Chapter 1

Sexual and Reproductive Health and Rights

Chiara Benedetto

Introduction

Sexual and reproductive health (SRH) has been defined as:

> 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. 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. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning, as well as other methods of their choice for 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. [1]

Reproductive health encompasses being able to control one's fertility through access to contraception and abortion, being free from sexually transmitted infections (STIs), sexual dysfunction and sequelae related to sexual violence or female genital mutilation. It also includes the possibility of safe sexual experiences free of coercion, discrimination and/or violence. Although the recognition of SRH as an essential component of human rights dates back to the second half of the twentieth century, the full achievement of these rights remains elusive for many [2]. This is why universal access to reproductive health is included in the 2030 United Nations Agenda for Sustainable Development Goals (SDG), specifically in SDGs 3, 5 and 16 (see Figure 1.1) [3].

Family Planning

Family planning is recognized as a fundamental human right and plays a pivotal role in gender equality and girls' and women's empowerment, reducing poverty and achieving sustainable development. High-quality contraceptive services are essential to assist women in exercising their right to have children by choice and to decide freely and responsibly on the number and spacing of their children. Access to family planning services and education is also pivotal to improving prevention of sexually transmitted infections, including HIV.

Worldwide Figures

Out of 1.1 billion women worldwide in the reproductive age range (15–49 years) who need family planning services, 190 million had an unmet need for contraception in 2019 [4].

The growing use of contraceptive methods has led to improvements in health-related outcomes such as the reduction in undesired and high-risk pregnancies and in maternal and infant mortality [5]. Indeed, increased contraception use has reduced the maternal mortality rate by 26% over the past decade. Reducing the number of pregnancies also reduces childbirth complications and mortality due to unsafe abortion practices and dangers associated with high parities. Moreover, the use of contraceptives by young girls and boys increases the chances of receiving proper education and finishing school, with consequent positive effects on women's status and economic outcomes [6].

Therefore, the right to family planning education, information and services is pivotal to children's health and reproductive choice and it is central to women's SRH and empowerment. States must eliminate all legal, financial, social and institutional barriers that hamper access to comprehensive, quality, child- and youth-friendly SRH services and should implement programs to guarantee access to a full range of family planning services and contraceptives.

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Figure 1.1 The 2030 United Nations Agenda for Sustainable Development Goals

Sexuality and Reproductive Information and Education

Sexuality and reproductive information and education should be universally available to all women and men to enable them to exercise and fulfil their SRH and rights. Sexuality education is defined as:

> Learning about the cognitive, emotional, social, interactive and physical aspects of sexuality. Sexuality education starts early in childhood and progresses through adolescence and adulthood. It aims at supporting and protecting sexual development. It gradually equips and empowers children and young people with information, skills and positive values to understand and enjoy their sexuality, have safe and fulfilling relationships and take responsibility for their own and other people's sexual health and well-being.

Worldwide Figures

Only 34% of young people have comprehensive correct knowledge about HIV prevention and transmission [7].

Sexuality information and education have various positive and lifelong effects on the health and well-being of young people. Indeed, the introduction of national sexuality education programs in several countries has been shown to increase the use of contraception, to delay the initiation of sexual intercourse and to reduce the number of sexual partners, the incidence of STIs and the number of teenage and unplanned pregnancies as well as the number of abortions. Moreover, good-quality sexuality education empowers young people to develop stronger and more meaningful relationships, thus contributing to the prevention of gender-based violence [8]. This is why access to sexuality and reproductive education is protected, which require governments around the world to guarantee the overall protection of health, well-being and dignity and specifically to guarantee the provision of unbiased and accurate sexuality education.

Access to Safe Abortion

Access to safe abortion is a complex determinant of girls' and women's health. Although it is a fundamental human right protected under numerous international and regional human rights treaties and national-level constitutions, it remains inaccessible, unavailable, illegal or permitted under very limited circumstances in 40% of countries worldwide. Moreover, even in countries where abortion is legal, there may be barriers to accessing safe abortion services such as restrictive laws, poor availability of resources, high costs of service, social stigma, conscientious objection of healthcare providers and unnecessary requirements (such as mandatory delays or counseling, misleading information, the need for

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family members' or a husband's authorization). These barriers contribute to increasing the number of girls and women who turn to unsafe abortion [9]. Unsafe abortion is defined as a procedure to terminate a pregnancy, practiced by individuals without the necessary training or using outdated or damaging methods or carried out in settings without meeting minimal medical standards.

Worldwide Figures

One out of three to four pregnancies ends in an induced abortion. Each year unsafe abortion is responsible for 4.7–13.2% of maternal deaths [10].

Unsafe abortion may lead to serious complications such as hemorrhage, sepsis, peritonitis, trauma to the gynecological and/or abdominal organs and reproductive tract infections, as well as permanent disability, including infertility [11]. Barriers to services and the laws that prohibit safe abortion expose girls and women to serious health risks, violating their rights to bodily integrity and to life itself. Sexuality and reproductive education, accessible contraception, training of abortion providers and access to legal abortion contribute to the prevention of unsafe abortion.

Maternal Healthcare

Maternal, perinatal and neonatal health matters to every person, society and country and should be considered pivotal from the point of view of human rights and well-being. Maternal health is the health of women during pregnancy, childbirth and the postpartum period.

Worldwide Figures

- More than 810 women die due to pregnancy and childbirth every day.
- Approximately 90% of maternal deaths occur in low- and lower-middle-income countries.
- The maternal mortality ratio dropped by about 38% between 2000 and 2017.
- Births attended by skilled health personnel increased from 58% in 1990 to 81% in 2019 [12].

The causes of maternal death may be directly related to childbirth such as obstetric complications during pregnancy, delivery or postpartum (e.g., hemorrhage, hypertension and sepsis) or indirectly related to childbirth, including existing health conditions during pregnancy or health problems that developed during the pregnancy itself. Interventions aimed at achieving adequate maternal nutrition, improving hygiene practices, antenatal care, emergency obstetric care and postnatal care contribute to the prevention of most maternal deaths [13].

Preconception counseling is a targeted counseling intervention that seeks to prevent specific problems before conception. It is based on three main concepts:

- **Risk assessment**: history of medical, surgical, psychosocial, genetic, nutrition, pharmaceutical and behavioral (e.g., smoking, alcohol and/or drug use) risks and implementation of control measures to remove or reduce them.
- **Health promotion**: optimization of health behavior by improving knowledge and increasing risk awareness, promotion of vaccination policies and of early booking into prenatal/antenatal services.
- **Targeted interventions**: involve preconception supplementation with folic acid and may entail the use of appropriate contraception to delay pregnancy until optimal health is achieved.

Antenatal care, provided by skilled healthcare professionals to pregnant women, tries to ensure the best health conditions, for both mother and child, during pregnancy and childbirth. It may include risk identification, prevention and management of pregnancy-related or concurrent diseases, health education and promotion (Table 1.1).

In 2016, the World Health Organization (WHO) drafted a model of antenatal care that recommends a minimum of eight antenatal contacts: the first up to 12 weeks' gestation (first trimester), two contacts in the second trimester (at 20 and 26 weeks' gestation) and five contacts scheduled at 30, 34, 36, 38 and 40 weeks (in the third trimester). Implementation of this

Table 1.1 Basic interventions recommended for antenatal care

Regular maternal and fetal well-being assessments
Nutritional counseling and physical activity advice
Iron and folic acid supplementation
Daily calcium supplementation in populations with low dietary calcium intake
Screening for major complications in pregnancy (e.g., hypertensive disorders, preeclampsia, asymptomatic bacteriuria, gestational diabetes mellitus)
Investigation as to smoking, alcohol intake and preexisting infectious diseases

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Table 1.2 Basic interventions recommended for postnatal care

Identification of postpartum complications (e.g., hemorrhage, preeclampsia or infection)
Identification of maternal mental health problems
Nutritional counseling and hygiene advice
Family planning and contraceptive counseling
Breastfeeding support
Assessment of the newborn

model allows for a decrease in stillbirth risk as compared to models with four or fewer contacts [14].

Postnatal care, provided by healthcare professionals to women and children in the 6–8 weeks after birth, is a continuation of the care given to the woman throughout her pregnancy, labor and birth (Table 1.2). Healthcare professionals should support breastfeeding for its multiple benefits for both child and maternal health [15].

Gender-Based Violence

Gender-based violence is any act of violence inflicted upon an individual because of his or her gender or sexual orientation. The violence may take different forms – physical, sexual or psychological – and it encompasses harmful practices such as child marriage and female genital mutilation. Although boys and men can also be subjected to it, most gender-based violence is inflicted on girls and women.

Worldwide Figures

An estimated 30% of girls and women have experienced physical and/or sexual intimate partner violence and 7% have experienced non-partner sexual violence in their lifetime.

Violence against women is a gross violation of women's human rights and a manifestation of unequal power relations between men and women. Violence can have a range of short- and/or long-term consequences. It can lead to disorders in psychological well-being such as depression, anxiety and post-traumatic stress disorder, suicide, alcohol and drug abuse and/or disabilities. Moreover, girls and women exposed to violence experience SRH problems including undesired pregnancies, adverse maternal and newborn health outcomes and STIs, as well as gynecological complications. Intimate partner violence during pregnancy can lead to miscarriage, stillbirth, premature birth and/or low-birth-weight babies [16, 17].

The twentieth and twenty-first centuries witnessed an increase in activities to research, raise awareness and advocate for the prevention of all kinds of gender-based violence at both the national and international levels. Most countries have laws that penalize at least some forms of violence, including some violence against girls and women (such as domestic violence or rape) and against children. Unfortunately, numerous countries continue to have inadequate legislation.

Female Genital Mutilation

Female genital mutilation (FGM) is defined as all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for nonmedical reasons. It violates the human rights of girls and women to health, security and physical integrity and to be free from torture and cruel, inhuman and/or degrading treatment, as well as the right to life. Female genital mutilation is often carried out on minors and therefore is also a violation of children's rights. Female genital mutilation is of global concern and is mainly practiced in Africa, the Middle East and Asia, as well as among migrants from these areas living around the world.

Worldwide Figures

- More than 200 million girls and women alive today have been subjected to FGM and more than 3 million girls are estimated to be at risk for FGM annually.
- About 500,000 European girls and women have undergone genital mutilation and 180,000 are at risk of doing so [18].

Female genital mutilation is associated with a series of short-term (i.e., pain, excessive bleeding, shock, infection, sepsis or even death) and long-term health risks (i.e., chronic pain, decreased sexual enjoyment, psychological consequences and childbirth complications) [19]. In 2012, the United Nations General Assembly passed a resolution banning the practice of FGM. The resolution advocates all necessary measures be taken, including enforcing legislation, raising awareness and allocating sufficient resources to protect girls and women from this form of violence.

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Child Marriage

Child marriage refers to any formal marriage or informal union between a child under the age of 18 and an adult or another child. Child marriage violates a range of human rights such as gender equality, freedom from slavery, access to education, freedom of movement, freedom from violence and the right to consensual marriage.

Worldwide Figures

- More than 650 million girls and women alive today were married before 18.
- Twenty-one percent of young women (20–24 years old) were child brides [20].

Child marriage increases the risk of STIs (in particular HIV and HPV) and cervical cancer, of pregnancy-related diseases and complications (i.e., preeclampsia, postpartum hemorrhage, sepsis and obstetric fistula) and of babies with low birth weight, preterm delivery and severe neonatal conditions. Most child brides have a lower level of education and financial independence and a higher risk of social isolation and domestic violence than more educated women who marry as adults [21].

The United Nations and other international agencies declared child marriage a violation of human rights in 1948. A multifaceted approach is required to end child marriage that includes targeted interventions at different levels with appropriate programs to provide families and communities with education and reproductive healthcare services.

Conclusive Remarks: Actions to Be Taken

Advancing SRH and rights requires not only improvements in healthcare services but also social, educational and legislative changes. Integrating human rights into healthcare can help overcome some of the most relevant challenges to SRH on a global scale. Political commitment, at the highest national and international levels, is to be obtained so as to allocate the necessary resources to promote gender equality and improve healthcare services. Indeed, the education of professionals toward a thinking approach wherein SRH and human rights are wholly integrated and girls and women are empowered is pivotal to ramp up this process and produce spin-offs that would benefit individuals and society as a whole.

Empowerment starts from education in the community: social policies should ensure primary education to all girls and boys and include sexuality and reproductive education programs. Education may also be provided in focus groups, at educational meetings or through social media, enabling minorities such as migrants to be correctly informed. Two such examples are the Global Communication Campaign for Women's Health and the WELL! (Women Empowerment Learning Links) Campaign set up by the International Federation of Gynaecology and Obstetrics (FIGO) Women Health and Human Rights (WHHR) Committee, which were run for the general population to raise awareness on hot topics within SRH.

Last but not least, changes in law and policies are to be made in some countries. The FIGO WHHR Committee prepared a handbook entitled *Advocating for Girls' and Women's Health and Human Rights* to provide guidance on how the National Societies of Obstetricians and Gynaecologists can engage in rights-based advocacy to influence Governments to make progress on achieving girls and women's health and rights (Figure 1.2) [22].

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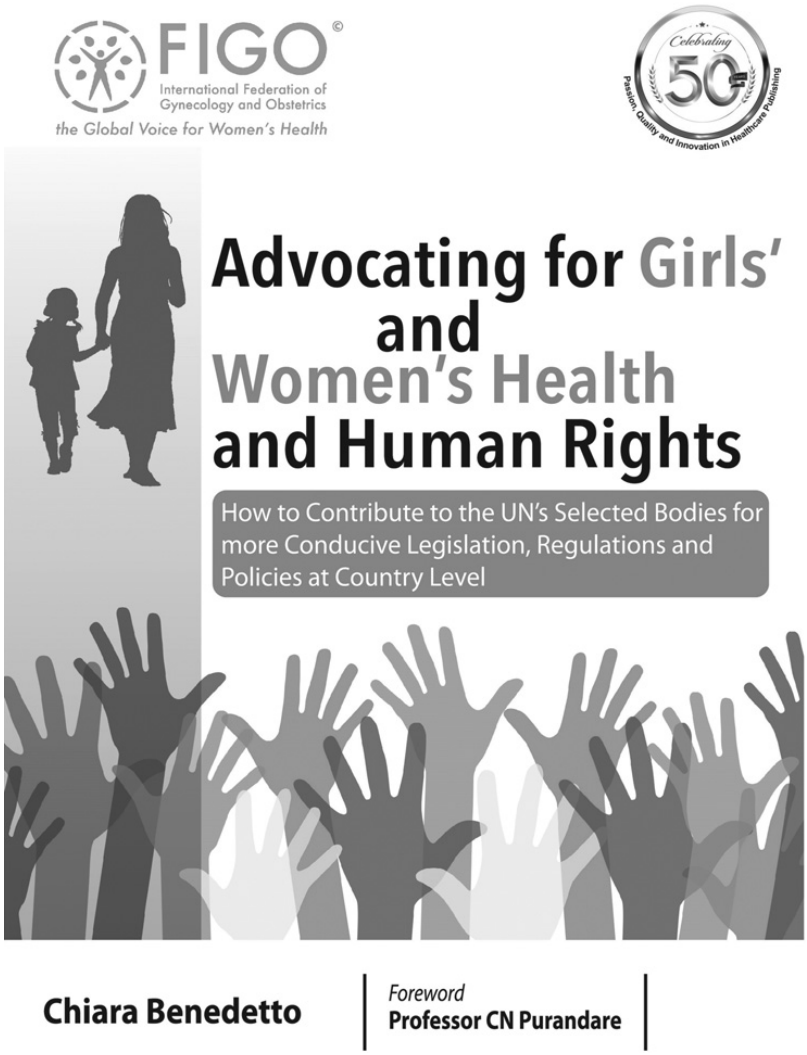

Figure 1.2 Handbook cover page

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