

I. Introduction

The right to sexual and reproductive health is a cornerstone of development. Conceptualized at the groundbreaking International Conference on Population and Development (ICPD) in 1994, reaffirmed and further amplified at the Beijing Fourth World Conference of Women in 1995,¹ important precedent exists underlying the right to sexual and reproductive health. The right has also been included in the Convention on the Elimination of Discrimination against Women (CEDAW) and the Convention on the Rights of Persons with Disabilities, and acknowledged by numerous treaty bodies, including the CEDAW Committee², the Committee on the Rights of the Child (CRC)³, and the Committee on Economic, Social, and Cultural Rights (CESCR)⁴. Within this international legal framework, a number of associated rights are applicable to the attainment of sexual and reproductive health. These include the right to life and survival; autonomy and confidentiality; information and education; equality and non-discrimination, and privacy, amongst others.

The United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has further defined the components, norms, and standards around sexual and reproductive health in his publications and reports to the United Nations.⁵ Development of this normative framework has influenced international consensus at the national level: According to the WHO, “every country in the world is now party to at least one human rights treaty that addresses health-related rights. This includes the right to health as well as other rights that relate to conditions necessary for health”.⁶ Furthermore, in the years following the ICPD and Beijing conferences, new reproductive health policies have been enacted and implemented in almost all countries.

Despite this strong foundation and progress made, poor sexual and reproductive health remains one of the most prevalent causes of disease and death for women between the ages of 15 and 44 in developing countries. Worldwide, it accounts for 20 per cent of the global disease burden for women and 15 per cent for men of fertile age.⁷ This includes maternal mortality and morbidity, reproductive tract and sexually transmitted infections including HIV, casualties and severe health consequences resulting from unsafe abortion. Furthermore, vast inequities remain around the world with regards to individual’s abilities to enjoy the right to sexual and reproductive health as well as to access sexual and reproductive healthcare services. For example, the risk of dying from pregnancy and childbirth is one approximately in 7300 in developed countries, and as high as one in 22 in Sub-Saharan Africa.⁸

Multiple reasons exist for the high incidence of sexual and reproductive ill health and for its lack of adequate prioritization worldwide. Explanations include the broad classification of the issues encompassed under the sexual and reproductive health construct, as well as to their sensitive nature. Indeed, in many ways, defining sexual and reproductive health is complex because it cuts across traditional measurement lines. “Sexual and reproductive health includes diseases (e.g., AIDS) and ‘non-diseases’ or normal physiological processes (e.g., pregnancy), as well as including both communicable diseases (e.g., STI) and non-communicable ones (e.g., breast cancer).”⁹ It also includes social phenomena such as sexual and gender-based violence and gender inequality.

This broad definition also complicates coordinated national and international responses. For example, despite the fact that HIV is primarily sexually transmitted, for many years it has been addressed separately from sexual and reproductive health. Increased emphasis on HIV has also shifted funding and

attention away from broader issues of sexual and reproductive health. At country level, “different components of sexual and reproductive health fall within the jurisdiction of different sectoral ministries”.¹⁰ Addressing these issues separately misses important opportunities to integrate and strengthen the kinds of services and programming necessary for comprehensive health approaches. Similarly, while sexual and reproductive health is a prerequisite for all the Millennium Development Goals (MDGs), no one goal in this framework covers all of its components. Rather, these issues are addressed over a range of MDGs, from maternal health to gender equality to HIV and AIDS.

Furthermore, strategies for the attainment of sexual and reproductive health touch upon delicate topics such as sexuality, the definition of the “family”, gender-based violence and discrimination, and power relations between men and women, among others, which cut to the core of how culture is defined and societies organized. Terms ranging from “family planning” to “gender-equality” to “sexual education” elicit varied responses within different political, social, and cultural contexts, as we will see through-out the course of this paper. Furthermore, while “sexual health” is a central element in reproductive health formulations, it is often left out of broader discussions of reproductive health and rights. In some instances, stigma and taboo around sexual and reproductive health issues have caused people to avoid discussing them altogether. Indeed, it is only within the past 20 years or so that sexual and reproductive health has become a “fit topic” for international discussion.”¹¹

However, as highlighted by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, “explicit recognition [of sexual and reproductive health] is important because what is unnamed is more likely to be unsupported.”¹² The 1994 ICPD conference in Cairo marked the beginning of new international dialogue around reproductive health and rights, as well as a turning point in the history of the population movement. Recognition of gender as a key determinant of an individual’s health, and of women’s disproportionate burden with regards to sexual and reproductive health shifted the focus of attention from achieving demographic targets to addressing women’s needs and rights. Consensus on a broad framework for sexual and reproductive health was achieved at the Cairo conference, along with targets for achieving universal reproductive health by 2015.

In the years since this pivotal international conference, the framework around sexual and reproductive health has been further developed by a broad array of stakeholders, with different cultural, political, and religious ideologues, as well as differing health needs and wants. This report analyzes frameworks, policies, and strategies on sexual and reproductive health as put forth by a range of actors including countries, institutions, and international agreements. Its purpose is to examine and compare select interpretations of sexual and reproductive health, and the ways in which these interpretations are shaping the international agenda on the right to sexual and reproductive health.

We first set the international context by offering background and analysis of the ICPD Programme of Action as the foundational document for the modern sexual and reproductive health movement. The report then briefly explores the development of an international legal framework whereby the right to sexual and reproductive health became grounded in human rights treaties, in the outcomes of international conferences and in the work of the treaty bodies. The ICPD paved the way for the 2001 Millennium Development Goals, which we explore in relation to universal access to sexual and reproductive health.

The ICPD and the MDGs are used as the jumping off point to examine three frameworks necessary for the advancement of sexual and reproductive health: These include human rights based approaches, cultural frameworks; and a gender and empowerment focus.

II. ICPD: Towards a Paradigm Shift and New Definition of Sexual and Reproductive Health

Fifteen years since the ICPD, the outcomes and definitions that emerged from Cairo are more relevant than ever. The shift from demographic targets to individual needs fundamentally changed the population movement. Whereas previous approaches treated women as tools through which to implement population programmes, the ICPD Platform for Action emphasized that demographic goals should not be prioritized over individual choice: “Population issues could no longer be treated from a top-down perspective with pre-set goals, but had to be regarded in light of the individual’s needs and rights.”¹³ This was the first wide-spread recognition of the connection between women’s empowerment and advancement of larger development issues such as poverty, education, public health, and protection of the environment. Women’s and young people’s rights were brought to the fore—including women’s ability to control their own fertility and the elimination of violence against women— along with men’s responsibilities in family planning and the promotion of sexual and reproductive health. A lifecycle approach was advocated, widening the focus of sexual and reproductive health from the reproductive years to larger issues of sexuality, gender equality, and power relations between men and women.¹⁴

Furthermore, this new focus encompassed proactive and preventative measures to ensure good health, such as family planning, counseling, and sexual education, rather than emphasizing disease prevention: According to the ICPD Programme of Action definition, “**Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.**” (Programme of Action , 7.2) Furthermore, implicit in the concept of reproductive health is that of sexual health, including the ability to have a “satisfying and safe sex life” and “the capability to reproduce and the freedom to decide if, when and how often to do so.” (Programme of Action , 7.2) The Programme of Action went on to define reproductive health care as “the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes **sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.** (Programme of Action 7.2)”

Several aspects of this new framework were notable: The shift from a more traditional public health discourse emphasizing risks to a human rights-based framework empowered individuals, particularly women and girls, to know their rights and make their own informed choices. The new framework made reference to other national and international consensus documents, acknowledging that “reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents.” (Programme of Action , 7.3) The Programme of Action also began to distinguish between reproductive and sexual health, the definition of which has been further refined and legitimized in the years since the conference. And targets set to achieve universal access by 2015 were an early attempt to hold policy makers accountable. Such strategies for accountability were more fully developed as part of the Millennium Development Goals.

Furthermore, the Programme of Action framework clarified certain contentious issues, helping to bring about a greater international consensus. Informed free choice was the new bedrock of family planning, with emphasis on “the ability of individuals and couples to make free and informed decisions about the number, spacing, and timing of births and protect themselves from STD (Programme of Action 7.19) Such decision making capabilities rested on availability of sexual education and information, and giving men, women, girls and boys the tools to make smart decisions was thus noted as critical. The recurring theme of “responsible human sexuality” further included “the right of individuals and couples to have information and access to a range of “safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility *which are not against the law.*” (Programme of Action , 7.16)

The wording of this phrase was so crucial because it legitimized access to contraception and abortion where it is legal, while allowing states with policies prohibiting abortion to “return home without needing to accept it in their own countries.”¹⁵ Indeed, while the Programme of Action emphasized that abortion should not be used as a form of family planning, it made a critical link between lack of effective family planning methods and services and recourse to unsafe abortion. Its message was further groundbreaking in linking unsafe abortion and maternal mortality, nothing that “in all cases, women should have access to quality services for the management of complications arising from abortion.” (Programme of Action, 8.25)

In other areas, ICPD pioneered discussions of issues that had heretofore not been addressed. This was the first international conference, for example, that affirmed the right of adolescents to sexuality education and reproductive care, including contraception. The Programme of Action carefully balanced the duties of parents with the rights and needs of adolescents to access “appropriate direction and guidance in sexual and reproductive matters”, including “on sexually transmitted diseases and sexual abuse”. . . .and to do so in an atmosphere of “privacy, confidentiality, respect, and informed consent.” Other firsts included an emphasis on male responsibility and involvement in sexual and reproductive health, and acknowledgment of the connection between women’s biological vulnerability, lack of social and economic power, and consequent greater susceptibility to HIV and AIDS.

III. Progress since Cairo: Varied and Uneven

The advances made at the ICPD were groundbreaking, including its approval by 179 governments. In the years following, the importance of the right to sexual and reproductive health was re-confirmed at a number of international fora. For example, the 1995 Beijing World Conference on Women both reaffirmed the ICPD platform and developed it further. The definition of reproductive health from ICPD was included verbatim in the Beijing Platform for Action, but with strengthened language on women’s rights to control their sexuality free from coercion, discrimination, and violence.¹⁶ The Beijing Platform also broached the subject of decriminalizing abortion, inviting governments to “consider reviewing laws containing punitive measures against women who have undergone illegal abortions”.¹⁷ The right to sexual and reproductive health was further affirmed in subsequent international conferences, including ICPD+5, ICPD+10, UNGASS, and the 2005 World Summit, to name a few.

The right to sexual and reproductive health has also been addressed by a number of treaties and treaty bodies. The 1979 Convention on the Elimination of All Forms of Discrimination against Women

(CEDAW) makes the most explicit reference women's reproductive health--including the right to determine the number and spacing of one's children, while the 2008 Convention on the Rights of Persons with Disabilities underscores the right of persons with disabilities to enjoy the same choices and services around sexual and reproductive health as other individuals. Furthermore, a number of treaty monitoring bodies from the CEDAW Committee to the Committee on the Rights of the Child have affirmed and developed the right to reproductive health in their general comments.¹⁸ Many of these committees have dealt with contentious issues such as unsafe abortion, making a similar link between illegal unsafe abortion and high rates of maternal mortality, as had been made at the ICPD. The Human Rights Committee, for example, which oversees the International Covenant on Civil and Political Rights, has explicitly characterized maternal mortality caused by unsafe abortion as a violation of women's right to life.¹⁹ The process of state reporting to these treaty bodies, along with the submission of NGO shadow reports, has created important dialogue and precedent around the interpretation of human rights, including the right to sexual and reproductive health.

The cumulative effect of consensus has been the development of an international legal framework around the right to sexual and reproductive health. This has led to important changes on the ground. For example, in the 15 years since ICPD, approximately 86 per cent of countries adopted institutional changes to promote or enforce reproductive health and 54 per cent had formulated new policies.²⁰ Yet, despite this consensus, understanding and agreement around the right to sexual and reproductive health continue to vary widely by culture, religious ideology and political administration. A range of actors from UN Agencies to bilateral donors to governments to NGOs of differing ideological stances continue to attribute a wide variety of meanings to sexual and reproductive health.

Furthermore, these interpretations are often shifting. For example, many Latin American countries which had expressed reservations at the ICPD then endorsed the use of progressive language at ICPD+5. A decade after the ICPD conference in 2004, the international political climate around sexual and reproductive health had become so contentious that ICPD+10 was organized by nongovernmental organizations, including the International Planned Parenthood Federation, Population Action International, and Family Care International, outside the United Nations framework.²¹ And whereas the United States had been one of the strongest proponents of the ICPD platform, its interpretations of the concept of sexual and reproductive health and the policies it consequently enacted have dramatically changed according to the government in power.²²

One interesting institutional example of a policy shift has been the World Bank, which has a strong history of support for sexual and reproductive health. In 2000, it was one of the institutions lobbying most intensely for a separate reproductive health goal as part of the MDGs. However, its current interpretation of sexual and reproductive health appears less comprehensive than that of other multilaterals. In fact, when its ten year "Health, Nutrition, and Population" strategy was first drafted in 2007, there were "virtually no references to women's sexual and reproductive health rights."²³

While intense advocacy from NGOs was successful in pressuring the Bank to reinsert sexual and reproductive health into its document, current strategy makes no reference to international consensus, and the strong theoretical foundation around the right to sexual and reproductive health. With the exception of

HIV and AIDS, there is also a paucity of reference to sexual and reproductive health priorities, from family planning to maternal mortality.²⁴

IV. Sexual and Reproductive Health and the Millennium Development Goals (MDGs)

Political sensitivity and equivocation around the right to sexual and reproductive health issues can be seen around creation of the Millennium Development Goals, the predominant framework for international development, emanating from the Millennium Declaration. Like the ICPD, the ambitious and far-reaching agenda of the MDGs recognizes the interconnectedness of development challenges, setting time-bound and measurable targets for achieving them. Components of sexual and reproductive health are directly incorporated into several MDGs from maternal health to gender equality to HIV and AIDS.

Yet the targets and indicators chosen to monitor these goals are often limited, compared to the enormity and breadth of the goals, chosen in some cases for their ability to be measured in short time frames.²⁵ For example, the elimination of gender disparity in education is only one of many elements necessary to achieve MDG #3, the promotion of gender equality and empowerment of women. Furthermore, the omission of a specific goal pertaining to sexual and reproductive health underscores the degree to which its achievement continues to be marginalized: “The importance of sexual and reproductive health to the attainment of international development goals has not been adequately translated into action frameworks and monitoring mechanisms at international, regional, and national levels.”²⁶

That omission was addressed at the 2005 World Summit which recommended that access to reproductive health be integrated into MDG monitoring mechanisms. In 2006, the United Nations General Assembly agreed to include “universal access to reproductive health” by 2015 as a target to MDG 5, improving maternal health. The concept of universal access is widely understood to mean “equitable access”, i.e. equal access for people with equal needs.²⁷ “Access” in this context refers not only to the physical and economic accessibility of health goods or services, but also their availability, acceptability within particular cultural contexts, and quality.²⁸

One definition of universal access to reproductive health proposed in a joint WHO/UNFPA consultation is the following: “The equal ability of all persons according to their need to receive appropriate information, screening, treatment and care in a timely manner, across the reproductive life course, that will ensure their capacity, regardless of age, sex, social class, place of living or ethnicity to: decide freely how many and when to have children and to delay or to prevent pregnancy; conceive, deliver safely, and raise healthy children, and manage problems of infertility; prevent, treat and manage reproductive tract infections and sexually transmitted infections including HIV/AIDS, and other reproductive tract morbidities, such as cancer; and enjoy a healthy, safe and satisfying sexual relationship which contributes to the enhancement of life and personal relations.”²⁹ While the associated indicators for the universal access target (contraceptive prevalence rate, adolescent birth rate, antenatal care coverage, and unmet need for family planning.³⁰) do not reflect all aspects of this broad definition, they are an important step towards equitable access. Furthermore, the newly incorporated target 6B, which calls for universal access to HIV and AIDs treatment by 2010, strengthens the emphasis on health equity.

Proponents of the right to sexual and reproductive health argue that its attainment is integral to the success of *all* the MDGs, eloquently articulating the strong linkages between sexual and reproductive

health and *every single one* of the goals.³¹ This interpretation makes the case that sexual and reproductive health must be viewed within the wider development context and understood in terms of its cross-cutting nature. For example, the overarching aim of the MDGs pertains to the eradication of extreme poverty and hunger, MDG #1. According to studies, “high levels of fertility contribute directly to poverty, reducing women’s opportunities, diluting expenditure on children’s education and health, precluding savings and increasing vulnerability and insecurity.”³² Regarding MDG #2, achieving universal primary education, research in a variety of settings asserts that educated girls are more likely to know the basic facts about HIV, are more empowered to negotiate safe sex, may be more likely to delay sexual activity, and are less likely to suffer from sexual and gender based violence.³³ Schools have also become the main venue for teaching sex and life skills education. Taught properly, such courses can change harmful gender stereotypes and empower boys and girls to make choices about healthy sexual behaviors.

Empowered women (MDG #3) are more likely to know their rights and be able to insist on safe sex. Multiple forms of gender based-violence—including rape inside a relationship and out, in times of peace and war, forced early marriage, sex trafficking and harmful practices such as female genital mutilation/cutting FGM/C—profoundly impact women’s health and well-being, particularly their sexual and reproductive health. Similarly, women’s and girl’s choices and opportunities regarding her sexual and reproductive health are a strong determinant of child survival. Indeed, reducing child mortality (MDG#4) is intimately connected to a mother’s age, spacing of her children, and decisions she makes about their care and welfare, include whether and how long to breastfeed. Improving maternal mortality (MDG #5) through peri-natal care, including the presence of skilled birth attendants, and universal access to reproductive health, will ensure greater survival outcomes for both mothers and children. Furthermore, as the great majority of HIV infections are transmitted during sexual intercourse, or associated with pregnancy, labor, delivery or breastfeeding, combating HIV (MDG #6) is inextricably linked to sexual and reproductive health.

As population dynamics put pressure on the environment, ensuring environmental sustainability (MDG#7) will only be achieved through effective family planning efforts. Lastly, global partnership between donors, developing country governments, NGOs, the public and private sectors are critical in order to provide the necessary resources for the attainment of sexual and reproductive health. Viewed through this lens of interconnection, sexual and reproductive health are actually “keystones” for meeting the MDGs. However, as articulated by the UN Population Fund, “the challenge is to ensure that countries take into account the linkages between population issues and poverty reduction and the importance of investing in reproductive health, gender equality, and young people.”³⁴

V. Evolving Sexual and Reproductive Health Frameworks

Both the ICPD and the MDGs set the international framework in which sexual and reproductive health advocates are operating. As a foundational document, the ICPD created not only a new set of norms, but a new approach to sexual and reproductive health. The international legal framework created in the wake of ICPD, Beijing, the MDGs and other consensus documents confirmed sexual and reproductive health as a human right and validated a set of standards around its interpretation. These include government obligations and mechanisms of accountability. For example, targets and indicators integral to the

attainment of the MDGs, are both a means to measure progress and a method for holding governments accountable.

Culturally constructed interpretations of sexual and reproductive health, as well as a tendency to use “culture” as a justification for abridging the right to sexual and reproductive health have necessitated development of culturally sensitive frameworks. Such approaches look at how cultural values can coexist with human rights, as well as what cultural knowledge can bring bear upon sexual and reproductive health. Cultural frameworks are closely related to gender and empowerment frameworks, which look at gender power dynamics and personal choice as they relate to sexual and reproductive health. Such approaches are so important because of women’s greater responsibility and vulnerability around sexual and reproductive health. It is important to note that these frameworks are not mutually exclusive. Not only do they readily complement one another, but stakeholders are incorporating elements from all of these frameworks into their own strategies. In this section, we explore frameworks grounded in **human rights**, **culture**, and **gender**, and examine ways in which states, institutions, and others have interpreted them in policy and practice.

A. Human Rights Based Approaches to Sexual and Reproductive Health

Under a human rights framework, the right to sexual and reproductive health comprises certain principles. These include *universality* and *inalienability*: All individuals and peoples are entitled to them, and they cannot be voluntarily given up or taken away. They are also *indivisible*, *inter-dependent*, and *inter-related*: Realization of one right often depends wholly or in part on the right of another. For example, attainment of the right to sexual and reproductive health may be dependent on realization of the right to information and education, the right to privacy, or other associated rights. These rights are distributed with *equality and non-discrimination* and cannot be abridged due to race, colour, sex, ethnicity, age, language, religion, political or other opinion, national or social origin, disability, property, birth or other status, as elaborated by human rights treaty bodies. Every person is entitled to active, free and meaningful *participation* in, and contribution to, the enjoyment and development of these rights.³⁵

The right to sexual and reproductive health is also subject to *accountability* and *rule of law*. Human rights approaches identify “rights-holders” (usually individuals) and their entitlements, along with corresponding “duty-bearers”, and their obligations. Entitlements include the right “to a system of health protection, including health care and the underlying determinants of health, which provides equality of opportunity for people to enjoy the highest attainable level of health.”³⁶ The reference to the underlying determinants of health is important because it defines a wide range of factors, from adequate sanitation to access to sexual and reproductive health education and information, that affect an individual’s ability to enjoy and take responsibility for her or her own sexual and reproductive health. The notion of entitlements also implies accountability on the part of the state and other duty-bearers, which are answerable for the observance of human rights. As defined by the Special Rapporteur on the Right to Health, “Ill health constitutes a human rights violation when it arises, in whole or in part, from the failure of a duty bearer—typically the state—to respect, protect, or fulfill a human rights obligation.”³⁷ Under this framework, “respect” implies that a state cannot deny or limit equal access to sexual and reproductive health including services, information, or education; “protect” implies a states obligation to “prevent third parties from jeopardizing the sexual and reproductive health of others” such as through laws prohibiting

marital rape or setting a minimum marriage age; while “fulfill” implies a responsibility to include sexual and reproductive health in national legal systems.³⁸ When duty-bearers fail to respect, protect, or fulfill this right, rights-holders are entitled to institute proceedings to obtain redress before a competent court of law.

The notion of entitlements also implies particular responsibility on the part of the state. As defined by the Special Rapporteur on the Right to Health, “Ill health constitutes a human rights violation when it arises, in whole or in part, from the failure of a duty bearer—typically the state—to respect, protect, or fulfill a human rights obligation.”³⁹ Under this framework, “respect” implies that a state cannot deny or limit equal access to sexual and reproductive health including services, information, or education; “protect” implies a states obligation to “prevent third parties from jeopardizing the sexual and reproductive health of others” such as through laws prohibiting marital rape or setting a minimum marriage age; while “fulfill” implies a responsibility to include sexual and reproductive health in national legal systems.⁴⁰

Furthermore, in order to provide equal opportunity for people to enjoy the highest attainable level of health, “services, goods, facilities, and the underlying determinants of health” must be *available, accessible, acceptable, and of good quality*, equally to everyone.⁴¹ This concept, which expands upon ICPD language around family planning and reproductive health services, was outlined by the Committee for Economic Social and Cultural Rights in General Comment 14, the right to the highest attainable standard of health. It constitutes the minimum entitlements and obligations against which duty bearers can be held accountable.⁴²

Availability in the context of sexual and reproductive health refers to the ability to obtain resources in sufficient quantities such as “safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs”⁴³. *Accessibility* of health facilities, goods and services refers in particular to their physical reach and affordability, particularly with regards to the most vulnerable or marginalized sections of the population, such as ethnic minorities and indigenous peoples, women, children, adolescents, older persons, persons with disabilities and persons with HIV and AIDS. It also includes the right to seek, receive and impart information and ideas concerning health issues. *Acceptability* refers to the fact that health facilities, goods and services should be culturally appropriate, particularly for marginalized groups and “respectful of medical ethics” such as observing the right to confidentiality and informed consent. Lastly, the goods and services must also be “scientifically and medically appropriate and of good *quality*.”⁴⁴ In order for a duty-bearer to fulfill the minimum standard required of the right to health, all of these conditions must be met.⁴⁵

South Africa is an example of a country which has evolved within the framework of respecting, protecting, and fulfilling the right to sexual and reproductive health. In apartheid era South Africa, there were no comprehensive sexual and reproductive health policies. Most health resources were allocated for the white minority living in urban areas, denying equal access to black majorities primarily based in rural, less developed areas of the country. The only policies aimed at South African blacks focused on contraception for the purposes of population control. Maternal health services were overcrowded and understaffed, large but untold numbers of women died from unsafe abortion in black townships⁴⁶, and infant mortality was ten times higher in the black than in the white population.⁴⁷ Coercive and unequal

policies severely undermined governmental responsibility, particularly around the health needs of poor, black women.

In contrast, the years following the first democratic election of 1994, saw passage of a significant number of sexual and reproductive health laws and policies. This was due in large part to the transition to democracy, and tremendous activism on the part of civil society to pass new and reformed health legislation. The Choice in Termination of Pregnancy Act of 1996, for example, was groundbreaking in recognizing the importance of reproductive choice, particularly for black women. Despite gaps in access to services, two years after the passing of the act, the number of women experiencing abortion-related morbidity was cut in half.⁴⁸ The 1997 patient's rights charter gave patients the knowledge and right to address inequities in the healthcare system; The 1998 Domestic Violence against Women Act is considered one of the most progressive in the world, addressing a wide range of violence including physical, sexual, emotional, verbal and psychological abuse.

Building on outcomes of the ICPD, the official 1998 Population Policy cited 12 guiding principles, including reference to reproductive rights, free and informed choice, non-discrimination, equal access to reproductive care, and women's rights.⁴⁹ This human rights-based framework emphasized "equity in resource distribution, expanded access, decentralized services aimed at promoting local health needs, community involvement through the district health care system, and preventative and promotive health care."⁵⁰ More than 1300 new primary health-care clinics were constructed, and user fees removed for maternal and child health services at the levels of primary health care and district hospital. A Mother, Child and Women's Health unit was established within the National Department of Health to help facilitate access to sexual and reproductive health.

Ecuador is an example of a country with a strong legal framework for fulfilling the right to sexual and reproductive health. One argument advanced by opponents to the recognition of this right in the region has been that as long as the right was not mentioned in the state constitution, it did not exist. Whereas countries such as Mexico, Colombia, and Brazil recognize aspects of sexual and reproductive health in their constitutions, Ecuador in 1998 became the only country in the region to explicitly include the term "sexual and reproductive health" in its constitutional text. Ecuador's new 2008 constitution articulates state obligation to provide sexual and reproductive health services--especially during pregnancy, childbirth and postpartum--as well as young people's right to sex education. It describes "the right to personal integrity" to include making free, informed, voluntary, and responsible decisions about one's sexuality, sexual orientation, and reproductive life, and includes new clauses on the state's responsibility to prevent violence against women and discrimination, including discrimination based on sexual orientation."⁵¹

In Ecuador, adoption of the 1998 Law for free maternity and infant care was both a step towards universal access to sexual and reproductive health, and an excellent example of incorporating all four components of availability, accessibility, acceptability, and quality into policymaking on the ground. Created in the wake of the ICPD through heavy lobbying by women's organizations, the law contributes to the *availability* of resources by requiring health centers and hospitals to provide 55 services connected with sexual and reproductive health for free. These include: antenatal, delivery and post-partum care, including obstetric emergency services; family planning; screening for breast and uterine cancer; testing women for

HIV and AIDS; care for victims of family violence; treatment for sexually transmitted diseases and treatment for the most common childhood ailments for children under five, including those requiring hospitalization.⁵² By breaking down economic barriers to access and targeting women and children—particularly vulnerable groups—the law also helps make health resources *accessible*, contributing to the concept of healthcare as a civil right and the importance of the state’s role in providing it.⁵³

In designing the law, the state actively sought the input of a wide range of civil society stakeholders, including women’s and indigenous organizations, in addition to health professionals. This helped ensure services were *acceptable*, particularly to more marginalized groups. Furthermore, Local Health Management Committees in different counties, rather than the Ministry of Health, oversee the channeling of funds to municipal health centers.⁵⁴ Input from a range of stakeholders sitting on the Local Management Committees has led to a diversification of healthcare providers, from traditional birth attendants to non-profit organizations.⁵⁵

Several innovations were incorporated into the law to evaluate the *quality* of services provided and ensure continuous quality improvement. Patient care protocols were developed, for example, to ensure high quality of services. The law also separated the functions of financing health services from healthcare delivery. Payments to health facilities are based on the volume and quality of services produced, with transfer of funds dependent on meeting quality of care requirements. Lastly, the creation of citizens/users’ committees to monitor the laws implementation is another mechanism formally recognized by the state to monitor quality of services provided.⁵⁶ The National Council on Women, a government agency, with assistance from UNFPA is working to ensure the user committee system is positioned in a human rights framework, so that committee members have a sophisticated understanding of how to apply a human rights-based approach to implementation of the law.⁵⁷

The UK Department for International Development (DFID) is an example of an institution whose policy on sexual and reproductive health pulls from the human rights standards elucidated in this section. DFID frames its focus on the rights of individuals and responsibilities of duty bearers through the prism of three guiding principles: “inclusion, participation, and fulfilling obligation.”⁵⁸ The first two principles refer to empowering and educating individuals, particularly those belonging to marginalized groups to become involved in ensuring their own sexual and reproductive health “and rights”⁵⁹

Inclusion, in this context, refers to ensuring participation of poor, vulnerable and excluded groups; addressing discrimination and disparity in access to services and health outcomes; empowering women to control their sexual and reproductive lives; and working with men and boys. Participation refers to increasing people’s information on sexual and reproductive health to offer people choices and “a sense of entitlement”⁶⁰ to quality services, and ensuring involvement of civil society, women’s groups, and community leaders, amongst others, in the promotion of their own health.

Obligation, in this framework speaks to the responsibilities of governments, policy makers, and donors. It refers to reforming legislation, implementing laws that protect women’s health and allow vulnerable groups to access services; guaranteeing a means of redress when rights are violated, and building capacity of policy-makers, governments and others at country level to promote sexual and reproductive health and rights.⁶¹

DFID's approach also emphasizes the "progressive realization of human rights".⁶² This means that what is expected of a country will vary over time, subject to resource availability,⁶³ and obliges governments to set indicators and benchmarks to assess the steady realization of human rights. Furthermore, according to DFID, this approach "recognize(s) the challenge of implementing human rights approaches in different cultural and political contexts."⁶⁴ It takes into account the fact that opposition to aspects of sexual and reproductive health may be based in deeply held religious beliefs and cultural traditions which are not easily forsaken. However, it also views cultures as dynamic and fluid, allowing communities the time and space to incorporate new norms into their own values and traditions.

B. Cultural Frameworks

Culture has long been used to qualify the right to sexual and reproductive health. At the ICPD, for example, a number of countries expressed reservations to particular clauses in the document, claiming them to be incompatible with cultural values or national law. These countries referred to the introduction to chapter II of the ICPD, stating "The implementation of the recommendations contained in the Programme of Action is the sovereign right of each country, consistent with national laws and development priorities, with full respect for the various religious and ethical values and cultural backgrounds of its people, and in conformity with universally recognized international human rights." Objections were raised to such phrases as "family planning", "reproductive health", "sexual health", "reproductive rights", even the term "safe motherhood", noting their interpretation did not include the right to abortion.⁶⁵ Others opposed the concept of "sexual education", stating it should not be offered outside of the family, or references to the term "individuals" in the context of reproductive decision making, where this would include people who are not married.⁶⁶

Balancing human rights-based frameworks with respect for cultural traditions in the context of sexual and reproductive health has often been tricky. Over the years, a number of international actors have developed strategies to attain that balance. One area of UNFPA's work, for example, focuses on developing "culturally sensitive approaches". These seek to understand ways in which local knowledge and relationships can be the basis for dialogue and positive change.⁶⁷ According to UNFPA, "Culturally sensitive approaches avoid wholesale generalizations about people and their cultures. They do not allow for ready-made assumptions about people's intentions, priorities and capacities, but take the time to learn about, accommodate and build on people's own efforts. They acknowledge that people within the same cultural contexts can have different values and objectives. They seek the deep local knowledge – the fluency – and relationships that can provide the basis for dialogue and mutual change."⁶⁸

UNFPA also emphasizes that while human rights frameworks are the starting point for their work, there is a need to build "cultural legitimacy" for sexual and reproductive health so it can be fully ingrained into communities. This may involve working with influential community members such as religious figures, or engaging groups not traditionally involved in this area, such as men. Several UNFPA projects in **Uganda**, for example, have focused on gaining the support of established "custodians of culture", including clan elders, tribal chiefs, and faith based organizations. Once those influential figures came on board, it became much easier to persuade the community to change particular attitudes and behaviors.

Several aspects of the culturally sensitive approach taken in Uganda are notable: Whereas the projects began with a focus on less controversial goals such as improving reproductive health, once trust was

established, more controversial issues could be broached, such as sexuality education or HIV and AIDS prevention.⁶⁹ Another important notion was that of separating cultural values from cultural practices. For example sharing evidence based analysis of the negative aspect of early marriage or female genital cutting can occur in an atmosphere that respects the cultural values upon which those traditions emerged. In this way, discussions are less threatening to local culture and customs and are not misinterpreted as a value judgment. Furthermore, framing the project through a deep appreciation and respect for cultural values creates the environment necessary for sustainable policy change.⁷⁰

In **Romania**, for example, Romani women bear the double burden of race and gender stereotypes. Despite a far-reaching legal framework around sexual and reproductive health—the 2003 Romanian Sexual and Reproductive Health Strategy strives to guarantee family planning, contraceptives, and pre-and postnatal care to disadvantaged populations⁷¹—Romani women’s ability to enjoy sexual and reproductive health is shaped by structural discrimination, cultural prejudices, school segregation and/or abandonment, and widespread unemployment, amongst other disparities.⁷² In many cases, lack of official state documents hinders their ability to obtain medical insurance and access health facilities. According to data, 44 per cent of Romani women aged 15-44 have never had a routine gynecologic exam, and 80 per cent receive inadequate prenatal care.⁷³ The Roma infant mortality rate is two times that for other Romanian infants.⁷⁴

In response to these challenges, the government of Romania, in partnership with donors and NGOs has instituted a Roma Health Mediator (RHM) Program to improve community health, including sexual and reproductive health. Mediators are members of the Romani community who provide basic health information, assist Roma women in obtaining the necessary identity documents to visit the doctor, and mediate between Roma patients and physicians during medical consultations.⁷⁵ Mediators are trained on reproductive health issues and make referrals to reproductive health services for Romani communities. Studies have demonstrated their effectiveness in encouraging pregnant women to obtain prenatal care, and informing the community about family planning including the prevention of sexually transmitted infections.⁷⁶ While structural discrimination remains endemic in the healthcare system, Roma Health Mediators are an important example of the use of culturally sensitive frameworks in promoting the right to sexual and reproductive health.

In **Peru** access to accessible and acceptable sexual and reproductive health services, including quality obstetric care, remains a challenge.⁷⁷ As part of efforts to stem high rates of maternal mortality by 2015, the government of Peru is reaching out to indigenous communities in its sexual and reproductive health programmes. Efforts include teaching the indigenous Quechua language to healthcare professionals, the creation of new healthcare clinics combining modern medicine with indigenous practices, and construction of maternal health “waiting houses” connected to the healthcare clinics.

Whereas indigenous women in Peru have traditionally given birth in their homes, with the assistance of their mothers, midwives, or other community members, the government is taking steps to make professional clinics more culturally acceptable to these communities. The centers encourage traditional practices such as vertical delivery, and allow women to squat, sit or leave on skirts during childbirth, as is common in Andean culture.⁷⁸ Women are encouraged to bring family members or even animals with them while they wait, and some use traditional herbs as a means of inducing labor.⁷⁹ Maternal waiting

houses connected to the clinics are a place for women who live far from health centers to stay before the birth, thus ensuring them access to skilled birthing attendants when their labor begins.

C. Gender Equality and Women's Empowerment

Gender equality and empowerment frameworks are closely connected to cultural approaches. Using a gender framework in the context of sexual and reproductive health involves looking at the context in which decisions around sexuality and reproduction are made, to better understand factors affecting motivations and behavior. This entails examining the gender power dynamics that influence, for example, women's ability to control their own fertility or male involvement in family planning decision making. It involves looking at societal norms around childbearing, the prevalence of violence against women, and the conditions in which women seek out abortion and receive post-abortion care, amongst other issues. Lack of gender equality is also a critical factor in the spread of HIV and AIDS. Women's lack of control over their bodies and sexuality, whether due to sexual coercion and violence, traditional practices such as forced early marriage, or other social conditions such as poverty, may make them vulnerable to HIV and AIDS.⁸⁰

Gender relations and women's empowerment are related to the attainment of "sexual health", which has received much less attention within "sexual and reproductive health" frameworks. Whereas women's empowerment and gender equality are pivotal components of the ICPD Programme of Action, and have been acknowledged as a critical for realizing sexual and reproductive health, the importance of "sexual health" within this framework is not always apparent. Ambivalence around the concept can be understood by looking at the modern movement for women's rights. "While sexual emancipation was a key factor in the struggle for women's equality in Western societies. . . it is not clear whether (or to what extent) the same formulation applies to settings with a different history."⁸¹ In all but the most progressive of sexual and reproductive health interpretations, even those focusing on gender and women's empowerment, sexual health is often ignored. Indeed, public discourse around sex and sexuality remains taboo in many countries and cultures.

While the ICPD provided a short definition of sexual health, as referenced in the introduction to this paper, interpretations of this concept have evolved over the years. A more comprehensive definition of sexual health, provided by the Special Rapporteur on the Right to the Highest Attainable Standard of Health, might be the following: "Sexual Health is a state of physical, emotional, mental and social well being related to sexuality, not merely the absence of disease, dysfunction or infirmity; sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence."⁸² In this context, relationships grounded in gender equality, where both partners equally respect and value one another, are more likely to promote sexual health.

Sweden is a country which ascribes to this new more, comprehensive definition of sexual health. The Government of Sweden uses the ICPD definition of sexual and reproductive health, but goes further in important ways. Their policy, for example, differentiates between "sexuality" and "reproduction", highlighting sexuality outside the framework of childbearing. According to their framework, focus on sexual health and rights includes a positive attitude towards sexuality; including its "life affirming, and life quality enhancing factors" and free and open discussion about sexuality and sex education.⁸³

Sweden sees itself as an active promoter of the ICPD and Beijing Platform, and has taken the gender and empowerment framework farther than other stakeholders in its international development work. They view gender equality and women's empowerment as pre-requisites for translating sexual and reproductive health into practice. Their strategy adopts a gender-based power structure perspective: Women and men are entitled to the same opportunities, rights, and responsibilities in all areas of life. Emphasis is placed on the role and responsibility of men in the promotion of gender equality and in all areas of sexual and reproductive health. Accordingly, the problem of gender-based violence is highlighted and broadly viewed, including physical, sexual, and psychological violence in the family and in society. Sex work is also viewed as a form of men's violence against women. HIV and AIDS are tackled with a view to how poverty and inequitable gender and power structures contribute to HIV infection.

In **Thailand**, attention to gender sensitive approaches to sexual and reproductive health is evolving. While the Thai government has long recognized the importance of addressing reproductive health--mainstreaming population issues into its policies since the 1960s—the integration of gender into strategy and programme has increased since the ICDP. The Cairo conference served as a catalyst for the development of a new National Population Action plan incorporating reproductive health into primary health care infrastructure.⁸⁴ In the fifteen years since ICPD, existing reproductive health services have been strengthened, while additional services have been made available, including pilot health care programmes for adolescents, sex education, post-abortion care, premarital counseling, women's health counseling, and prevention of mother-to-child transmission of HIV and AIDS.⁸⁵ Attention to the gender dimensions of reproductive health was first seen in the Eighth National Development Plan (1997-2001), and has increased in subsequent plans.⁸⁶

The evolution of integrating gender into sexual and reproductive health can be seen in government efforts to curb the spread of HIV and AIDS. Whereas Thailand is considered a model country in its response to the epidemic, only recently have responses to the disease begun to focus on women's concerns. While the first phases of the response (1984-1990) targeted high risk groups such as sex workers, the second phase (1990-1995)—which occurred by the time HIV had penetrated the general population—emphasized prevention and education in the home. However, the onus was on women to curb the spread of the disease, rather than male responsibility, particularly in terms of introducing HIV into the household setting. It was not until the third phases of HIV prevention and response efforts, which occurred after the ICPD (1996-2003), that the issue was addressed within the broader framework of reproductive health, sexuality and gender.⁸⁷ It was also around this time that the government began to emphasize sex education, producing guidelines for a national curriculum, including emphasis on issues such as sexual development, interpersonal relationships, and prevention of sexual violence and harassment. The government has further developed programs for parents to discuss sexuality with their children, including conveying information on sex in a positive light. Such programs can be seen as evidence of the government's increasing attention to gender and the empowerment of women and girls within their reproductive health approach.

Sri Lanka is a different kind of case study of the connections between women's empowerment and better reproductive health outcomes. Attention to women's needs in both the public health and education systems has contributed to the creation of sexual and reproductive health conditions in Sri Lanka's far outpacing that of other countries in the region. Education, for example, has been free since the dawn of

the state, and over a decade ago was made compulsory for the 5–14 year-old age group.⁸⁸ Consequently, girls' enrollment in schools dramatically increased. Data from 2006–2007 show more than 82 per cent of women in Sri Lanka have secondary school or higher education.⁸⁹ Sri Lanka's education system is credited with helping raise demand for reproductive health services.⁹⁰ The rise in educational attainment correlates both with increased age at marriage, greater use of contraceptives—with over 99 percent of married women aware of at least one method⁹¹—and overall declines in fertility rates.

Health services in Sri Lanka are also provided free of charge as part of a “welfare package”. In the wake of the ICPD, policy emphasis on improving maternal and child health shifted to the provision of wider reproductive health services and a focus on women's needs and rights. A wide-reaching reproductive health policy was promulgated in 1998, and to this day remains the basis upon which reproductive health programs are developed. Achieving gender equality was one of eight goals⁹² of the far reaching program whose hallmarks are counseling and choice.

Every household in Sri Lanka, for example, is matched with a Public Health Midwives, grass root level health workers, responsible for providing preventive and promotive health services.⁹³ Because Public Health Midwives are recruited from the villages they serve and provide home based care, they help ensure healthcare is accessible and culturally acceptable, even to women in remote and rural areas. Their work includes family planning counseling (including provision of state subsidized contraceptives), peri-natal and newborn care. They also serve as a conduit to state sponsored healthcare, and are one reason that 99 per cent of all births in Sri Lanka occur in the presence of skilled birth attendants. From a gender equality and empowerment perspective, Public Health Midwives give women the tools to make informed decisions around family planning and reproductive health. The availability of such reproductive health information has contributed to Sri Lanka's low rates of maternal mortality, equivalent to that of many developed countries.⁹⁴

Conclusion (Recommendations for General Comment)

In the years following adoption of the ICPD and the Beijing Platform a number of frameworks have gained currency within the movement to promote the right to sexual and reproductive health. This report examined a variety of interpretations around this right, how and why it remains contentious, and how such sensitivity has affected its prominence on national and international stage. A number of themes have reoccurred through-out the course of this document, relevant across a variety of frameworks and approaches. These concepts can thus be considered essential components of the right to sexual and reproductive health.

Informed Free Choice: From ICPD and Beijing through today, informed free choice has been a bedrock of sexual and reproductive health programs and policy. The phrase speaks to the offering of information (i.e. sexuality education to youth) and proactive and preventative measures (family planning counseling, HIV and AIDS prevention efforts, provision of a range of contraceptive options), as well as to the ability of individuals to exercise “responsible human sexuality”. As illustrated through-out the report, international consensus is that where abortion is legal there should be access to it, and where it is illegal, there must be adequate care for victims of unsafe abortion. The concept of informed free choice also encompasses sexual health, that is, individuals should have the choice to engage in a healthy, safe and satisfying sexual relationship

Stakeholders profiled in this report have described this concept in different ways: The Beijing Platform for Action, for example, references women's right to control her own sexuality, free from "coercion, discrimination, violence", while DFID refers to offering people choices and a "sense of entitlement" to quality services. The Government of Ecuador speaks of "the right to personal integrity" as "making free, informed, voluntary and responsible decisions about one's sexuality, sexual orientation, and reproductive life". Yet the sentiments around informed free choice are similar, making this a core concept of the right to sexual and reproductive health.

Universal Access/Equal access for equal needs: Universal access to sexual and reproductive health rights can be practically understood as equal access for people with equal needs. This refers, for example, to the ability of all individuals who want to be tested for HIV and AIDS to be able to do so free of stigma and discrimination, or all women who want to delay pregnancy to have access to a range of contraceptive options.⁹⁵ The "available, accessible, acceptable, quality" criteria for health services, goods, and facilities is integral to this framework because it describes the minimum standards that must be met in order to achieve equal access. It also speaks to addressing the needs of marginalized and vulnerable groups, and doing so in a culturally sensitive manner. As reviewed though out the report, this concept was first referenced in the ICPD, further refined through the work of treaty monitoring bodies, and reports of the Special Rapporteur, and has been added as a new MDG target. International consensus on its importance makes it a critical feature of the right to sexual and reproductive health.

Participatory Processes: One striking element of activity since the ICPD has been the influence of civil society in moving sexual and reproductive health agendas forward. From the influence of advocates in passing a range of groundbreaking laws in newly democratic South Africa, to the leadership of international NGOs in organizing ICPD+10 outside the UN framework, civil society has been instrumental in validating the right to sexual and reproductive health. Participation and inclusion, particularly of marginalized groups is a cross cutting theme vital to all the frameworks presented in this report. The sensitive nature of sexual and reproductive health issues makes participation all the more important, allowing a range of stakeholders to influence its interpretation. ICPD's emphasis on the needs and rights of disadvantaged populations continues to shape interpretations of the right to sexual and reproductive health today. DFID, for example, grounds its human rights-based approach within participatory processes, which ensure involvement of civil society, women's groups, community leaders, and others. Community participation is also a critical component of UNFPA's approach to building cultural legitimacy for its work.

Integrated Efforts: ICPD was groundbreaking in placing sexual and reproductive health within a wider development framework. Current interpretations of the Millennium Development Goals demonstrate the importance of sexual and reproductive health in addressing a range of development challenges from poverty to environmental sustainability. A critical component of the right to sexual and reproductive health is that it can only be achieved through integrated efforts working with allied sectors. For example, closer collaboration should be forged between sexual and reproductive health advocates and those working in the fields of HIV and AIDS, gender and women's empowerment. Engaging with the custodians of culture, whether community leaders or faith based organizations is also a means of ensuring the right to sexual and reproductive health is integrated into community and cultural values.

¹ See Beijing Platform for Action, Paragraphs 89-96.

² See CEDAW General Recommendation No. 24, 1999 addressing women and health. Also CEDAW Articles 5-6, 11-12, and particularly 16, address issues related to reproductive health and rights.

³ See Committee on the Rights of the Child, General Comment No. 4, 2003 on Adolescent Health and Development

⁴ See CESCR General Comment Number 14, 2000. Additional support for the right to sexual and reproductive health has been made by the Committee Against Torture (CAT); the Human Rights Committee (HRC), now the Human Rights Council; and the Committee on the Elimination of All Forms of Racial Discrimination (CERD).

⁵ See for example, Report to the Commission on Human Rights E/CN.4/2004/49 and Report to the General Assembly, A/61/338.

⁶ WHO Health and Human Rights Information Sheet. Website:

http://www.who.int/hhr/information/MIP_HHR_InfoSheet_final7.pdf, accessed September 12, 2009.

⁷ Special Rapporteur on the Right to Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, E/CN.4/2004/49, p.6.

⁸ High Level Event on MDG's: Goal 5 Improve Maternal Health Fact Sheet, September 2008. Website:

<http://www.un.org/millenniumgoals/2008highlevel/pdf/newsroom/Goal%205%20FINAL.pdf>, accessed September 6, 2009.

⁹ Millennium Project. Development Goals. Public Choices, Private Decisions, Sexual and Reproductive Health and the Millennium Development Goals, 2006, p. 32.

¹⁰ Ibid. Executive Summary.

¹¹ Ibid.

¹² Special Rapporteur on the Right to Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, E/CN.4/2004/49

¹³ Swedish Association for Sexuality Education, A Passion for Rights: Ten Years of Fighting for Sexual and Reproductive Health, 2004. p.8.

¹⁴ Millennium Project. Development Goals. Public Choices, Private Decisions, Sexual and Reproductive Health and the Millennium Development Goals, 2006. Executive Summary.

¹⁵ Swedish Association for Sexuality Education, Passion for Rights: Ten Years of Fighting for Sexual and Reproductive Health, 2004.

¹⁶ Beijing Platform for Action, Paragraph 96.

¹⁷ Beijing Platform for Action, Paragraph 106(K)

¹⁸ See CEDAW General Recommendation No. 24, 1999 addressing women and health; CRC General comment General Comment No. 3, 2003 addressing HIV/AIDS and the rights of the child, and General Comment No. 4, 2003, adolescent health and development, and, which both contain guidance on how countries should design sexual health education programs for adolescents.

¹⁹ In 2003, the then UN Human Rights Committee declared Peru's restrictive abortion laws a violation of the right to life and freedom from torture.

²⁰ E/CN.9/2009/4. Website: http://www.unfpa.org/icpd/docs/financial_flows.pdf, accessed on 20 August, 2009.

²¹ Barbara Crossette, Reproductive Health and the Millennium Development Goals: The Missing Link, 2004.

²² In the years between 2000 and 2008, United States funding for sexual and reproductive health was increasingly ideologically driven, rather than evidence based. For a longer term perspective on the influence of politics on sexual and reproductive health, see also, Allen Rosenfield and Karyn Schwartz, Population and Development: Shifting Paradigms, Setting Goals, New England Journal of Medicine, 2005.

²³ AWID, World Bank to Continue Promoting Sexual and Reproductive Health Rights. Website:

<http://www.awid.org/eng/Issues-and-Analysis/Library/World-Bank-to-continue-promoting-Sexual-and-Reproductive-Health-Rights2>, accessed on 1 September, 2009.

²⁴ World Bank. Healthy Development: The World Bank Strategy for Health, Nutrition, and Population Results, 2007.

²⁵ Millennium Project. Development Goals. Public Choices, Private Decisions, Sexual and Reproductive Health and the Millennium Development Goals, 2006, p.4.

²⁶ Ibid., p.7.

²⁷ WHO. National-level monitoring of the achievement of universal access to reproductive health: conceptual and practical considerations and related indicators. Report of a WHO/UNFPA Technical Consultation, 13–15 March 2007.

²⁸ Ibid.

²⁹ WHO. National-level monitoring of the achievement of universal access to reproductive health: conceptual and practical considerations and related indicators. Report of a WHO/UNFPA Technical Consultation, 13–15 March 2007. As the document notes, it is also important to distinguish between demand-side factors in services use (e.g. need for, and perceptions and beliefs about, formal health care), and the supply-side characteristics.

³⁰ <http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm>

³¹ See for example, Millennium Project. Public Choices, Private Decisions, Sexual and Reproductive Health and the Millennium Development Goals; Center for Reproductive Rights, Using the Millennium Development Goals to Realize Women's Reproductive Rights, 2009.

³² Millennium Project. Development Goals. Public Choices, Private Decisions, Sexual and Reproductive Health and the Millennium Development Goals, 2006, p.7.

³³ See for example, Vandemoortele and Delamonica, 2000; Kirby et al, 2004; Shuey et al, 1999

³⁴ UNFPA Doc DP/FPA/2007/17.

³⁵ UNGD Background Note. The Human Rights Approach to Development Cooperation: Towards a Common Understanding Among the UN Agencies

³⁶ Special Rapporteur on the Right to Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, E/CN.4/2004/49, p.10.

³⁷ Special Rapporteur on the Right to Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, E/CN.4/2004/49, p.7.

³⁸ Ibid.

³⁹ Special Rapporteur on the Right to Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, E/CN.4/2004/49, p.7.

⁴⁰ Ibid.

⁴¹ CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health, 2000.

⁴² UNFPA/Harvard Program on Health and Human Rights Manual: A Human Rights Based Approach to Programming. Practical Implementation Manual and Training Materials, 2009.

⁴³ CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health 2000.

⁴⁴ Ibid.

⁴⁵ UNFPA/Harvard Program on Health and Human Rights Manual: A Human Rights Based Approach to Programming. Practical Implementation Manual and Training Materials, 2009.

⁴⁶ Reproductive Health Matters. Ten Years of Democracy in South Africa: Documenting Transformation in Health Policy and Status, 2004.

⁴⁷ The Lancet. Saving the Lives of South Africa's Mothers, babies, and Children: Can the Health System Deliver, 2009.

⁴⁸ Reproductive Health Matters Ten Years of Democracy in South Africa: Documenting Transformation in Health Policy and Status, 2004. p.75.

⁴⁹ Ibid., p.73-74.

⁵⁰ Ibid., p.72.

⁵¹ International Women's Health Coalition, Top Ten Wins for Women's Health and Rights, 2008. Website: http://www.iwhc.org/index.php?option=com_content&task=view&id=3512&Itemid=1119, accessed August 23, 2009.

⁵² Services under antenatal, delivery and post-partum care include diagnosis of congenital abnormalities, early referral of high risk pregnancies, vaginal delivery or Caesarian section, treatment for pregnancy induced hypertension, hemorrhage, and sepsis, and immediate post-partum care; family planning services include counseling, pregnancy and STI prevention, sterilization, vasectomy, early detection of breast cancer, and treatment for women affected by domestic violence, including legal appraisal; health services provided to children under five include, care and treatment of newborns, including intensive care, dental care, diagnosis of child abuse, etc. See Hermida, J., Romero, P., Abarca, X. Vaca, L., Robalino, M.E., and Vieira, L. 2005. The Law for the Provision of Free Maternity and Child Care in Ecuador. LACHSR Report Number 62. Published for the U.S. Agency for International Development (USAID) by the Quality Assurance Project, p.3.

- ⁵³ Ibid.
- ⁵⁴ Ibid.
- ⁵⁵ Ibid.
- ⁵⁶ Ibid.
- ⁵⁷ Harvard School of Public Health and UNFPA. UNFPA at Work: Six Human Rights Case Studies, 2008.
- ⁵⁸ DFID. Sexual and Reproductive Health and Rights: A Position Paper, 2004.
- ⁵⁹ DFID uses the terminology “sexual and reproductive health and rights”.
- ⁶⁰ Ibid.
- ⁶¹ Ibid.
- ⁶² Ibid.
- ⁶³ Special Rapporteur on the Right to Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, E/CN.4/2004/49.
- ⁶⁴ DFID Sexual and Reproductive Health and Rights: A Position Paper, 2004.
- ⁶⁵ Swedish Association for Sexuality Education Breaking Through: A Guide to Sexual and Reproductive Rights, 2004. p. 17.
- ⁶⁶ Ibid., p. 16
- ⁶⁷ UNFPA, State of the World Population. Reaching Common Ground: Culture, Gender, and Human Rights, 2008
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- ⁶⁹ UNFPA. Culture Matters. Working with Communities and Faith Based Organizations: Case studies from Country Programmes, 2004.
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- ⁸⁰ See for example, UNAIDS/UNFPA/UNIFEM. Women and AIDS: Confronting the Crisis, 2004.
- ⁸¹ Family Planning Perspectives. The Cultural Context of Reproductive Health: Implications for Monitoring the Cairo Agenda, 1999. Website: <http://www.gutmacher.org/pubs/journals/25s5099.html>, accessed on August 20, 2009.
- ⁸² Special Rapporteur on the Right to Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, E/CN.4/2004/49.
- ⁸³ Swedish Ministry for Foreign Affairs. Sweden’s International Policy on Sexual and Reproductive Health and Rights, 2006.
- ⁸⁴ UNFPA. Reproductive Health of Women in Thailand. Progress and Challenges Towards Attainment of International Development Goals, 2005.
- ⁸⁵ Ibid.
- ⁸⁶ Ibid.
- ⁸⁷ Ibid.
- ⁸⁸ The Policy Project. Adolescent and Youth Reproductive Health in Sri Lanka., 2003. Website: http://www.policyproject.com/pubs/countryreports/ARH_Sri_Lanka.pdf, accessed August 28, 2009.
- ⁸⁹ The World Bank. Sparing Lives: Better Reproductive Health for Poor Women in South Asia, 2009.
- ⁹⁰ Ibid. (CHECK)
- ⁹¹ UNESCAP: Harmful Traditional Practices in Three Countries in South Asia: Culture, Human Rights, and Violence against Women.
- ⁹² The other seven goals are maintaining current declining trends in fertility; ensuring safe motherhood and reducing reproductive health system related morbidity and mortality; promoting responsible adolescent and youth behavior;

providing adequate health care and welfare services for the elderly; promoting the economic benefits of migration and urbanization while controlling for their adverse social and health effects; increasing public awareness of population and reproductive health issues; and improving population planning and the collection of quality population and reproductive statistics at the national and sub national levels, see http://www.searo.who.int/LinkFiles/Reproductive_Health_Profile_policies.pdf

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