Turning Promises into Progress

Gender equality and rights for women and girls - lessons learnt and actions needed

This is an extract from the report *Turning Promises into Progress.* To access the full report please visit www.gadnetwork.org or www.gaps-uk.org

Introduction

2015 represents an important moment for gender equality and women's and girls' rights. It is twenty years since the landmark Beijing Conference on Women and fifteen years since the ground-breaking United Nations Security Council Resolution (UNSCR) 1325 on Women, Peace and Security was adopted. In light of these key milestones and as the post-2015 development framework is agreed and implemented, three UK Networks – the Gender and Development Network (GADN), Gender Action for Peace and Security (GAPS), and the Sexual and Reproductive Health Rights Network UK - have come together to assess progress and make recommendations for turning the promises made into progress.

Over the last two decades there have been many new commitments and increasing political rhetoric on gender equality and the realisation of rights for women and girls, but limited real progress in achieving either. In our report, *Turning Promises into Progress*, we conclude that this is, in part, because the underlying causes of gender equality have not been addressed and there was insufficient political will to make the changes needed on the ground.

Every woman and girl experiences discrimination differently, and resources should be particularly focused on those facing multiple discriminations such as on the basis of their income, sexuality, ethnic group or disability. But there are also shared realities, universal themes and common lessons. Most striking is the need to tackling the underlying barriers that perpetuate gender equality and prevent transformative change. Unequal power relations between genders are a fundamental way in which societies are organised; yet failure to recognise these social relationships has led women and girls to be labelled as a 'vulnerable group' to be protected. In this way, the status quo remains unchanged and discriminatory social norms and unjust social and economic structures continue to hinder progress.

Part two of the report looks at progress and challenges across eight areas relevant to gender equality: women, peace and security; violence against women and girls; sexual and reproductive health and rights; political participation and influence; education; women's economic equality; unpaid care and social norms. While spotlighting specific

issues, it is also important to underline the interconnectedness of gender inequality and recognise the underlying causes that impact across issue areas and span political, social, economic, cultural and environmental spheres. The recommendations throughout the report are therefore inter-linked and mutually reinforcing. While the actions are intended to be relevant for all women and girls, specific attention must be given those who are the most marginalised, and who face multiple discrimination on the grounds of race, ethnicity, sexuality, age, disability and marital status. Recommendations made are aimed at the broader international community with relevance primarily to official international institutions and governments but also to civil society organisations (CSOs) and the private sector. This document is an extract from the report – the issue section on 'Women, Peace and Security'. For the full report please visit www.gadnetwork.org/turning-promises-into-progress or www.gaps-uk.org.uk.

Part two: Section 3

3. Sexual and Reproductive Health and Rights (SRHR)

"We need to understand that one of the priorities in family planning programmes should be access without shame or guilt. This is missing from most programmes. In general, there are very high levels of stigma and discrimination in health services such as family planning. And the needs of HIV-positive people are not addressed. There has been a narrow, myopic view of providing services, but this needs to be widened: we need to see it through a justice lens."
Sarita Barpanda, Civil Society Representative, India[1]

3.1 The Issues

Sexual and reproductive health and rights (SRHR) are a critical part of women's rights. The ability of all women, including young women and adolescent girls, to exercise their reproductive rights to make free and informed choices about their fertility, and about whether and when to have children is a central component of gender equality. Access to contraception, based on informed choice, empowers women and girls to decide when to have children and can transform their position in the household, community, school, the labour force, political sphere and wider society.[2] Sexual rights, including the ability to control all aspects of one's sexuality, free of discrimination, coercion, or violence, are also a vital component of women's rights. Both reproductive and sexual rights, in turn, impact on women's and girls' health and safety and can increase opportunities to access education, political participation and employment.

Universal access to sexual and reproductive health services comprises a full range of integrated services including 'family planning counselling, information, and education and a full range of contraceptive services; education and services for pre-natal care, safe delivery, and post-natal care; prevention and treatment of infertility; safe abortion services and post-abortion care; treatment of reproductive

tract infections, sexually transmitted infections, and other reproductive health conditions; prevention and treatment of breast cancer, cervical cancer, and other cancers of the reproductive system; and comprehensive sexuality education, among other things, that are delivered through the primary health care system in a way that respects human rights, including the right to bodily integrity and informed consent.'[3]

Poor access to sexual and reproductive health has a major impact on women's lives. Pregnancy, unsafe abortion and childbirth remain the leading causes of death and disability among women of reproductive age in developing countries today.[4] Almost 800 women die every day in pregnancy and childbirth, largely from preventable causes.[5] Women in low-income countries are particularly affected. For example, the maternal mortality ratio in developing countries is 15 times higher than in developed countries.[6]

Many women lack the power to negotiate whether, with whom and under what circumstances they have sex. Data from 33 developing countries reveals that almost one third of women cannot refuse sex with their partners and more than 41 percent across those 33 countries say they could not ask their partner to use a condom.[7] Women's choices about their bodies are further limited by violence, stigma and discrimination when seeking services, and a lack of access to safe and effective modern methods of contraception as well as to information about sexual and reproductive health services.

What does the Beijing Platform for Action (BPfA) Say?

- Recognises the right of women to have control over matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.[8]
- States should undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV and AIDS, and sexual and reproductive health issues.[9]

3.2 What's happened in the last 20 years?

Greater recognition at international and national levels

The International Conference on Population and Development (ICPD) held in Cairo in 1994 recognised the interrelationships between human sexuality and gender relations. It also recognised the impact of gender-based sexual violence, and efforts to control women's sexuality. Over the past two decades, this has been followed by an increasing understanding of women's SRHR as a central pillar in achieving human rights, reducing poverty and attaining gender equality. This has been reflected in commitments at the global level, such as at events including ICPD+5, ICPD+10 and the United Nations General Assembly Special Session on HIV and AIDS in 2006.[10] In October 2007, the target of universal access to reproductive health was added to

Millennium Development Goal (MDG) 5, for improving maternal health. Various other international frameworks have also recognised the importance of SRHR (see box below).

After the ICPD, many countries enacted national laws and policies on sexual and reproductive health and reproductive rights and introduced specific programmes within their health-care systems. According to a 2004 UNFPA survey on progress, about 86 percent of countries had adopted policy measures, laws or institutional changes at national levels to promote or enforce reproductive rights.[11] More recently, there has been welcome interest by organisations such as the World Health Organisation (WHO) and global partnerships such as Family Planning 2020, in promoting and supporting a rights-based approach to family planning. However there continues to be fierce opposition from some countries to the inclusion of rights language, particularly sexual rights, in international agreements and conventions, such as in the post-2015 framework.

International Frameworks on SRHR

The Cairo Programme of Action sets out the concept of reproductive rights in Chapter 7, including freedom to make decisions regarding the number, spacing and timing of children, the right to attain the highest standard of reproductive and sexual health and the right of all to make decisions concerning reproduction free of discrimination, coercion, and violence. CEDAW specifies the right to information and advice on family planning (Article 10(h)), access to healthcare including family planning (Article 12.1)), prenatal and postnatal healthcare (Article 12.2), reproductive choice and calls for a minimum age for marriage.

MDGs 4 and 5 focus on the less contentious areas of reproductive health, specifically in relation to maternal health and family planning.

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003) articulated a woman's right to abortion when pregnancy results from sexual assault, rape or incest; or when continuation of the pregnancy endangers the life or health of the pregnant woman. It also explicitly called for the legal prohibition of harmful practices such as FGM. UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) Committee General Recommendation no. 30 on Women in Conflict Prevention, Conflict and Post-Conflict Situations explicitly indicates that states should provide safe abortion services as a component of their obligation to provide sexual and reproductive healthcare.

There are various other international commitments in relation to FGM and child, early and forced marriage including a UN General Assembly Resolution on Child, Early & Forced Marriage adopted in November 2014[12] and a United Nations General Assembly Resolution condemning FGM adopted in December 2012.[13]

Progress on maternal mortality, but a significant problem remains

There has been real progress in reducing maternal mortality. The number of women dying in pregnancy and childbirth has reduced by almost half since 1990.[14] Three-quarters of the 75 countries where more than 95 percent of maternal and child deaths occur reduced maternal mortality faster in 2000–2013 than in the 1990s.[15] However, these gains have been uneven across and within countries. Women face the greatest risks in sub-Saharan Africa: the region which has the world's highest fertility rate and unmet need for contraception.[16] For example, 16 countries, all of them in sub-Saharan Africa, currently have a very high maternal mortality ratio (500 or more deaths per 100,000 live births).[17] The most vulnerable and excluded women and groups have been left behind including women living in extreme poverty, young women and girls, Dalit women and women living with HIV and AIDS.[18] Much remains to be done and MDG 5 continues to be one of the most off-track of the MDGs.[19]

For every woman who dies due to pregnancy-related causes, 20 or 30 encounter complications with serious or long-lasting consequences. At least 15 percent of all births are complicated by a potentially fatal condition. Women who survive such complications often require lengthy recovery times and may face lasting physical, psychological, social and economic consequences. Although many of these complications are unpredictable, almost all are treatable. Without treatment, these conditions can kill, disable or lead to stillbirths. The costs of medical care and lost productivity can also drive women and their families into poverty. Obstetric fistula, for example, can result in chronic infections, social isolation and deepening poverty.[20]

Reluctance to tackle unsafe abortion

Unsafe abortions are responsible for close to 13 percent of all maternal deaths[21] and a reluctance to tackle this issue is impacting on progress. Despite numerous international commitments to reduce unsafe abortion and investments and policy development in this area from some donors and institutions (such as WHO which developed technical and policy guidance on safe abortion[22]), there remains a reluctance to ensure access to affordable comprehensive abortion care services, particularly for young women and girls. Many initiatives to tackle maternal mortality still fail to address the role of unsafe abortion in maternal deaths and complications and even less adopt a comprehensive approach to the problem.[23]

Increased use of contraception but unmet need remains

The shift in the Global South from large to smaller families is viewed by some as one of the most significant social transformations of the 20th century.[24] Increased use of contraception is one of the main mechanisms which has reduced fertility levels. The use of modern contraceptive methods by married women aged 15–49 in developing countries rose from negligible levels in the 1960s to an estimated 47 percent in 1990 and 55 percent in 2000. However, this has barely changed over the last decade with 57 percent of married women using modern contraceptives in developing countries in 2012.[25] 222 million women in developing countries have an unmet need for family planning and UNFPA estimates that the unmet need for voluntary family planning will

grow by 40 percent in the next 15 years.[26] Research suggests that women with disabilities are particularly likely to have an unmet need for contraception, as they are frequently considered to be asexual and therefore not asked about their sexual health needs.[27]

Family planning refers to supplies and services which enable individuals and couples to attain and plan for their desired number of children, and the spacing and timing of births. Supplies include modern contraceptive methods, such as oral pills, injectables, IUDs, hormone-releasing implants, vaginal barrier methods, and male and female condoms. Services include health care, counselling and information and education related to sexual and reproductive health.[28]

Lack of donor support

Financial support for family planning is decreasing, and the gap between needs and available resources is growing. Donor support for family planning declined significantly in the 1990s, reaching an all-time low of US$394 million in 2006, increasing slightly to US$462 million in 2007.[29] Funding gaps have remained a persistent problem. In Asia and the Pacific, the funding gap in 2010 for SRHR was US$6.73 billion.[30] In 2011, of the estimated US$6.7 billion needed annually for contraceptives worldwide, only US$3.1 billion had been made available.[31] Some funding is also limited to specific areas of SRHR. For example, the United States is prevented by law from directly addressing the issue of unsafe abortion as part of its aid programme.[32] Furthermore, spending in sectors such as emergency response often fails to prioritise family planning services and other emergency reproductive health services.[33]

3.3 Challenges and ways forward

To make real progress, there are a number of areas which require urgent action to empower women and girls to exercise their reproductive and sexual rights and to ensure universal access to sexual and reproductive health services.

Reducing maternal mortality

It is now widely recognised that there are three key mechanisms that most effectively reduce preventable maternal deaths: provision of emergency obstetric care; ensuring skilled birth attendance; and provision of access to contraception and safe abortion. Provision of each type of intervention could prevent approximately one third of the deaths, and should be available and resourced in an integrated combination. For example, research suggests that enabling women to plan and space their families will avert 30 percent of maternal deaths.[34] The majority of maternal deaths are preventable and what is required now is not technical solutions, but resources and political will.[35]

Comprehensive sexuality education is also vital (see Part two: Section 5 on Education). There is a need for evidence-based, accurate information about sexual and reproductive health to be accessible to young people. This should be combined with

ensuring young people have the knowledge, skills and opportunities to make and negotiate informed, autonomous decisions in relation to healthy, safe and enjoyable sexual relationships. These choices must be free of coercion, subjugation, violence or discrimination.[36]

Relatively simple and affordable solutions have been identified; the focus must now be on implementing these solutions and addressing the barriers which impede women's access to these interventions.[37] Women, particularly marginalised women, should be involved in the design, implementation, monitoring and evaluation of SRHR programmes, services, policies and laws.[38]

Access to contraception

Defining a rights-based approach to family planning is important, and interest in the last few years, particularly from the WHO and the Family Planning 2020 Initiative[39], is welcome. Barriers and challenges to contraceptives provision include unnecessary policy restrictions, a lack of government commitment and resources, poor quality services, stigma and discrimination from providers, cost, a lack of trained providers, and a lack of contraceptive commodities or the logistics required to ensure they get to where they are needed. Historically, preventative health care has always been less of a priority than curative care, and the politics around reproductive health and choice compound these issues.

Demand for family planning by women and their partners also dramatically varies by country and across communities. Reasons for low demand include social norms and values, a lack of information or misinformation and myths, fear of spousal/parental disapproval, poor quality or non-existent services in close proximity, high cost of services, or the fear that healthcare providers might be judgemental or non-confidential. This last problem is especially true for young people and the poorest and most marginalised women and girls. There is also a lack of access to information about sexual and reproductive health services. An in-depth study of four sub-Saharan African countries found that 60 percent or more of adolescent women and men had poor knowledge about the prevention of unintended pregnancy and HIV and AIDS or believed common misconceptions and one third or more did not know of a source for contraceptives.[40]

Meeting unmet demand for contraception requires increased funding and political commitment.[41] To uphold reproductive rights, a full method mix of quality contraceptives must be available, affordable, in the right place where and when needed, accessible, and appropriate for different groups of users.[42] Services need to be designed to ensure young people know they are welcome and that their specific needs are being met.

Access to safe abortion

21.6 million women experience an unsafe abortion worldwide each year and unsafe abortion is responsible for close to 13 percent of all maternal deaths.[43] Yet, it remains a contentious issue. Deaths from unsafe abortion happen disproportionately to young women.[44] The first step is to ensure that the law supports women's access to comprehensive safe abortion services. In countries where the number of circumstances under which an abortion can be provided have been increased such as Nepal, Ethiopia and South Africa, there have been significant reductions in maternal mortality.[45] However, it is also important to address other issues to access such as cost, training providers, social norms and knowledge about the legal environment. In India, for example, where an abortion can be provided on social or economic grounds, around 70 percent of women still think that seeking abortion services is illegal in all circumstances.[46]

The development of low-cost medication that can induce abortion with few side effects and without the need for surgical intervention has also been revolutionary for women's reproductive health.[47] Not only is medical abortion a safe and effective way to carry out abortions at minimal cost, it has significant potential to increase access to safe abortion, particularly in remote areas where health infrastructure may be limited.[48]

It is critical that the law supports women's access to comprehensive safe abortion services and that investment in family planning and safe abortion programmes should be prioritised together with increasing access to, and awareness of, medical abortion programmes.

Accessible and affordable health services

The poorest people, the majority of whom are women, face barriers in accessing healthcare services. Transport may be unavailable or too costly or the services themselves may be too expensive. Further, the stigma associated with age, disability, ethnicity, sexuality, caste, HIV status or marital status can also prevent people from accessing quality health services.[49] For example, discrimination prevents transgender people in India from getting access to specific HIV and AIDS and SRHR services.[50] In conflict and humanitarian emergencies, where support structures and social networks are destroyed, emergency responses rarely include adequate reproductive and sexual health services.[51] Stigma is a barrier for young women and girls in accessing reproductive and sexual health services, particularly if they are unmarried and especially if parental or spousal consent is needed. Furthermore, services are often unresponsive to their needs.

Poor quality health services and a lack of essential medical supplies and equipment is compounded by the acute shortage of trained health workers, as well as the over-medicalisation of services which could be provided safely and effectively by mid or

lower-level providers. Currently, there is a need for more than 3.5 million health workers worldwide.[52] Integrating sexual and reproductive health and HIV and AIDS programmes could result in significant public health benefits such as improved coverage, quality and more cost-effective comprehensive programmes with greater impact.[53] This is particularly important given current questions about the relationship between HIV and AIDS and some forms of contraception: and the proposed trial of hormonal contraceptives by the Evidence for Contraceptive Options and HIV Outcomes (ECHO) Consortium.[54]

Governments must ensure that well-funded, quality health services are accessible and affordable to all. In order to reach the poorest and most marginalised women, services should be free at the point of use and culturally appropriate. Increased investment is needed in reproductive and maternal health services in order to meet the growing demand for SRHR services including the training of more health workers and access to medical supplies and equipment including contraceptives.[55] Programmes should support equitable access to quality contraception, sexual and reproductive health (SRH), and HIV and AIDS services for all girls and women regardless of age, marital status, HIV status and socio-economic background, and without the need for parental or spousal consent.[56]

Violence against women and girls (VAWG)

Allowing women to control their fertility and exercise sexual and reproductive rights should go beyond the provision of family planning to recognising the context in which many women live. VAWG profoundly limits women's ability to manage and control their SRHR (see Part two: Section 2 on VAWG). FGM has been recognised internationally as a severe form of violence.[57] Over 125 million girls and women have been subjected to FGM and an additional 30 million girls are at risk over the next 10 years.[58] FGM is a manifestation of social norms which control women and girl's sexuality and consider their bodies, their sexuality and their future, to be the property of others.[59] Over 30 percent of girls in developing countries marry before 18 years of age.[60] Child, early and forced marriage holds back 15 million girls a year;[61] it violates a girl's right to choose freely if, when, how and with whom to have sex or to marry; and the right to make decisions in relation to having children; and increases the risk of sexually transmitted infection (STIs).[62] Furthermore, it robs girls of the opportunity for education, skills, and social networks that could empower them for a healthier life.[63]

Ensuring access to and fulfilment of SRHR is a key strategy to both address violence, and to support women and girls who have experienced violence. VAWG can expose women and girls to unwanted and high-risk pregnancies, unsafe abortion, STIs (including HIV and AIDS) and long-term gynaecological and psychological problems. Clinical services are therefore an essential, yet frequently overlooked, component of a comprehensive response to addressing VAWG.

The impact of VAWG on women's and girl's ability to manage and control their SRHR must be acknowledged. Further, the fulfilment of SRHR and access to adequate services should be recognised as a key component of a comprehensive approach to VAWG. This includes services for women and girls who have experienced FGM and/or child, early and forced marriage which are developed in consultation with girls and women who have experienced these forms of VAWG, including women living with HIV and AIDS.[64]

Sexual rights

Sexual rights protect all people's right to be allowed to fulfil and express their sexuality, with due regard for the rights of others and within a framework of non-discrimination. This includes freedom of thought and expression in relation to sexuality, sexual orientation, gender identity.[65] Stigma and discrimination are rife, and this issue remains one of the most contentious in international fora.[66] 76 countries continue to criminalise at least some aspect of private, consensual same sex relationships.[67] In many more cases, discrimination, including on the grounds of sexual orientation or gender identity, prevents citizens from accessing services and public goods and from participating fully in society free from fear, threat or harm.

As a first step, governments should repeal laws, policies and practices that have the effect of increasing stigma and discrimination against women, men and young people on the grounds of sex, sexuality, sexual orientation or gender identity.[68] States should accept their duty to respect, protect and fulfil the sexual rights of all.

Conflict settings, fragile states and emergency situations

Women are disproportionately affected in conflict and humanitarian crisis and are at a heightened risk of maternal and neonatal mortality and sexual violence in fragile states and emergency settings. Over 50 percent of the 536,000 maternal deaths each year occur in fragile states where the average health spend is just US$9 per person per year.[69] Rape and forced pregnancy as a tactic in conflicts have been documented in a number of conflict-affected countries including Bosnia-Herzegovina, Sierra Leone, Somalia and Sudan (see Section 1 on WPS).

However, reproductive health services are often forgotten or seen as irrelevant or 'non-life saving' in humanitarian emergencies and conflict/post-conflict environments, leaving refugees, internally displaced people (IDPs), and other affected groups without access. From the onset of an emergency, the Minimum Initial Service Package,[70] for reproductive health in emergencies should be implemented and as soon as the situation allows, comprehensive reproductive health services should be provided. In cases where women have experienced sexual violence in conflict, medical care should

include access to safe abortion and post-abortion care services, in compliance with international law.

The provision of emergency reproductive health services in humanitarian and conflict contexts is essential to fulfilling women's and girls' rights. SRHR services for all women and girls should be prioritised in post-conflict and emergency settings and recognised as life-saving.

3.4 Recommendations

International institutions/governments should:

1. Improve access to rights-based family planning, skilled attendance at delivery, emergency obstetric care and safe abortion.
2. Ensure that quality sexual and reproductive health services are accessible and affordable to all.
3. Design services and provide information for adolescent girls to meet their specific needs.
4. Mobilise increased resources for sexual, reproductive, maternal and health services including in conflict-affected and humanitarian settings.
5. Ensure the regular supply of reproductive health commodities including contraceptives, abortion equipment and medication.
6. Ensure that policy is evidence-informed, rights-based and reinforces measures to promote, protect and fulfil sexual and reproductive rights and achieve gender equality.

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Gender and Development Network (GADN)

GADN brings together over 100 expert NGOs, consultants, academics and individuals committed to working on gender, development and women's rights issues.

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