CHAPTER 1
IMPROVING WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH: THE RIGHTS APPROACH

Learning Objectives
By the end of this chapter, the participant will:

1. Summarize the significant historical events that contributed to the Safe Motherhood movement as a human rights issue.
2. Explain the etiological and contextual factors that contribute to maternal mortality and morbidity.
3. Describe actions that health care providers can take to advocate and promote women's sexual and reproductive rights.

> *"Women are not dying because of diseases we cannot treat… they are dying because societies have yet to make the decision that their lives are worth saving."*
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Preamble

The purpose of this chapter is to provide a wider framework from which to consider emergency obstetrical care (EOC). In the ALARM International Program (AIP) we will review the five main causes of maternal mortality, and practice the management of these emergencies so that mothers and newborns lives will be saved. However, the overarching cause of maternal mortality worldwide is not clinical—it is the lack of respect for the sexual and reproductive rights of women.

Sexual and reproductive rights (SRR) may be defined as the rights of a woman to have information about her health, to make her own choices about when and how to receive care, and to have access to quality care. Nevertheless it also recognizes men's reproductive health concerns, and the roles men can play in promoting women's reproductive health. Sexual and reproductive health (SRH) is of concern to both women and men.

Women's sexual and reproductive life is deeply embedded in the cultural, historical, religious, and political context in which they live. Sexual and reproductive rights are variable from country to country, society to society, and community to community. With this in mind, in our individual and/or collective practice(s), we can better serve women and female adolescents, and more specifically the millions of women and female adolescents who currently do not have access to quality reproductive health services.

The vision of the AIP is the improvement of maternal and newborn health, including increased survival rates. The survival of a newborn depends upon the survival of his or her mother. Promotion and improvement of women's SRR and SRH are the fundamental basis for universal access to Safe Motherhood. The role of the AIP is to provide a forum in which we can discuss an international framework to advocate for and promote improved SRR and SRH worldwide.

Maternal Mortality and Morbidity: An International Tragedy[1]

- More than 530,000 women die annually from pregnancy-related complications. More than 99% of these deaths occur in underdeveloped countries, demonstrating that most maternal deaths are preventable if adequate resources and services are made available to women in less developed countries.

- Over 300 million women in the developing world currently suffer from short- or long-term illness related to pregnancy and childbirth. These include uterine prolapse, fistulae, incontinence, pain during intercourse, nerve damage, pelvic inflammatory disease, and infertility.
- Women's lifetime risk of maternal death varies considerably in the developing and the developed world; it is estimated at almost 40 times higher in the developing than developed world.
- It is internationally recognized that skilled attendance at birth can reduce maternal mortality and morbidity by 80%. Unfortunately, skilled attendance at birth varies considerably in different parts of the world; it is estimated to be as low as 11% in some countries[2,3].

The above facts and figures attest to the poor maternal health status of many women of the world, particularly those women who live in low-resource countries. They are also a clear indication of women's overall poor SRH. When women's health is poor, the health and well-being of their newborns is equally at risk. Improving women's health will impact significantly on the survival rate of newborns.

The five main direct causes of maternal deaths are:
- Hemorrhage (25%)
- Sepsis (15%)
- Hypertensive disorders (13%)
- Complications due to unsafe abortions (13%)
- Obstructed labour (7%)

An additional 20% of maternal deaths in developing countries are attributed to pre-existing medical conditions that are aggravated during pregnancy, such as anemia, malaria, and HIV/AIDS.

Not all obstetrical complications can be predicted or prevented. It is estimated that for every 100 women who become pregnant, 15 will develop complications mostly around the time of birth.[4] For every woman who dies, an estimated 15 to 30 women will suffer from chronic illness or injury as a result of their pregnancy (i.e. obstetric fistula).[5]

A woman's capacity to survive complications is influenced by a number of other factors such as:
- Women's poor health and nutrition during childhood, as well during pregnancy
- Inadequate, inaccessible and unaffordable health care services
- Poor hygiene and care during childbirth
- Socioeconomic and cultural factors, such as:
  - poverty,
  - unequal access to resources (health care, food and preventive services)
  - heavy physical work load
  - lack of decision-making power in families, communities and societies[6] (see Appendix 1)

Skilled care by a health care provider during pregnancy and birth as well as timely access to EOC for women who face complications are two internationally recognized key strategies promoted in an effort to reduce the exceptionally high rates of maternal mortality and morbidity that persist in many parts of the world.

EOC refers to the continuum of health services required to treat obstetrical complications that need to be available 24 hours a day, 7 days a week. Health care facilities that provide EOC may be described as basic or comprehensive. These services are described in Table 1.

Table 1 Description of emergency obstetrical care services

Basic EOC is performed in a health care facility Basic EOC provides:	**Comprehensive** EOC requires an operating theatre and is usually performed in district hospitals. Comprehensive EOC provides:
• IV/IM antibiotics • IV/IM uterotonics • IV/IM anticonvulsants • manual removal of the placenta • removal of retained products • operative vaginal delivery	• all six basic EOC functions PLUS • cesarean section • blood transfusion

Skilled attendance[7] is defined as the process by which a woman is provided with adequate care during labour, delivery, and the early postpartum period. It is composed of two components:

- Skilled attendants: Health care providers with midwifery skills trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage, or refer complications.
- Enabling environment: Supplies, equipment, and drugs; transportation and communication system for referrals; supportive policies; technical guidelines and laws, involved and mobilized communities; prepared and informed women and family members, and mother-friendly approach to service delivery.

Women's Right to Safe Motherhood

In light of the above, it is irrefutable that much work remains to be done to improve women's right to Safe Motherhood. Safe Motherhood is defined as a woman's ability to receive the care needed to be safe and healthy throughout pregnancy and childbirth. This approach can be used to promote and advocate for the rights of women worldwide to attain Safe Motherhood.

Reaching Millennium Development Goals: Investing in Sexual and Reproductive Health

In 2000, the international community reached global consensus on a set of goals that aimed to reduce poverty and to make major improvements to peoples' lives worldwide. Several of the Millennium Development Goals focus on improving women's overall human development outcomes, and in particular their education, status, and health to achieve wider poverty reduction goals. Table 2 outlines all the goals, with set targets and indicators for those relating to the promotion of women's overall development. Goals 4 and 5 are particularly pertinent to our work in EOC.

Table 2 - Millennium development goals

Goals and Targets	Indicators
Goal 1: Eradicate extreme poverty and hunger	
Goal 2: Achieve universal primary education	
Target : Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	• Net enrolment ratio in primary education • Proportion of pupils starting grade 1 who reach grade 5 • Literacy rate of 15 to 24 year olds
Goal 3: Promoter gender equality and empower women	
Target: Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015	• Ratio of girls to boys in primary, secondary, and tertiary education • Ratio of literate females to males of 15to 24 year olds • Share of women in wage employment in the non-agricultural sector • Proportion of seats held by women in national parliament
Goal 4: Reduce child mortality	
Target: Reduce by two-thirds, between 1990 and 2015, the under 5 year old mortality rate	• Under-five mortality rate • Infant mortality rate • Proportion of 1 year olds immunized against measles
Goal 5: Improve maternal health	
Target: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	• Maternal mortality ratio • Proportion of births attended by skilled health personnel
Goal 6: Combat HIV/AIDS, malaria, and other diseases	
Target: Have halted by 2015, and begun to reverse, the spread of HIV/AIDS	• HIV prevalence among pregnant 15 to 24 year olds Contraceptive prevalence rate • Number of children orphaned by HIV/AIDS
Target: Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases	• Prevalence and death rates associated with malaria • Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures • Prevalence and death rates associated with TB • Proportion of TB cases detected and cured under DOTS (Directly Observed Treatment Short Course)
Goal 7: Ensure environmental sustainability	
Goal 8: Develop a global partnership for development	

It is internationally recognized that the attainment of most of these goals is contingent on major improvements and investments in the SRH of the population, and especially of women**.** This is especially true for Goals 3 to 8.

What Is Sexual and Reproductive Health, and What Are Sexual and Reproductive Rights?

SRH and SRR of women were debated extensively at two United Nations conferences: the 1994 International Conference on Population and Development (ICPD) and the 1995 Fourth World Conference on Women (Beijing). These consensuses were reaffirmed and developed further at subsequent United Nations forums. Within these conferences, the interlinkages between population and development were further explored, and the concepts of SRH and SRR were clearly defined.

The ICPD Programme of Action defines SRH as:

> *A state of complete physical, mental and social well-being [which goes beyond] the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so*[8].

It further states that:

> *. . . reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsively the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents*[9].

The Beijing Platform for Action goes further by asserting women's human rights to control their sexuality, including their SRH. The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including SRH, free of coercion, discrimination and violence.[10]

What about SRH services?

The ICPD Programme of Action also recognizes the individual's right to affordable, accessible and quality SRH services:

> *. . . the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for the regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant*.[11]

It further defines what these services should look like:

> *In line with the above definition of reproductive health, reproductive health care is defined 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 reproductive and sexually transmitted diseases*.[12]

And recognizes the need for the SRH services to

> *. . . be particularly sensitive to the needs of individual women and adolescents and responsive to their often powerless situation, with particular attention to those who are victims of sexual violence*.[13]

This new way of looking at women's SRH is innovative and progressive from the approach promoted earlier, which focused mainly on demographic goals and regulating women's fertility. Some of the differences are the:

- Holistic approach to health with focus on well-being rather than disease and injury
- Rights of women to make decisions about their bodies and all matters affecting their reproductive health
- Importance of empowerment of women

- Responsibilities of governments to provide quality SRH services, integrated within their primary health care systems, and not as parallel services; these should include family planning services, maternal health services (including pre- and post-natal care, and EOC), prevention and treatment programs for STDs (including HIV/AIDS and actions which aim to eliminate harmful traditional practices such as female genital cutting (FGC), son preference, violence against women, and child marriage among others) .;
- Prominence of gender and equality issues, and the need to respond to the needs of all people equally (including unmarried women, adolescents, abused women, women from other ethnic groups, men, and people beyond their reproductive years)
- Recognition that SRH applies both to women and men, and further that men can contribute to the promotion of women's reproductive health in a number of ways—by sharing the responsibility for family planning using a male method, by supporting their partners in using female contraception, by reaching agreement with their partners on the appropriate number of children to have, and by responsible sexual behaviour (including the use of condoms to protect their partners)[14]

What Human Rights Protect Women's Sexual and Reproductive Health?

Sexual and reproductive rights are human rights. Furthermore, they are not considered new rights, but are a group or cluster of rights found within the different existing human rights documents.

The following core human rights are the ones most frequently identified as relating to women's SRH; they are presented below with examples of infringements and/or violations.

Table 3 - Human rights and violations of women's rights

Core Rights	Examples of Human Rights' Instruments that Protect these Rights	Examples of Infringements and/or Violations
The right to life	Universal Declaration of Human Rights (1948) / Civil and Political Rights Covenant (1966)	• Maternal death due to unavailability or inaccessibility of EOC • Maternal death due to unsafe abortion
The right to liberty and security of the person	Universal Declaration of Human Rights (1948) / Civil and Political Rights Covenant (1966)	• Girl children or adolescents subjected to FGC • Children's and women's inability to access protection from gender-based violence by a partner and/or family member
The right to equality, and to be free from all forms of discrimination	Racial Discrimination Convention (1965) / Civil and Political Rights Covenant (1966)	• Unmarried women or adolescents' inability to access facility planning services • Denial of employment to a women due to having young children • Women shunned by their families because they have a fistula
The right to privacy	Civil and Political Rights Covenant (1966) / Children's Rights Convention (1989)	• Adolescents' inability to access reproductive health information without parental consent • Breach of confidentiality

The right to freedom of thoughts	Civil and Political Rights Covenant (1966)	• Women's inability to access a contraceptive method of her choice • Women's inability to negotiate the use of condoms by their partner
The right to information and education	Convention on the Elimination of All Forms of Discrimination Against Women (1979) / Vienna Programme of Action (1993)	• Unmarried women's inability to access the information needed to make choices about contraceptive methods • Adolescents' inability to access SRH information
The right to choose whether or not to marry, and to found and plan a family	Universal Declaration (1948) / Economic, Social and Cultural Rights Covenant (1966) / Convention on the Elimination of All Forms of Discrimination Against Women (1979)	• Women forced into an arranged marriage against their will • Women's inability to choose the number of children to bear Women's inability to negotiate the use of condoms by their partner.
The right to decide whether or when to have children	Convention on the Elimination of All Forms of Discrimination Against Women (1979) / ICPD Programme of Action (1994)	• Women's inability to access a wide range of contraceptive methods • Women's inability to access abortion services
The right to health care and health protection	Economic, Social and Cultural Rights Covenant (1966) / Children's Rights Convention (1989)	• Women's inability to access to quality SRH services, such as pre- and post-natal care • Women's inability to be informed if her partner tests positive for HIV
The right to the benefits of scientific progress	Economic, Social and Cultural Rights Covenant (1966) / Civil and Political Rights Covenant (1966)	• Women's inability to access human papilloma virus (HPV) vaccine to protect against cervical cancer • Women's inability to access safe abortions
The right to freedom of assembly and political participation	Civil and Political Rights Covenant (1996)	• Community's inability to organize to end violence against women • Adolescents' inability to meet and/or mobilize on issues related to SRH
The right to be free from torture and ill treatment	Universal Declaration of Human Rights (1948) / Children's Rights Convention (1989) / Convention Against Torture (1984)	• Rape and/or involuntary sterilization • Denial of abortion services • Denial of adequate medical treatment (e.g., EOC)

Why Is the SRR Approach So Important?

Looking at the issue of SRH through the "rights lens" permits us to advocate and promote women's SRH from a totally different view—one that is based on the concept of RIGHTS and not PRIVILEGES.

The rights-based approach can be used in a number of ways:

- As an advocacy tool, to promote and bring visibility to blatant violations and social injustices as those listed below
- As a framework for the development of policy and SRH programs
- As a tool to identify gaps in policies and/or barriers to services
- To make governments and/or states accountable
- As a prerequisite for effective Safe Motherhood strategies

Facts and Figures Related to Women's Poor Sexual Health Status

The social injustices women, female adolescents, and girl children experience are numerous and may be found in all nations of the world. This attests to their lack of status and worth, and the gender discrimination they face

The following section outlines a number of SRH issues within which human rights are infringed upon and/or outwardly violated. They are included as a reminder of the vulnerability and gender-discrimination that girl children, female adolescents, and women face with regard to their SRH, and the difficulties and challenges they encounter in controlling and protecting their SRH and SRR.

Maternal mortality and newborn health

- Newborn deaths represent almost 40% of all deaths of children under age 5.
- Each year, 4 million newborns die before they are 1 month of age and an equal number are stillborn.
- Women who give birth when they are too young, or too old, to have babies too closely spaced put themselves and their newborns at an increased risk of complications.[15]

Maternal mortality due to unsafe abortion[16]

- There are approximately 55,000 unsafe abortions each day; 95% of these abortions occur in developing countries, and 1 in 8 maternal deaths is caused by unsafe abortion.
- Of the estimated 19,000,000 unsafe abortions that occurred in 2000, 18,400,000 occurred in developing countries.
- Of all unsafe abortions in 2000, approximately 25% occurred in Africa and 50% in Asia.[17]
- 10–50% of all women who undergo unsafe abortions need medical care for complications.[18]
- The outcome of complications of unsafe abortion depends on the availability and quality of post-abortal care and the woman's ability to seek care (she may fear legal or other consequences to her actions).
- Unsafe abortion accounts for 13–14% of all maternal deaths.
- These deaths are completely preventable.
- The incidence of unsafe abortion is very difficult to measure because women are reluctant to admit to the procedure—particularly in regions where induced abortion is illegal. Estimates of unsafe abortion tend to reflect an underreporting of events. The methods used to gather information have constraints and are subject to error.

Table 4 - Unsafe abortion: regional estimates of mortality and risk of death [19]

	Risk of dying after unsafe abortion	% of maternal deaths due to unsafe abortion
Africa	1 in 150	13%
Asia*	1 in 250	12%
Latin America	1 in 900	21%
Europe**	1 in 1900	17%
* Excludes Japan, Australia and New Zealand **Primarily in Eastern Europe		

Adolescent health[20,21]

- A report released by Save the Children in 2004 revealed that pregnancy and childbirth are the leading cause of death among girls and young women aged 15 to 19 in low-resource countries.
- Approximately 70,000 teenagers die annually because of complications from pregnancy and childbirth.
- Babies of teen mothers are 50% more likely to die than those born to older women.

- A conservative estimate of the total number of abortions among adolescents in developing countries ranges from 2 million to 4.4 million annually.
- Adolescents are more likely than adults to delay abortion, resort to unskilled persons to perform it, use dangerous methods, and delay seeking care when complications arise. Furthermore, adolescents are more likely to experience complications, such as hemorrhage, septicaemia, internal organ damage, tetanus, sterility, and death.
- In some sub-Saharan African countries, the rates of HIV infection in young women between the ages of 15 and 19 are between five and six times higher than in young men of the same age.
- Other significant threats to adolescent health include abuse, exploitation and violence, and lack of knowledge about SRH.

HIV/AIDS[22]

- In 2006, approximately 17.7 million of the 39.5 million adults (aged 15 to 49) living with HIV were women. In sub-Saharan Africa, approximately 13.3 million women were living with HIV; women account for 59 % of the adult population living with HIV[23]
- The proportion of women with HIV is growing in Asia, Eastern Europe, and Latin America.
- Although the HIV prevalence has appeared to have stabilized among young pregnant women in many places, there remain exceptions to this success. For example, in South Africa, the prevalence of HIV among pregnant women attending antenatal care has risen by 35% between 1999 and 2005.[24]
- In 2006, the total number of children orphaned by AIDS was estimated at 15 million.[25,26]
- Although the prevalence rate among pregnant women in urban areas has decreased considerably in some sub-Saharan countries (e.g. Uganda, decreased from 29.5% in 1992 to 11.25% in 2000), in other regions it continues to rise at an alarming rate. Examples of median HIV prevalence among urban, pregnant women include:

    - Botswana: increased from 38.5% in 1997 to 44.9% in 2001.
    - Zimbabwe: increased from 29% in 1997 to 35% in 2000,
    - Namibia: increased from 26% in 1998 to 29.6% in 2000.

Harmful traditional practices affecting the health of women and children

Female Genital Cutting

Female genital cutting (FGC), also known as female genital mutilation and female circumcision, involves the removal of parts or all of the most sensitive female genitalia. A description of the various types of FGC is provided in Table 5. This practice currently takes place in at least 28 countries in Africa and the Middle East, and a few minority groups in Asia also perform FGC. A survey of 18 African countries (from Senegal to Ethiopia) demonstrated that the prevalence of FGC in these areas can range from 5–97%. It is estimated that between 100–140 million women worldwide have undergone FGC, and an additional 3 million girls and women are subjected to the practice annually. FGC is most commonly performed on girls under the age of 15.

Table 5 - WHO classification of female genital cutting

Type	Description
FGC 1	Excision of the prepuce, with or without excision of part or all of the clitoris
FGC 2	Excision of the clitoris, with partial or total removal of the labia minora
FGC 3	Excision of part of all of the external genitalia and stitching or narrowing of the vaginal opening (infibulation)
FGC 4	Unclassified: includes • pricking, piercing or incising of the clitoris and/or labia • stretching of the clitoris and/or labia • cauterization by burning of the clitoris and surrounding tissue • scraping of tissue surrounding the vaginal orifice or cutting of the vagina • introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it • any other procedure that falls under the definition of female genital cutting given above

Although some countries have recognized that FGC is harmful to the health of women and children and have included FGC as a human right's violation in policy, they have not been able to make the practice illegal. In some areas where FGC has become illegal, the practice has been driven underground for fear of prosecution. This results in increased incidence of unsafe practices and thus increases the physical and psychological harm to women and children.[27] The International Federation of Gynecology and Obstetrics (FIGO) has passed a resolution regarding professional conduct regarding FGC (see Appendix 2).

The complications arising from the practice of FGC are described in Table 6.

Table 6: Complications arising from female genital cutting [28,29]

Physical Consequences	
Short-term	Long-term
• Severe pain and trauma leading to shock (especially when performed without anesthesia) • Protracted bleeding resulting in long-term anemia • Infection of site (when performed without sterile instruments in unhygienic conditions) • Sometimes may result in fatal septicemia and tetanus • Urinary retention (especially when the skin is stitched over the urethra) • Injury to adjacent tissues	• Pelvic, uterus, vaginal and urinary tract infections • Painful cysts • Keloid scarring Increased risk of obstetric complications:* • Vesico-vaginal fistula • Cesarean section (FGC 3) • Postpartum hemorrhage (FGC 3) • Extended hospital stays (FGC 2 & 3) • Need for infant resuscitation due to obstructed labour (FGC 2 & 3) • Early neonatal death *The more extensive the FGC, the higher the risk of obstetric complications.
Psychological and Psychosocial Consequences • Possible loss of trust in caregivers • Changes in eating and sleeping habits • Changes in mood : feelings of incompleteness, anxiety, terror, depression, humiliation or chronic irritability • Symptoms of impaired cognition (thinking): sleeplessness, recurring nightmares, loss of appetite, weight loss or excessive weight gain, panic attacks, difficulties in concentrating and learning • Impact on girl's education: absenteeism, poor concentration, low academic performance, loss of interest • Chronic pain	

Son preference

Son preference refers to a range of values and attitudes resulting in practices that demonstrate a clear preference for the male child and neglect of the female child. Although neglect of the girl child is the most common practice, it may also include abortion of a female child or female infanticide in extreme cases.[30] Son preference can be seen in the comparison of such statistics as differences in malnutrition rates and education opportunities between girls and boys, For example, malnutrition is nearly three times as common among girls than among boys in rural Bangladesh,, and 91 females per 100 males attend secondary school in Peru whereas only 49 females per 100 males are enrolled in Bangladesh and 50 per 100 in Mali).[31]

Early marriage

Early marriage continues to be a reality for many girl children around the world. Although the age of females at marriage is slowly rising in many countries, it is unfortunately decreasing in others because young virgins, considered less likely to be infected with HIV/AIDS, are sought as brides. Early marriage is most prevalent in sub-Saharan Africa and in South Asia. For example, in Bangladesh, 47% of women, ages 20 to 24, report being married by age 15. In Guatemala, India, and Niger, the rates are 12%, 18%, and 50%, respectively.[32] Early marriage often leads to early pregnancy and thus harmful consequences (e.g. obstructed labour for both young mothers and infants) because the adolescent body has not yet fully developed,

Violence against women

Violence against women, also know as gender-based violence, is "the most pervasive yet least recognized human rights abuse in the world."[33] It has recently been established as the "greatest human rights scandal of our time" by Amnesty International. The UN Declaration on the Elimination of Violence Against Women defines it as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm and suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life."[34] Violence against women may be physical, psychological, or sexual. Women are vulnerable to it "from birth to death, in times of peace as well as war… women face discrimination and violence at the hand of the state, the community and the family.[35]

Gender-based violence may have the following consequences—direct and indirect—on a woman's reproductive health: unwanted pregnancies and restricted access to family planning information and contraceptives; unsafe abortion or injuries sustained during a legal abortion after an unwanted pregnancy; complications from frequent, high-risk pregnancies and lack of follow-up care; sexually transmitted diseases, including HIV/AIDS; persistent gynecological problems and psychological problems, including fear of sex and loss of pleasure.[36]

Roles of Health Care Providers in Promoting Women's Sexual and Reproductive Rights

Health care providers—obstetricians and gynecologists, general practitioners, midwives, and nurses—have a pivotal role to play in advocating and promoting women's SRR. Depending on their discipline and sphere of practice, all can positively influence legislators, policy makers, and health administrators on matters related to women's SRH and SRR, whether it be at the local, regional, and/or national levels. Furthermore, health care providers within their own daily practice have an opportunity to either promote women's SRR or withhold these same rights (e.g. rights to privacy, right to all the information that will permit women to make a decision, right to health care, etc.).

International federation of gynaecology and obstetrics (FIGO)

In November 2003, FIGO adopted at its World Congress a human rights based code of ethics for obstetricians and gynecologists related to SRR. Entitled "FIGO Professional and Ethical Responsibilities Concerning Sexual and Reproductive Rights," this document outlines concrete ways that specialists, and hopefully all of those involved in the provision of SRH services, can advocate and promote women's SRR.

FIGO's code of ethics identifies three specific spheres of actions:

- The professional competency level
- The service delivery level
- The community level [37]

Professional competency level

1. ***Attain and maintain*** the highest standards of professional competence in women's health, utilizing the most current and best available medical evidence within the context of available resources.
2. ***Assure*** that professional competence includes offering only services for which one is trained to a recognized standard and referring to suitably skilled professionals as circumstances permit.
3. ***Assure*** respectful professional conduct that promotes the dignity and security of every woman**.**
4. ***Avoid*** inappropriate relationships with patients or their families, that may be exploited for sexual, emotional, financial, or research purposes.
5. ***Assure*** that a physician's right to preserve his or her own moral or religious values do not result in the imposition of those personal values on women. Under such circumstances, they should be referred to another suitable health care provider. Conscientious objection to procedures does not absolve physicians from taking immediate steps in an emergency to ensure that the necessary treatment is given without delay.
6. ***Refuse*** to practice or support practices that violate human rights or principles of medical ethics.
7. ***Maintain and promote*** the highest standards of integrity and honesty with patients, colleagues, and learners, and in the conduct of research.
8. ***Model*** appropriate interpersonal behaviour with patients and others to assure that optimal care and learning environments are promoted by all members of the health care team.
9. ***Advocate*** for lifelong learning for health care professionals in regard to reproductive and sexual health, rights, and ethics.

Service delivery level: women's autonomy and confidentiality

1. ***Support*** a decision-making process, free from bias or coercion, that allows women to make informed choices about their SRH. This includes the need to act only on the basis of a fully informed consent or dissent, based on adequate provision of information and education to the patient regarding the nature, management implications, options, and outcomes of choices. In this way, health care professionals provide women with the opportunity to consider and evaluate treatment options in the context of their own life circumstances and culture.
2. ***Ensure*** that confidentiality will prevent privileged information and recorded documents from being shared verbally or otherwise, except as required by law or desired by the patient.
3. ***Adhere*** to the principle of non-discrimination to assure that every woman is treated respectfully regardless of age, marital status, ethnicity, political affiliation, race, religion, economic status, disability, or other status. Women should be treated with respect for their individual judgment and not that of their partners or family.
4. ***Assure*** that adolescent women are treated without age discrimination, according to their evolving capacities — rather than merely their chronological age—in helping them to make free and informed decisions regarding their SRH.

Community level: responsibility to the community

1. ***Advocate*** for the rights of women to have access to the information and education needed to allow them to determine the timing of their reproduction in keeping with the ethical principle of autonomy and the human right to freely choose if and when to have children.
2. ***Advocate*** for the rights of women to make choices about sexual relationships as a natural part of their lives, assisting them to enter into these relationships freely and safely.
3. ***Advocate*** for appropriate resources and care for women seeking better reproductive and sexual health to ensure the rights to the highest attainable standard of health and the right to benefit from scientific progress.
4. ***Inform*** communities about the issues of SSR and SRH to promote a broad respectful dialogue, based on best health evidence to influence health practices, policies, and laws.
5. ***Attain*** and maintain the highest standards of professional competence in women's health, utilizing the most current and best available medical evidence within the context of available resources.

Society of Obstetricians and Gynaecologists of Canada and its international partners

Within its international women's health program, the Society of Obstetricians and Gynaecologists of Canada also recognizes the active role health care providers can play in promoting SRH and further, advancing women's rights and empowerment.

> "[Health care providers] have the medical expertise, status, credibility, and commitment to health improvement as well as contact with the broader community. They have great influence on decision and policy makers at local, national and international levels. ...Adding a social dimension to their work makes a long-term impact upon the status of women's reproductive health in their community."[38]

The following are concrete examples of ways health care providers can positively promote women's SRH and SRR within their respective professional associations and practices. These are provided here for discussion purpose and to motivate health care providers to seek ways they can also contribute, individually or collectively, to ensuring that the SRR of the women they serve are respected and promoted fully.

In your professional associations:

- Partner with national and international health associations to develop codes of ethical conduct (such as the one promoted by FIGO), evidence-based guidelines, and basic rights documents relating to reproductive health care.
- Develop, distribute, and implement ethical codes to ensure that the practice of health care providers meets human rights, ethical, and professional standards.
- Educate health care providers about possible barriers to communication with female patients and ways in which they can ask for women's judgments about their own health needs.
- Develop guidelines for the patient and health care worker relationship that protect women's reproductive rights and ensure that women receive quality, efficient, and professional services.

In your day-to-day practice:

- Ensure that all services are provided in a way that promotes ethical and human rights principles.
- Encourage women to speak openly. Guarantee confidentiality in all communications with patients.
- Perform physical examinations with appropriate respect for privacy.
- Ensure that women are not denied services because of their sex, race, marital status, age, disability, socio-economic class, location, etc.
- Ensure that clinics and health service centers offer accurate, plain language information about reproductive and sexual health rights to women and adolescents.

In summary, the challenge remains how we, as health care providers, can contribute to improving women's overall SRH and promoting their SRR. As stated by Dr. Dorothy Shaw, President Elect, FIGO:

> *As professionals, our privileged position in society obliges us to advocate for improvement of health services for women and to reflect on how best to collaborate with others to bring about the necessary changes so that women will be valued equally to men and will be able to exercise their sexual and reproductive rights as enshrined in human rights laws. How do you envision your role?*[39]

Key Messages

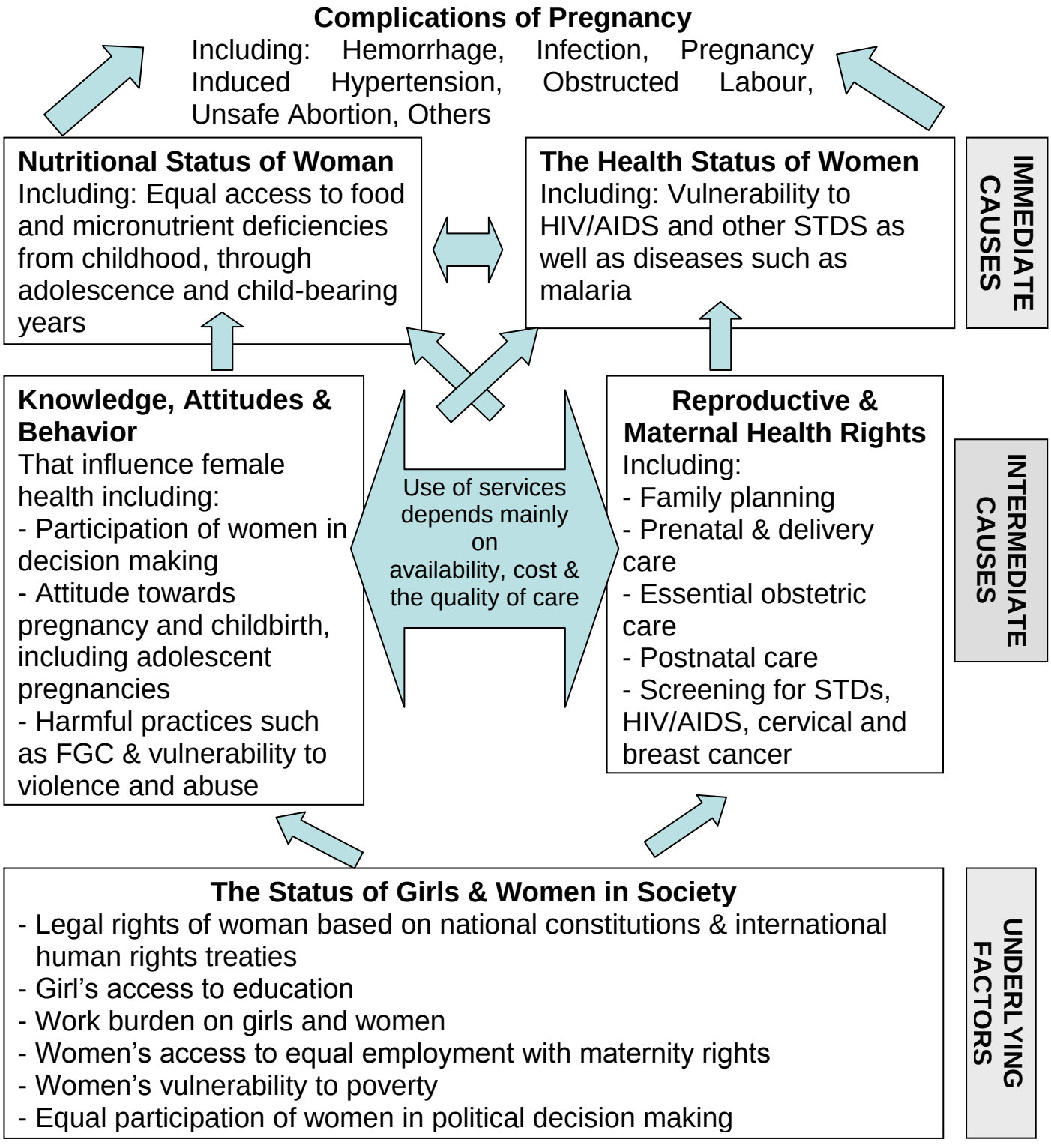
1. 99% of maternal deaths happen in low resource countries. The tragedy is that these deaths are preventable. Their occurrence demonstrates a breach of SRR.
2. Be aware of the three delays that affect women's access to care. Address women's barriers to health care by advocating for change at the local and national levels of health care organization in your country of practice.
3. The SRR framework is the foundation of AIP. The SRR framework must be promoted continually and consistently by all health care providers in their daily practice.

Suggestion for Applying the Sexual and Reproductive Rights Approach to this Chapter

At the end of each chapter you will find a box like this one that will provide with an example about how you, as a health care provider, can apply a Sexual and Reproductive Rights Approach into your daily practice and clinical management.

APPENDIX 1[40]

MATERNAL MORBIDITY AND MORTALITY SURVIVAL



APPENDIX 2

Resolution Accepted by FIGO General Assembly, Montreal, Canada 1994

FEMALE GENITAL MUTILATION

The FIGO General Assembly,

CONSIDERING that female genital mutilation (female circumcision) is a harmful traditional practice which is still prevalent in over 30 countries of the world, including areas of Africa, Asia and the Middle East;

CONCERNED about the serious adverse effects of this practice on the physical and psychological procedure performed on a child who cannot give informed consent;

RECOGNIZING that female genital mutilation is a violation of human rights, as a harmful procedure performed on a child who cannot give informed consent;

RECALLING the 1994 World Health Assembly Resolution WHA47.10 welcoming the policy declarations to the Untied Nations Special Rapporteur on traditional practices by governments in countries where female genital mutilation is practiced;

1. **INVITES** Member Societies to:

   - **URGE** their governments to ratify the Convention on the Elimination of ALL Forms of Discrimination Against Women, if they have not already done so, and to ensure the implementation of the articles of the Convention, if the Convention has already been ratified.
   - **URGE** their governments to take legal and/or other measures to render this practice socially unacceptable by all sectors and groups in society.
   - **COLLABORATE with national authorities, non-governmental and inter-governmental** organizations to advocate, promote, and support measures aiming at the elimination of female genital mutilation.

2. **RECOMMENDS** that obstetricians and gynaecologists:

   - **EXPLAIN** the immediate dangers and long-term consequences of female genital mutilation to religious leaders, legislators, and decision makers.
   - **EDUCATE** health professionals, community workers and teachers about this harmful traditional practice.
   - **SUPPORT** those men and women who want to end the practice in their families or communities.
   - **ASSIST** in research for the documentation of the prevalence of the practice and its harmful consequences.
   - **OPPOSE** any attempt to medicalize the procedure or to allow its performance, under any circumstances, in health establishments or by health professionals.

Resources:

- Amnesty International. *It's in our hands, Stop Violence Against Women*. Oxford: Amnesty International Publications; 2004. (http://web.amnesty.org/aidoc/aidoc_pdf.nsf/Index/ACT770012004ENGLISH/$File/ACT7700104.pdf)
- Amnesty International. *Making Violence Against Women Count, Facts and Figures.* Amnesty International Media Briefing; 2004. (http://web.amnesty.org/library/Index/ENGACT770362004?open&of=ENG-373)
- Carbert A, Stanchieri J, Cook RJ. *A Handbook for Advocacy in the African Human Rights System, Advancing Reproductive and Sexual Health*. Ipas Regional Office, Kenya; Nairobi; 2002. (www.ipas.org/english/publications/international health_policies.asp)
- Centre for Reproductive Rights. *Reproductive Rights are Human Rights*. 4th ed. Center for Reproductive Law and Policy; 2003. (www.crlp.org/pub_bo_rrhr.html)
- Chalmers, Beverley and Kowser Omer-Hashi. *Female Genital Mutilation and Obstetric Care*. Victoria: Trafford Publishing; 2003.
- Cook R, Dickens B, Fathalla MF. *Reproductive Health and Human Rights*. Oxford: Clarendon Press; 2003.
- Isfahan Merali. *Improving Reproductive and Sexual Health: Integrating Women's Empowerment and Reproductive Rights / Empowering Women: Making Reproductive Rights a Reality*. Ottawa: Society of Obstetricians and Gynaecologists of Canada; 2001. (www.sogc.org/intl/resources_e.htm#book)
- International Planned Parenthood Federation. *IPPF Charter on Sexual and Reproductive Rights, Vision 2000*. 2nd ed. London: International Planned Parenthood Federation; 1996.
- International Planned Parenthood Federation. *IPPF Charter Facts on Sexual and Reproductive Rights*. London: International Planned Parenthood Federation; 2003. (www.ippf.org/charter/full.htm#factcard)
- United Nations. *Fact Sheet No.23, Harmful Traditional Practices Affecting the Health of Women and Children*. Geneva: United Nations Office of the High Commissioner for Human Rights. (www.unhchr.ch/html/menu6/2/fs23.htm)
- United Nations. *Implementation of the United Nations Millennium Declaration, Report of the Secretary-General. A/57/270 (*www.who.int/mdg/goals/en)
- World Health Organisation. Unsafe Abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2000. – 4th edition. Geneva, 2004.

1 The facts and figures included in the sections were obtained from the Safe Motherhood web site (www.safemotherhood.org/resources/facts/globaldata.html#risk).

2 WHO Factsheet: Skilled attendant at birth—2006 Updates. Department of Reproductive Health and Research

3 http://www.who.int/reproductive-health/global_monitoring/skilled_attendant_at_birth2006.pdf accessed on Feb 20, 2007

4 UNICEF. Programming for Safe Motherhood – Guidelines for Maternal and Neonatal Survival. 1st ed. New York: UNICEF; 1999.

5 http://www.unfpa.org/upload/lib_pub_file/150_filename_checklist_MMU.pdf - Accessed on Feb 20, 2007

6 UNICEF. Programming for Safe Motherhood – Guidelines for Maternal and Neonatal Survival. 1st ed. New York: UNICEF; 1999.

7 White Ribbon Alliance for Safe Motherhood/India. Saving Mothers' Lives: What Works. Field Guide for Implementing Best Practices in Safe Motherhood. Mumbai: White Ribbon Alliance for Safe Motherhood; 2002.

8 International Conference on Population and Development. Program of Action: para. 7.2; 1994.

9 International Conference on Population and Development. Program of Action: para. 7.3; 1994.

10 Beijing Platform for Action: Para 96. 1995.

11 International Conference on Population and Development. Program of Action: para.7.2; 1994.

12 International Conference on Population and Development. Program of Action: para.7.2; 1994.

13 International Conference on Population and Development. Program of Action: para.7.11; 1994.

14 Cook R, Dickens B, Fathalla MF. Reproductive Health and Human Rights. Oxford: Clarendon Press; 2003.

15 Healthy Newborn Partnership. Newborn Survival: Time of Action, 2003.

16 Germain A, Kim T. Expanding Access to Safe Abortion: Strategies for Action. New York: International Women's Health Coalition; 1999. (www.iwhc.org/uploads/expanding%2Epdf).

17 WHO. Unsafe Abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2000. – 4th edition. Geneva, 2004.

18 http://www.safemotherhood.org/facts_and_figures/unsafe_abortion_fact.htm accessed on February 20, 2007

19 http://www.safemotherhood.org/facts_and_figures/unsafe_abortion_fact.htm accessed on February 20, 2007

20 Save the Children, USA. Children Having Children – State of the World's Mothers 2004. Westport: Save the Children; 2004.

21 International Women's Health Coalition. Fact Sheets on The Human Rights of Children and their Sexual and Reproductive Health. Distributed in Canada by Action Canada for Population and Development (http://www.acpd.ca/acpd.cfm/en/section/SRResources/articleid/96).

22 World Health Organization. Women and HIV/AIDS Fact Sheet No 242. WHO; June 2002. (http://www.who.int/mediacentre/factsheets/fs242/en/)

23 UNAIDS. AIDS epidemic update: special report on HIV/AIDS. Geneva. December 2006.

24 UNAIDS. AIDS epidemic update: special report on HIV/AIDS. Geneva. December 2006.

25 UNICEF. Unite for Children. Unite against AIDS Programme Master Files, UNICEF, March 2006. Global Summary of the HIV and AIDS epidemic, 2006, UNAIDS.

26 http://www.unicef.ca/portal/Secure/Community/502/WCM/WHATWEDO/hiv/assets/HIV%20and%20AIDS%20Statistics%20and%20Facts.pdf accessed on febr 20, 2007

27 Center for Reproductive Rights. Female Circumcision/Female Genital Mutilation: Legal Prohibitions Worldwide. Centre for Reproductive Rights; 2004. (http://www.crlp.org/pub_fac_fgmicpd.html.)

28 WHO-Department of Reproductive Health and Research. Progress in Sexual and Reproductive Health Research: Female Genital Mutilation—new knowledge spurs optimism. No 72. Geneva, Switzerland. 2006

29 WHO study group on female genital mutilation and obstetric outcome. Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. Lancet 2006; 367: 1835-41.

30 United Nations Office of the High Commissioner for Human Rights. Harmful Traditional Practices Affecting the Health of Women and Children, Fact sheet No. 23. Geneva: United Nations Office of the High Commissioner for Human Rights. (http://www.unhchr.ch/html/menu6/2/fs23.htm)

31 Hersh, L. Giving up Harmful Practices, Not Culture. New York: Advocates for Youth; 1998. (source: http://www.advocatesforyouth.org/publications/iag/harmprac.htm)

32 Hersh, L. Giving up Harmful Practices, Not Culture. New York: Advocates for Youth; 1998. (source: http://www.advocatesforyouth.org/publications/iag/harmprac.htm)

33 UNFPA. Ending Widespread Violence Against Women. New York: UNFPA. (http://www.unfpa.org/gender/ violence.htm)

34 United Nations. Declaration on the elimination of violence against women. Assembly resolution 48/104: Article 1; December 20, 1993.

35 Amnesty International. World Wide Scandal. Amnesty International. (http://web.amnesty.org/actforwomen/scandal-index-eng).

36 UNFPA. Ending Widespread Violence Against Women. New York: UNFPA. (http://www.unfpa.org/gender/ violence.htm.)

37 International Federation of Obstetrics and Gynaecology. FIGO Professional and Ethical Responsibilities Concerning Sexual and Reproductive Rights. FIGO; November 2003.

38 Merali, I. Improving Reproductive And Sexual Health: Integrating Women's Empowerment and Reproductive Rights. Ottawa: The Society of Obstetricians and Gynaecologists of Canada; 2001.

39 Shaw, D. Sexual and Reproductive Rights in Action - Obligations and opportunities. IJGO, 2004. 84: 197-199.

40 UNICEF. Programming for Safe Motherhood. New York: UNICEF; 1999.