are an inalienable, integral and indivisible part of universal rights."

In 1994, the *International Conference on Population and Development, ICPD,* in Cairo reacted to the prevailing family planning policies and programmes for fertility reduction. A new agenda was established with three main themes: human rights, women's empowerment and sexual and reproductive health and rights. Previously women were seen as a target group to reduce population growth. The strength of the new agenda is that it stresses that women's empowerment and women´s health constitute goals in their own right.

The *United Nation's Conference on Women,* in Beijing 1995, confirmed the results from ICPD, but framed its goals within a broader context of gender equality. The Beijing conference reaffirmed the focus on individual human rights and expressed them in the Platform of Action thus "the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality..." (Para 96).

### *New Concepts*

At these UN conferences a number of concepts were elabourated, defined and presented in the concluding documents. Some of the major new concepts may be summarized as follows:

- *Women's empowerment* is the process through which women gain better control over their life. Economic resources, favorable laws and institutional rules, as well as favorable social norms are all important for women's empowerment. With increased control over their lives, women may use their reproductive and sexual rights to improve their reproductive and sexual health. Male participation and acceptance of changed roles are essential for women's empowerment.

- *Reproductive health* means that people have the capability to have children. Women and men have the right to health services for contraception and treatment of infertility. Women have the right to safe abortion care where abortion is legal. Everyone has the right to good care for abortion complications. This right includes also appropriate health care during pregnancy, childbirth and the perinatal period.

- *Sexual health* means that people should be able to have a safe and satisfying sex life including a healthy psycho-sexual development. Gender relations should be equal, responsible and mutually respectful. The concept of sexual health is broader than that of reproductive health. Its importance has been highlighted by such health problems as the HIV/AIDS pandemic.

- *Reproductive rights* means that couples and individuals have the right to decide if and when they want to have children, without any discrimination, coercion or violence. Reproductive rights apply to all sexually mature women and men, irrespective of civil status, and include the right to knowledge about sexuality and reproduction, and to reproductive health care services, including fertility regulation. They also include the right for women to appropriate maternal health care.

- *Sexual rights* include all people's right to decide about their sexual life, with full respect for the integrity of the partner, and the right of girls and women to say no to sex. It includes not only legislation, but also norms and practices which hinder women and men from taking responsibility for their sexual behaviour. Societies must take action to eliminate coercive laws and practices.

### *Changing Contexts in the Health Sector*

Health sector reforms are increasingly being addressed by governments and supported by donor agencies. This international agenda includes the sub-sector sexual and reproductive health and takes cognizance of the economic, social and political *contexts* in which programmes and services have to function. The strategies have to be cost-effective, affordable, culturally acceptable and gender sensitive.

*Cost-effectiveness and social equity* have become key factors, as the resources of governments and donor communities are diminishing in the hardening economic climate of the 90s. The World Bank, the World Health Organization and others have initiated a process of reexamining health policies in this light and are looking at new strategies to finance health services. The questions currently being posed relate to such issues as: what services are essential to ensure a reasonable level of sexual and reproductive health in the population; what services have to be provided by the public health services and what can be contracted out to the private sector; what services

can people afford to pay for; and how can one ensure that people who cannot afford to pay still receive essential services.

The *organization and management* of such essential services is an issue not only of cost-effectiveness but also of the quality of services, as well as the most rational use of health workers. *Integrated* delivery of services remains a debated issue. At the peripheral level integration is seen as the most feasible way of meeting health needs. But discussions concern how much work a community level health worker actually can take on, and what services will need some type of separate delivery system. *Quality* of services is closely linked with decentralization of decision making and involvement of the consumers, not least women, in the planning and monitoring of services.

*Public information* and *advocacy* directed to political representatives and to decision makers in other sectors also needs renewed attention. The messages have changed with the new agenda. The concepts that need to be promoted are possibly less easily accepted, and need their advocates. Women's health advocates have been active in promoting the new agenda, and will continue to play an important role. There has been a tremendous development in information technology over the last decade, but the messages to be spread through these, as well as through other channels need to be differentiated and better targeted.

The needs for *evaluation of approaches* and for *applied research* are obvious if countries and agencies are serious about the implementation of the new agenda. There is a need to build up the capacity for applied research within the health systems, to find more effective ways to involve district level planners and to create stronger links between administrative decision makers and researchers in this work. The international community needs to collaborate in monitoring the progress of implementation of the Cairo and Beijing resolutions. Time must be granted for the new ideas and concepts to become accepted and firmly anchored, not only at the top political level, but throughout the health system and among ordinary people in the different countries.

## *1.2 Sida Perspectives*[1]

### *Experiences in Development Cooperation*

Reproductive health has been important in Swedish development cooperation history from its start. The perspective has gradually been widened from mainly family planning, maternal health and sex education to the broad area covered in this strategy.

1 In this document we use the acronym "Sida" throughout, even though up to July 1995 it rightfully should be spelled "SIDA" . On that date SIDA merged with four other development cooperation authorities and became Sida.

Sweden was a pioneer within international family planning support already 40 years ago. It started in Ceylon (now Sri Lanka) in 1958 and in Pakistan in 1961. The introduction in the 1960s of two new contraceptive methods, the IUD and the Pill, were important in the early family planning projects, and led to activities to increase the availability of contraceptives.

From 1960 to 1968 the Swedish development assistance budget for family planning grew from a few percent to 12 percent of the bilateral development budget. The Swedish parliament had selected a limited number of recipient countries for development assistance. But the global population problem was considered so important that parliament decided that support to family planning projects could be given to any country which requested it.

In the early 1970s, 35 countries received Swedish support for family planning projects. This was in addition to substantial contributions to the United Nation's Fund for Population Activities, UNFPA, the International Planned Parenthood Federation, IPPF, and the Special Programme of Research, Development and Research Training in Human Reproduction, HRP, within WHO. The UN population conference in Bucharest in 1974 marked a policy change, based on the experience that it was not enough simply to make the contraceptives available. People needed to be informed about and motivated to use family planning. Programmes for information, education and communication, the IEC-programmes and sex education, were launched, and also supported by Sweden.

In 1979 when the seven so-called pillars of Primary Health Care were launched by WHO and UNICEF at Alma Ata, maternal and child health care (MCH) including family planning, was defined as one of the pillars. This integrated approach became the basis for Sida's health development cooperation during the 1980s.

Two important Sida decisions influenced the formulation of Swedish development cooperation policy in the 1980s. The first related to India and its national family planning programme. Coercive sterilization campaigns led to the downfall of the Gandhi goverment. Sida decided, in 1979, to withdraw its support for ethical reasons. A similar decision was taken in 1985 in relation to Bangladesh, where the use of incentives and disincentives in the national family planning programme prompted Sida to withdraw support.

Since then, increasingly, a broader perspective has been applied to sexuality and reproduction. This has been reflected in official Swedish policy and statements, in Sida's *Action Plan for Promotion of Sexual and Reproductive Health*, 1994, and in a large number of projects supported by Sida. Programmes for sexual and reproductive health and rights today account for approximately 40 percent of Sida's health development cooperation disbursements.

A *Policy for Development Cooperation in the Health Sector,* 1997 provides the overall framework for Sida's health cooperation. The recently published *Position Paper on Population, Development and Cooperation,* 1997, summarizes Sida's views on the relations between demographic dynamics and development.

### *Key Development Strategies*

Based on the Swedish goals for development cooperation, Sida has developed four interlinked key development strategies which shall guide all international cooperation. These are elaborated in four specific action programmes and address

- poverty alleviation;
- promotion of gender equality;
- promotion of peace, democracy and human rights;
- environmentally sustainable development.

Sexual and reproductive health and rights are linked to all four action programmes.

*Poverty is* recognized as a root cause of poor health and premature death all over the world. The majority of the poor are women. The vast majority of maternal deaths take place in poor countries. The reasons include malnutrition and living conditions related to poverty, as well as lack of services. High parity, i e to have many children, which increases reproductive health risks, is also related to poverty. Poor people are also more exposed to prostitution and child exploitation.

*Gender equality* is central to matters relating to sexuality and reproduction. Women and men have different roles, needs and perspectives, which must be respected. But in patriarchal societies control over women is expressed in several ways, among them as male control over women's sexuality and reproduction. Women's empowerment is essential for the protection of women's sexual and reproductive health and rights.

*Democratic institutions and respect for human rights* are increasingly recognized as important. In order to be able to take responsibility for their behavior and for their own health, men and women need at least a minimum of control over their own body, their living conditions and some voice in political matters.

*Development towards environmental sustainability* requires better care of natural resources and a balance between population growth, technological development and natural resources. Poor nutrition has severe effects on maternal and newborn health. The use of pesticides in agriculture and chemicals in industrial processes create reproductive health hazards for women. Men's reproductive health is also threatened. In certain countries

environmental factors damage sperm quality. In severly polluted areas increasing numbers of infants are born with low birth weight and defects.

### *Forms of Cooperation*

Swedish health sector cooperation is carried out by many divisions and departements in Sida, with the Health Division within the Departement for Democracy and Social Development, DESO, having main responsibility.

In the *bilateral health cooperation*, i.e. country to country, the Health Division participates in the preparation of an overall country cooperation strategy for each country, to analyse the health sector and define priorities. Sexual and reproductive health and rights is a priority in the health cooperation.

The programmes or projects *financed* by Sida, can be implemented by the recipient government or channelled through an organization, e.g. the World Bank or the United Nation's Childrens Fund, UNICEF. Within the programmes supported, the main emphasis is on *capacity building*, which can be accomplished through different mechanisms, including technical assistance, institutional strengthening, by consultancy companies and through institutional collaboration.

The Health Division is also responsible for the allocation of so-called programme development funds. These funds are mainly utilized for global efforts to enhance *normative work*, such as method and policy development and operational research in priority areas. This work may be carried out by UN-organizations, notably the WHO and UNFPA or by international volontary organizations, e.g. IPPF. Innovative advocacy and policy work is often carried out by smaller NGOs and merit support for highlighting sensitive issues related to sexuality and reproduction.

International *training programmes* on sexual and reproductive health and rights are supported through the Department for Infrastructure and Economic Cooperation, INEC.

Sida also provides support to *non-governmental organizations* in other countries through Swedish non-governmental organizations. This is administered by the Department for Cooperation with NGOs and Humanitarian Assistance, SEKA.

The Department for Research Cooperation, SAREC, is responsible for the *research cooperation and research capacity building*. The building up of research capacity and strengthening of institutions at national level is given priority. In international research programmes, SAREC takes special care to secure that the priorities of poor countries are reflected, and that researchers from all countries work in partnership and equity.

## *1.3 Swedish National Experiences*

Swedish women's struggle for equality and empowerment has a long history. Compulsory education for boys and girls began in 1842, equal inheritance rights were established in 1845. Over the following decades Swedish women achieved the right to higher education and the right to gainful employment. Finally, in 1921, women got equal rights to vote. This prompted increased attention to women's issues in legislation and policies. Women's organizations, the labour movement and other popular movements were all active in this political process.

Today women take part in *decision-making* at all levels of society. They form 40 percent of the members of parliament and make up half of the cabinet. More than 80 percent of eligible women are active in the labour force. However, many women hold part-time jobs and the labour market is still segregated. Women form the majority in the public, not least the service sector, while men tend to choose from a wider range of jobs and professions. There is still a substantial difference between men's and women's average income.

The empowerment of women during this century, as well as changes in the situation for children, has gradually led to a *changed role for Swedish men.* Initially it was the women's movements who argued that man and woman should share responsibilities in the home and for the children. As from the 1960s it became increasingly natural that the father of a child is present at the delivery. In 1974 the previous rights to maternal leave were changed into parental leave. This included the right for either of the parents to take payed leave to care for the new baby. Even though women still take out most of the parental leave (98 percent), almost half of all fathers of children born in 1989 took out some leave. This has contributed to changes in men's parental role.

Since the 1980s joint custody of children is the general rule at divorce. The thought is that adults can separate from each other but a child has its right to both parents.

*Maternal health* in Sweden is good with one of the lowest levels of maternal and perinatal mortality in the world. The substantial increase in the earlier part of this century in standard of living and level of education ensured better maternal and infant health. Another very important contributing factor was the system for public maternal health care, available since the 1930s. Today, virtually all expectant mothers attend maternal health centres for monitoring of their pregnancy. Simultaneously both the expectant mother and father receive so-called parental education, provided by a midwife. The high standard of midwifery education, the independent role of the midwife, along with increased technical development in obstetric care and access to free safe abortion, have all contributed to the high standard of maternal health in Sweden.

The *reproductive pattern* in Sweden began to change distinctly around 1870. Until then women had borne children all through their fertile years. The emerging pattern was for a concentration of births to a shorter period after marriage, followed by fertility regulation. The change started in middle-class families and gradually reached poor families. Society reacted by introducing a law in 1910, prohibiting information on and distribution of methods for fertility regulation. This law was valid until 1938 when it was abolished. Simultaneously the first abortion law was introduced, permitting abortion on certain medical, humanitarian and eugenic indications. Since 1974 *abortion* is free on demand for all women. The present abortion law was introduced along with improved contraceptive services and counselling. It is noteworthy that the changed legislation did not lead to an increase in number of abortions.

*Fertility regulation* is based on the right of all individuals to make decisions concerning their own fertility. Provision of contraceptives is the responsibility of the health care system. By mid 1990, the average number of children was down to 1.6 children per woman.

Activities to diagnose, treat and prevent *sexually transmitted diseases* are intregrated into primary health care and have been reinforced by the presence of HIV/AIDS. Special efforts are made to reach particularly high-risk groups, such as intravenous drug users and men who have sex with men.

*Sex education* became compulsory in schools in 1955. Content and methodology have developed over the years, and now cover both the life affirming aspects of and the risks related to sexuality. It starts in primary school.

There has been an increased openness in Sweden concerning sexual matters and people's right to a sexual life irrespective of marital status and age, as from 15 years. Since 1988 homosexual people have legal right to enter into a registered partnership, but cannot marry nor jointly adopt children.

Female genital mutilation was unknown in Sweden until increased immigration and refugees mainly from Africa highlighted the existence of the practice. This harmful practice is prohibited by law in Sweden since 1982 and can yield a 2-10 years jail sentence for the performer.

It is an accepted fact that *adolescents,* both young men and young women, are sexually active. In addition to the knowledge given by parents, in schools and from the media, adolescents have access to special youth centres run by the health services. Here they can get gender sensitive information and services, e.g. to control sexually transmitted diseases, including HIV and to prevent unwanted pregnancies. The Swedish experience has shown that sex education does not lead to an earlier entry into sex life.

# 2. Strategies

## *2.1 Objectives*

*An estimated 580 000 women die every year in connection with pregnancy and childbirth. For every woman who dies, between 200 and 300 more women survive but will suffer from cronic illness or physical impairment. (UNFPA, State of the World's Population 1994).*

Sida's strategy for sexual and reproductive health and rights is based on the conviction that sexual and reproductive health and rights are at the center of human dignity and well-being. All people are sexual beings and sexuality is necessary for the survival of humankind. Sexual behaviour has profound consequences for individuals, families and societies. For individuals, sexual acts can mean life-affirming connections or life-destroying encounters. For families and societies, more children means needed labour and talent, but also additional dependents.

The goal of Sida´s cooperation with partner countries and organizations in the fields of sexual health, reproductive health, sexual rights and reproductive rights is that women and men may

- have the capacity for healthy, equitable, and responsible relationships and sexual fulfilment, and experience healthy sexual development;
- achieve their reproductive intentions, the desired number and timing of children, safely and in good health;
- avoid illness, disease, disability and injury related to sexuality and reproduction, and receive appropriate counselling, care and rehabilitation;
- achieve equal rights in private as well as public life.

In order to reach the above goals, Sida will focus on selected strategic areas which are of crucial importance to the sexual and reproductive health and rights of women and men. The areas chosen lend themselves to interventions and are possible for a donor organization to support. However, when provided as services at district level, the areas are closely interlinked and may form integrated programmes.

Each area is addressed in terms of scope and main problems, implications for health services, and its relation to human rights and legislation. Summary conclusions for each area are presented in boxes. A concluding section describes Sida's views on research and research capacity building.

The selected areas are:

- human rights and gender equality;
- maternal health and newborn care;
- services for fertility regulation;
- abortion;
- HIV/AIDS and other sexually transmitted diseases;
- adolescent health;
- female genital mutilation;
- discrimination, violence and abuse.

## *2.2 Human Rights and Gender Equality*

Human rights are universal and apply to everyone. Through international agreements governments have committed themselves not to discriminate against women and children. Any strategy to improve gender equality and sexual and reproductive health must be based on the fact that women´s rights have been defined and accepted as universal rights at the UN conferences in Vienna, Cairo and Beijing. Human rights as defined in international law have implications for nations. Countries are responsible for the realization of human rights. Human rights treaties and agreements impose restrictions on what governments can do; they define obligations for governments to defend women and men against violations of their rights, and they raise demands on governments to ensure people their human rights. However, international treaties only become legally binding to a state when ratified, and national ratification often lags behind. And international procedures for monitoring compliance and implementation are not always effective.

Empowerment is important for women's participation in public life and for their chance to make decisions in family life. It entails the actual rights of women and girls, as well as the establishment of enabling conditions in the form of legal frameworks, changed norms and values and access to knowledge and services. Education and control over economic resources are important elements to create empowerment, and so is female participation in leadership and decision making.

Reforms in national legislation are urgently needed to eliminate discriminatory laws and to provide effective protection from gender-based discrimination. To reduce gender-based inequalities is an enormous challenge, because they are pervasive and reinforced by cultural traditions, as well as by social, economic and political structures.

*The minimum legal age to marry is 15 years in thirteen countries, mainly in Latin America and West Africa. A few countries permit marriage when a girl is 12 years old. (IPPF, Reproductive Rights Chart, 1996)*

Numerous laws affect sexual and reproductive health, directly and indirectly. Many of them are found in family legislation and include such matters as minimum legal age of marriage, women's consent to marriage and equal rights to divorce. In many countries women need spousal authorization even for such everyday concerns as seeking health care. In most countries women do not have equal access to property, employment, social benefits or political participation. Of particular relevance for women are labour market laws and laws on the rights to hold, own and inherit land, to take loans and credits and to travel freely.

Equally important as changed legislation are efforts to make existing laws known. In many countries women's groups and other non-governmental organizations are active in educating women about their rights and how to get access to the legal system.

Equal gender relationships will need to be based on a redefinition of the rights and responsibilities of men and women in all spheres, including family, the workplace and society at large. Changes in women's situation, from dependency and submissiveness to increased empowerment and participation, will lead to changes for men in their roles in society as well as for their sexual and reproductive roles. It is a challenge to motivate more men to participate in defining the visions and strategies for a more gender-equal society.

There are disadvantages and costs to men in the traditional patterns of gender difference. Cultural norms and practices about masculinity and expectations of men as leaders, husbands, and sons cause men to concentrate on the material needs of their families, rather than the nurturing and care relationships usually assigned to women.

The link between women and reproduction has led to neglect of men and their sexual and reproductive role as husbands, fathers and, not least, as men. It is essential to address men's sexual and reproductive needs, rights and obligations, in relation to themselves, to their women partners and to their children. Men have responsibilities, emotionally and economically, for children they beget, whether inside or outside marriage.

The elimination of gender-based inequality and violence goes far beyond the health sector. To secure a fundamental change requires the committment and participation of all sectors. The basis for a positive human development is to secure mutual respect between individuals.

***Human Rights and Gender Equality***

Sida will focus on strategic actions for:

- Enabling conditions for the empowerment of women and gender equality;
- Awareness of relevant international human rights treaties and conventions, and monitoring of adherence to these;
- Legislation on sexual and reproductive rights of women and men, as well as improved knowledge of these rights;
- Changes in national laws and creation of enabling conditions that may enhance women's empowerment, e.g. the right of pregnant girls to complete schooling;
- Changes in men's roles in society and in relation to sexuality and reproduction, e.g. through work of male groups.

## *2.3 Maternal Health and Newborn Care*

Most pregnant women in poor countries are exposed to considerable health risks. The aim of maternal health care is to safeguard the health of the woman and the newborn child by reducing nutritional deficiencies, morbidity, and mortality during pregnancy and childbirth and during the post-natal period.

Reductions in maternal mortality related to childbirth depend largely on the availability of qualified birth attendants and of emergency obstetric care. Quality and access to maternal health care vary considerably between and within countries.

Many complications of pregnancy and childbirth can be prevented through adequate antenatal care and screening to detect high-risk pregnancies. But currently available screening methods only identify about half of those pregnant women who will develop acute problems. Complications during delivery can occur unpredictably and they require immediate medical treatment. Therefore, well-functioning basic hospital care, including rapidly available operation facilities and a functioning blood bank, is crucial for dealing with complications. These services should be available at the first referral level i.e. the district hospital, but in many cases they can and should be available in health centers as well.

*Maternal mortality is twice as high for teenagers as for women in the age group 20-24 years. (WHO, World Health Report 1995)*

*Only an estimated 55 percent of all biths worldwide are attended by trained personnel (WHO, Executive Board, 1991)*

Post-partum care is provided to avoid infection after birth in mother and child and to care for the newborn. The overall infant mortality rate has improved. However, perinatal deaths, defined as stillbirths and deaths during the first week of life, have fallen only slightly. Perinatal deaths reflect problems related to pregnancy and delivery. Contraceptive counselling and vaccinations are also important components of post-partum care.

In many other countries medically trained midwives form the backbone of modern antenatal programmes and normal birthing care. Today an advanced midwifery education covers normal deliveries, care for newborns and infants, preventive reproductive and sexual health services, detection of abnormal conditions and criteria for when to call for medical assistance, as well as capacity to perform emergency interventions when no physician is available. Most midwives are women. Midwives are important for counselling and to provide fertility regulation and other sexual and reproductive health services. However most trained midwives still tend to be posted to hospitals and in administrative or teaching positions. For most partner countries it will take a long time before there are enough nurse-midwives in the periphery to give quality delivery care.

Therefore there is also a need to train other cadres of health workers, e.g. nurses and nurse aids, in antenatal care and delivery. In this way the coverage of births by trained health workers can be substantially increased. Male health workers are also needed to reach men with information and services related to sexual and reproductive health and rights.

Traditional birth attendants are important care-givers and health educators, but they have only a limited capacity to prevent maternal deaths and to deal with emergency delivery complications. Training programmes for traditional birth attendants should be continous and have as their objective to include this category into the health system, improve their knowledge in obstetric hygiene and in identifying high-risk mothers for referral.

A supportive environment for breastfeeding is essential for both infant and mother. The health services should support and promote breastfeeding through adequate routines, e g baby-friendly hospitals. In order to protect breastfeeding against commercial interests, the International Code of Marketing of Breast-milk Substitutes must be monitored and enforced in national and localsettings. Exclusive breastfeeding for four to six months is advocated, but will require great effort to achieve. Working mothers lack conditions, including legal rights, to enable them to breastfeed.

***Maternal Health and Newborn Care***

*Sida will focus on strategic actions for:*

- Service coverage of antenatal, delivery and newborn care of good quality at community level;
- Emergency obstetric care and functioning referral systems;
- Midwifery competence among health staff, and better defined roles and responsibilities for medically trained midwives;
- Possibilities for women to breastfeed from right after delivery and also when at work;
- Protection against unethical marketing of breast-milk substitutes.

## *2.4 Services for Fertility Regulation*

Fertility regulation is practiced in all societies. According to WHO, fertility regulation includes delaying childbearing through the use of contraceptive methods and termination of unwanted pregnancies. The balance between prevention and termination of an unwanted pregnancy varies, but if both contraceptives and safe abortion are accessible, people will use contraception as their first choice, with abortion as a back up when contraception fails.

During three decades family planning has been extensively propagated, mainly as a means to reduce fertility. Conventional family planning programmes have stressed the use of effective, modern contraceptive methods, while condoms and other barrier methods have been given less attention. Hormonal and technical contraceptives were introduced without adequate information being available about their function or health impact, while traditional methods such as withdrawal, lactational amenorrhoea or abstinence were ignored or discredited.

*About one third of couples in developing countries use male contraceptive methods, or methods that require male cooperation. Yet only a small fraction of family planning programme efforts is usually directed towards men. (Planned Parenthood Challenges 1996/2)*

The new approach to fertility regulation focuses on reproductive health and quality of services. Couples and individuals have the right to choose when to use contraceptives. If they so wish they shall have access to appropriate information and services on a wide range of contraceptive methods. All types of force or coercion should be abandoned. This includes also unethical disincentives and research trials.

To be able to control one's fertility is a reproductive right of all sexually mature women and men. This right is violated in many ways. Approximatly twenty countries around the world still lack official support to programmes for contraceptive services. Some countries restrict by law access to modern contraceptives from certain groups, e.g. adolescents. People's reproductive rights may also be manipulated through use of incentives and disincentives to health staff and clients for contraception and sterilization.

In the research for new and improved contraceptives suitable for men and women, biomedical studies must be better integrated with social and behavioural research to enhance understanding of the needs and constraints under which the methods are to be used.

***Services for Fertility Regulation***

*Sida will focus on strategic actions for:*

- Training and continuous education of service providers and policy makers on how to respect people's sexual and reproductive rights;
- Provision of quality personal counselling to all, irrespective of marital status, age on sexuality, reproduction and gender issues;
- Provision of accessible fertility regulation services of good quality and with a wide range of affordable contraceptive methods.

## *2.5 Abortion*

Abortion is a politically and ethically sensitive issue and remains illegal in many countries. It is only recently that induced abortion was recognized as an important women's health issue. At the Cairo conference significant progress was made, when unsafe abortion was recognized as a "major public health concern". The Beijing conference considered induced abortion as a method for fertility regulation and stated that governments should "consider reviewing laws containing punitive measures against women who have undergone illegal abortions". This recommendation may lead to an opening for decriminalization of abortion.

Abortion is practized by women worldwide, irrespective of the legal status of abortion or quality of services. Even in societies where contraceptives are accessible and commonly used, as in Sweden, there will always be

situations when women have to consider an abortion and need access to safe abortion services.

In many countries all over the world, abortion is a serious and neglected public health problem. The social and health consequences for women undergoing abortion differ considerably between and even within countries. Unsafe abortion constitutes a major cause of maternal mortality and the overwhelming majority of all maternal deaths from abortion occur in poor countries. Unsafe abortions may also lead to infertility.

Menstrual regulation (MR) is used for early termination of pregnancies. These services can be provided by trained health workers or paramedicals, and thus be accessible to women even in rural areas. MR is usually accepted by women as a method to re-establish normal menstruation, regardless of the origin of the delay.

Generally speaking, abortion related mortality and morbidity is highest in countries where abortion is illegal or legally restricted, where reproductive health services are insufficient, and where women lack control over their sexuality and fertility. Where abortions are legal, the health services may prevent the clandestine abuse of women in distress. The experiences of many countries confirm that legalization of abortion does not increase the abortion rate. It only determines whether abortions are performed under safe or unsafe conditions.

To reduce the number of unsafe abortions and abortion-related mortality requires a number of steps. These include legalization of abortion, equal rights and opportunities for women, and appropriate reproductive health care including contraceptive and abortion services. All these are equally important.

*Complications arising from unsafe abortions account for about 25 percent, in some areas between 30 and 50 percent, of maternal deaths, and are almost entirely confined to developing countries. (WHO, Complications of abortion. Technical and managerial guidelines for prevention and treatment, 1995)*

***Abortion***

*Sida will focus on strategic actions for:*

- Availability of medically safe termination of pregnancy, including menstrual regulation;
- Access to quality care for abortion related complications;
- Liberalization of abortion laws, and decriminalization of women who have undergone illegal abortion.

## *2.6 HIV/AIDS and other Sexually Transmitted Diseases*

When the AIDS epidemic began, only some 15 years ago, it was seen as a disease mainly affecting men. The HIV-virus can be transmitted in various ways, but sexual transmission is the most common, accounts for 3/4 of all cases. Women are increasingly affected. Globally, more than 40 percent of those infected are women. In many countries, predominantly in Africa, there are at least as many newly infected women as men. Pregnant women pass on the infection to the fetus/newborn child in one third of the cases. The majority of newly infected adults are below 25 years.

Young women are among the most susceptible to HIV, for both biological and social reasons. Older men may prefer younger women, partly in the hope that the younger the partner, the less likely that she is HIV-positive. If the sex is forced upon the girl, the risk of infection increases markedly. The vulnerability of girls and young women is evident from AIDS mortality statistics. These peak, on average, 10 years earlier for women than for men.

Sexually transmitted diseases (STDs) began to receive more attention from health services when it was demonstrated that HIV spread much faster in countries where untreated STDs were common. Existing STD programmes tend to emphasize curative aspects. The HIV/AIDS pandemic has made it urgent to integrate programmes for STD and HIV/AIDS control and to deliver these services in an integrated manner all through the general health system. In order to prevent the spread of STDs, measures to influence particularly men's sexual behaviour should be developed. Correct use of condoms greatly reduce the risk for both STDs and HIV. The quality of services need improvement, especially with regard to communication and counselling.

Common STDs like syphilis and gonorrhea, have often been ignored by the health services and by the donor community, presumably because they are not immediately fatal, carry a certain stigma and relate to sexual behaviour, considered difficult to change.

*Worldwide, 333 million curable cases of sexually transmitted diseases occur every year, mostly in developling countries. (WHO, An overwiew of selected Curable Sexually Transmitted Diseases, 1995)*

STDs have often wrongly been considered less serious for men than for women and easier to cure in men. But untreated or inadequately cured STDs are a major cause of infertility in both women and men. Infertility is a big problem, for both women and men, but infertility treatment is often both costly and technically complicated.

In women STDs often do not present clear symptoms, but may cause severe problems such as chronic pelvic pain, tubal defects, extra-uterine pregnancy, infertility, stillbirths and disability in newborns. Syphilis is one of the main culprits for pregnancy loss. Unhygienic procedures at childbirth or abortion carry added risks for women to develop reproductive tract infections (RTIs), and these too may lead to infertility.

Research and development is needed to validate symptom-based approaches to generate simple, appropriate and inexpensive diagnostics and therapies for sexually transmitted diseases, and to create women-controlled methods that protect against disease either with or without contraceptive effects.

In poor countries cervical cancer, caused by a sexually transmitted virus is a major health problem for women of fertile ages. If diagnosed early, cervical cancer can be cured. Mass screening of symptom-free women is not realistic for most poor countries, but limited projects may be possible.

***HIV/AIDS and other Sexually Transmitted Diseases***

*Sida will focus on actions for:*

- Gender sensitive HIV/AIDS information through various sectors e.g. the school system, the health services, and the media;
- Behavioural changes, particularly among men, to prevent the spread of HIV/AIDS and other sexually transmitted diseases;
- Integration of services for fertility regulation, STDs and HIV/AIDS;
- Development of simple, appropriate diagnostic methods and therapies against sexually transmitted diseases.

## *2.7 Adolescent Health*

The majority of first time mothers in the world are still in their teens, most of them married. But globally the trend is that people reach sexual maturation at earlier ages but marry later, leaving a growing time span when young people are sexually active but not yet in stable union. Changes in the traditional patterns for social control and behaviour and weakening family ties reinforce this trend.

Young people's sexual life is only recently being acknowledged. Adults, and especially parents, often find sexual relationships of adolescents such a difficult subject that they avoid it. Young girls and boys do not receive adequate information and counselling, and lack the means to control their

*In parts of Africa, HIV infection is increasing among adolescent girls. Studies reveal that girls aged 15-19 years are three to five times more likely than boys to be infected. Om average, women become infected five to ten years earlier than men. (World Bank, A New Agenda for Women's Health and Nutrition, 1994)*

fertility. If they get a sexually transmitted disease or experience an unwanted pregnancy, they often do not have access to services or even know about them.

Adolescent girls are exposed to considerable risks related to sexuality and reproduction. Early marriages and early childbearing prevent young girls from completing school and getting professional training. Unwanted adolescent pregnancy often has negative consequences for the young mother's social possibilities. Health services often operate on the premise that sexual relations are consensual. In fact, this is often not the case. Girls are vulnerable to sexual abuse by partners or even by family members. The consequences for their sexual, reproductive as well as mental health may be serious. In many cultures adolescent boys are under pressure from peers to have early sexual experiences to "prove they are men".

Education is recognized as a key to improving sexual and reproductive health and informing about sexual and reproductive rights. Strategies to reach out should include formal as well as non-formal education, adult literacy programmes and school-parent organizations. Mass media have an important role in making sexual and reproductive ill-health and injustices visible, as well as in informing about efforts to challenge these evils. It is also important to inform about the positive aspects of sexuality involving love and tenderness and mutual respect of each others feelings.

Young unmarried people have the right to comprehensive sex education and services for their reproductive and sexual health. Young girls who have become pregnant have the right to finish their education.

### *Adolescent Health*

*Sida will focus on strategic actions for:*

- Gender sensitive education on sexual and reproductive health and rights for young people, in school and out-of-school;
- Integrated approaches to counselling, supply of contraceptives and STD services, e.g. through youth clinics;
- Development of methods to involve the adolescents themselves; e.g. through peer counselling and youth clubs;
- Advocacy to change attitudes among policy-makers about adolescents' right to information and health services.

A problem for the development of effective programmes for young people in many countries is that so little is known about how to approach them or how development in society affects them. Therefore research should involve the young women and men themselves in a search for ways to reach out, as well as on how to accomplish behaviour changes.

## *2.8 Female Genital Mutilation*

Circumcision of male infants or young boys is a hygienic practice common in Muslim, Jewish and Christian communities all over the world. It does not affect the sexuality of the adult man nor carry any particular risk of complications. In contrast, female genital mutilation (FGM) or female circumcision as it is sometimes arguably called, is usually carried out as a more or less extensive mutilation of the external genitalia, and has no hygienic rationale, but is an expression of men's strive to control women's sexuality. It has substantial negative effects on the possibilities for the adult woman to have a satisfying sex life and a safe reproductive life.

Female genital mutilation is mainly found in Africa. There are three main types according to how much of the female genitalia are cut away. The majority of women are mutilated during childhood, often just before puberty and mostly under unhygienic conditions.

The immediate medical consequences can be severe and even lethal. The long-term complications include infections, chronic pelvic pain and excessive growth of scar tissue. This can cause prolonged delivery, which poses risks also for the child. In connection with childbirth, the occurence of fistulae is a risk particularly for teenage mothers. Many of the women have no or very limited possibilities to get medical care.

Female genital mutilation can cause sexual frustration and fear and thus reduce sexual fulfilment. The psychological effects are deep and the memory of the excision may persist throughout life, leading to a wide range of mental problems. But the tradition is deeply rooted in complex cultural practices, which differ between ethnic groups. It cannot be treated as an isolated phenomenon but must be understood as part of a greater socio-cultural context.

In communities where female mutilation is practiced the social consequences of not being excized are generally perceived as being more severe than the physical consequences of being excized. This means that it is not enough simply to inform people of the health damaging aspects of the practice, to make people change. Emphasis must instead be on the cultural and social significance of the practice, and people from all parts of society must be engaged. Strategies against female genital mutilation include debates on attitudes among people such as religious leaders, men in general, the elderly of both sexes, traditional birth attendants, midwives,

*With the current rate of population growth approximately 6 000 girls are at risk of being excised each day and two million girls per year. (Toubia, A Call for Global Action, 1995)*

health workers and school staff. Last but not least the practitioners themselves, who are often revered women, earning their living from this practice, must be involved and encouraged to take on a different role.

An important part of the solution is education and empowerment of girls and women to increase women's control over their lives socially, economically, politically and culturally.

Since the beginning of the 1980s a slow process of change can be seen. Many non-governmental organizations and women's groups in developing countries, as well as some governments and international organizations have taken action against female genital mutilation. It is increasingly spoken of in terms of human rights.

***Female Genital Mutilation***

*Sida will focus on strategic actions for:*

- Dissemination of knowledge about harmful effects of female genital mutilation among health staff, and persons who perform the mutilations;
- Advocacy for changed attitudes among people from all parts of society, e.g. the older generation, policy-makers and teachers;
- Changes in legislation, and monitoring of adherence to existing laws and treaties prohibiting the practice.

## *2.9 Discrimination, Violence and Abuse*

Gender-based discrimination and violence is the cause of many sexual and reproductive health problems The list of gender based violence is long. It contains sexual harrassment, rape, coercive provision of contraceptives, forced sterilization and forced abortion, female genital mutilation, prenatal sex selection, female infanticide and forced prostitution.

Discrimination, violence and abuse against women and children received considerable attention at the Beijing Conference. Violence against women was recognized as a product of historically unequal gender relations, used by men to control women and keep them in a subordinate position. Thus, violence is intimately linked to the issue of women's autonomy. Violence, or the threat of it, effectively limits women's possibilities to move freely, to

***Discrimination, Violence and Abuse***

*Sida will focus on strategic actions for:*

- Enhanced capacity in the health system to detect effects of violence and abuse on women and children;
- Cooperation between NGOs and social and legal authorities to fight discrimination;
- Protection and emergency care for women in crisis situations and counselling to enable them to decide about violent relationships;
- Prevention of sexual exploitation of children.

participate in public life, and to make decisions related to sexuality and reproduction. All over the world there is considerable lack of data and consistent under reporting.

Patriarchal cultures allow men to exert control over women's reproductive capacity. Changes in women's roles in family and society have often proved to be threatening to men. Women's quest for empowerment and right to autonomy may cause male frustration and lead to increased violence against girls and women. Societies also often react less strongly, legally as well as in practice, to men who yield to violence against women, than to other types of crime.

Obviously, the health sector can not alone address the problems. But the health services are often better placed, than e.g. the police, to obtain information since it is the health workers who meet the battered women. But although gender-based violence affects women's health, most health centres are not aware of this and do not screen for signs of violence. Even when violence is recognized as the primary cause of an injury or disease, this is rarely registered in medical records, and support services are not available. Domestic violence is seen as a family problem, and many health workers are reluctant to interfere. In countries with adequate health infrastructure, the health services and particularly antenatal programmes could provide an opportunity to detect violence and reach battered women.

Some societies have a strong preference for sons, for economic, cultural or religious reasons. In situations of despair and poverty, or where strict

*Worldwide, 25 percent of all women have at some point been beaten by their partner. Regional surveys have yielded as high figures as 80 percent. (UNICEF, State of the World's Children, 1995)*

population policies exist to reduce family size, son preference may result in infanticide of baby girls and general neglect of girls. Selective abortion of female foetuses is increasing, and has become possible with the availability of modern technology, e.g. mobile ultra sound equipment.

Both girls and boys are increasingly victims of commercial sexual exploitation, such as child prostitution and sale of children for sexual purposes, including child pornography. This market is growing at an alarming rate and with considerable economic profits. The children are exposed to a number of sexual and reproductive health risks and the psychological damages are extremely difficult to repair.

# 3. Research and Research Capacity Building[2]

Even though our knowledge about sexual and reproductive health is improving, there are still significant gaps. Research is a crucial part of the efforts to develop more effective strategies and interventions. It is a tool which can contribute information for strategic decisions on investments in sexual and reproductive health, for development, assessment and improvement of health care routines, as well as methods for treating diseases. A lack of reliable information leads to the danger of applying and maintaining inappropriate methods.

The research needed encompasses a broad range of issues particularly in relation to maternal and neonatal health, adolescents' sexual health, fertility regulation, abortion, infertility, gender-based violence and men's sexual and reproductive health. Research on sexual and reproductive health and rights encompasses the medical, biomedical, epidemiological, social and behavioural issues sciences, and interdisciplinary collaboration should be encouraged.

In rich countries, research on health problems is an unquestioned part of the health system, and includes the feasibility and effectiveness of different health care methods and routines. This type of research is limited in poor countries for lack of research capacity and in the face of urgent health problems. It is simply not perceived as priority activities, and tend to be overlooked not only by national decision-makers but also by the donor community.

Many sexual and reproductive health problems are to a large extent locally specific and have to be addressed by locally organized research. Therefore, the importance of building up research capacity at national level has to be placed on the agenda and emphasized discussions with counterparts in other countries. Research should use the needs of women and men as its starting point and, when appropriate, be multidisciplinary in concept and practice.

Scientists and researchers can play a strategic role in the early stages of planning development cooperation projects. The dissemination of research results to policy makers and the public is important and often overlooked.

Many sexual and reproductive health problems are general to different societies. Therefore international research programmes are needed as well. They provide an opportunity for the involvement of advanced laboratories

2. See also Sida/SAREC-WHO, *Sexual and Reproductive Health: The Challenge for Research*, 1996.

and institutions in industrialised countries. All research collaboration between countries in the North and the South must always be based on the principle of partnership and equity.

### *Research and Research Capacity Building*

*Sida will focus on strategic actions for:*

- National research and research capacity building with particular attention to universities;
- High quality international research programmes of relevance to developing countries;
- Institutional research cooperation in response to needs and priorities of developing countries.

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