Eldis Health Key Issues

Universal access to sexual and reproductive health services

In September 2006, as a result of advocacy by international and national non-governmental organisations (NGOs), the United Nations (UN) General Assembly finally adopted the target of universal access to reproductive health. This health key issues guide explores issues relating to universal access to sexual and reproductive health (SRH) services using a rights-based approach. The guide examines factors that inhibit access to and use of SRH services, and discusses methods for removing barriers to care and improving access.

Lack of access to SRH services and information contributes to high levels of morbidity and mortality for largely preventable SRH problems, particularly in developing countries. Every year, half a million women die during childbirth because there is not a skilled attendant present at the birth, and insufficient provision of condoms has contributed to the spread of sexually transmitted infections (STIs), including HIV. Restrictions on information about sexuality, contraception, prevention and healthcare, limit people's ability to make choices regarding their own sexual and reproductive health and rights (SRHR).

Whilst the importance of reproductive health has been acknowledged in international agreements, many countries do not consider sexual health as a legitimate health issue, and conservative ideology emanating particularly from current US policy prevents it from receiving global recognition. Donor support for SRH services (apart from HIV) has been falling; and stigma, discrimination and restrictive laws and policies continue to prevent many people from utilising services. A rights-based approach to access draws attention to the inequities in service delivery and the discriminatory practices that marginalise people and deny them the opportunity to seek care. It also justifies prioritising efforts towards fulfilling their SRH needs and rights.

The online version of this guide is available at:

www.eldis.org/health/Universal/index.htm

This guide is based on a literature review written by Sally Griffin for the PANOS Relay Programme in association with the Realising Rights Consortium (**www.realising-rights.org/**).

Contents:

What does universal access to services mean?

What is universal access?

Universal access means that enough services and information are available, accessible and acceptable to meet the different needs of all individuals. This requires that people can safely reach services without travelling for a long time or distance, and that those with disabilities can easily access buildings. Services and treatments must be affordable, and based on principles of equity such that poor people do not bear a higher burden from the cost than more wealthy people. Care should also be sensitive to social and cultural considerations including gender, language and religion.

Universal access requires that services are of adequate quality (availability of skilled medical personnel, approved and unexpired drugs and equipment, proper infrastructure including safe water and sanitation); and that providers do not discriminate on the basis of sexuality, gender, ethnicity and age. In many countries, perceived poor quality of services, inappropriate treatment and discrimination by health professionals deters many people from using services [7].

Universal access to SRHR encompasses access to information and services on prevention, diagnosis, counselling, treatment and care, in order that:

- everyone can make informed choices about sexuality and reproduction and have a safe and satisfying sexual life, free from violence and coercion
- all women experience pregnancy and childbirth safely, couples have the best chance of having an infant, and women can avoid unwanted pregnancy
- everyone has access to prevention, treatment and care for STIs including HIV
- all women and men are able to access high quality SRH services that cater to their needs
- the rights and needs of people living with HIV and AIDS (PLWHA) are recognised and appropriate SRHR information and services are made available.

See also: Access to services and information section in the health topic guide on sexual and reproductive health: **www.eldis.org/health/sexrepro/access.htm**

Featured article:

Sexual and reproductive health: a matter of life and death
This article is the first in a series of papers on Sexual and Reproductive Health published by the Lancet. The article notes that worldwide, the burden of sexual and reproductive ill-health remains enormous: unsafe sex is the second most important risk factor for disease, disability and death in the poorest communities. [14]

Photo: Panos Pictures / Giacomo Pirozzi (**www.panos.co.uk**)

Universal access to SRH services and the Millennium Development Goals

Ensuring universal access to SRH services and information is essential for achieving many, if not all, of the Millennium Development Goals (MDGs), especially those on maternal health, child survival, HIV and AIDS and gender equality [5]. Most maternal deaths can be prevented if there is skilled attendance at birth to cope with potentially fatal complications. Access to safe and effective family planning services and contraception empowers women to have more control over when to have children and lessens the incidence of unsafe abortions. Also, contraception can help reduce the transmission of STIs, including HIV. At a macro level, lower levels of maternal mortality and slower population growth increase social and economic development and reduce poverty.

The omission of universal access to reproductive health from the MDGs has resulted in the neglect of SRH services and programmes by policymakers and donors. However, there have been recent signs of increasing recognition of the importance of access to these services. In September 2006, the UN General Assembly incorporated universal access to reproductive health as a target of the MDG 5, to reduce the maternal mortality ratio by three-quarters (see **www.un-instraw.org/revista/hypermail/alltickers/fr/0711.html**).

See also: Health topic guide section on the millennium development goals:
www.eldis.org/health/mdgs.htm

A rights-based approach to access

A rights-based approach to access is based on the framework of international values and standards, set out in the Universal Declaration of Human Rights (see **www.unhchr.ch/udhr/index.htm**) and other international human rights conventions. These are primarily concerned with promoting the wellbeing and free choice of all individuals, especially people made vulnerable through poverty, stigma, marginalisation or violence. The right of individuals to access sexual and reproductive health services and information, to use services with privacy and confidentiality, and to be treated with dignity and respect, was explicitly recognised at the UN International Conference on Population and Development (ICPD), in Cairo, 1994 (ICPD programme of action: **www.unfpa.org/icpd/icpd_poa.htm**).

A rights-based approach to access draws attention to the social, cultural, political and economic forces and inequalities that marginalise people and deny them access to services and the opportunity to satisfy their SRH needs. It moves beyond considering universal access as a goal to be strived towards, and, through human rights laws and advocacy, obliges governments to ensure equity in access to services, and address the wider discriminatory policies and laws that can constrain access.

See also: Rights and advocacy in the health topic guide on sexual and reproductive health:
www.eldis.org/health/sexrepro/rights.htm

Recommended readings: [**5**], [**7**], [**8**], [**13**], [**14**], [**19**]

Factors affecting access to sexual and reproductive health services

There are a number of interlocking social and cultural factors, reinforced by restrictive laws and policies, which can impede access to services and information. People who are most vulnerable to sexual and reproductive ill health are often those who are denied access to SRH services.

Socio-cultural factors

Social taboos

Issues around sex and sexuality are taboo in many cultures, and perceived stigma and embarrassment can lead to a reluctance to discuss and address sexual health issues. Taboos are even more pronounced for people who do not conform to socially accepted norms of behaviour such as adolescents who have sex before marriage and men who have sex with men (MSM). Unmarried adolescent girls are routinely denied or have limited access to SRH services even though they are vulnerable to violence and sexual abuse, and the consequences of early sexual experiences including unwanted pregnancy, STIs and unsafe abortions. In West Africa, some donors are apprehensive to fund research and support the service needs of MSM for fear that these activities might fuel anger in some communities and restrict progress made on less sensitive reproductive health programmes [30].

Gender roles

Gender norms in many societies tend to make men macho, women passive, and marginalise transgender people – making all of them vulnerable in different ways to SRH problems, and inhibiting access to services. For example, men may associate masculinity with taking risks in their sexual relations which expose them to HIV and STIs, and may be reluctant or too embarrassed to seek out appropriate health information and care (these are often focussed on women) [3].

Women who are financially, materially or socially dependent on men may have limited power to exercise control in relationships, such as negotiating the use of condoms during sex. Social expectations about how women should behave can place women in subordinate roles and increase their risk of being sexually assaulted, contracting STIs and having unwanted pregnancies, and also limit their access to SRH services. In Zanzibar, unmarried women are denied contraceptives from health professionals, while in Botswana and Senegal married women are restricted from using contraceptives without the permission of their husbands [16]. In many societies, women's health concerns are often considered less important than those of men and children, and household responsibilities can prevent them from spending time visiting a clinic [26].

Religious conservatism

Religious fundamentalisms expressed through policy and funding decisions undermine progress towards achieving universal access to SRH services. Conservative Christian attitudes towards sexuality in the United States have led to government funding restrictions on services for sex workers, and the promotion of narrow sex education programmes for young people which focus only on abstinence as a means of STI prevention. These policies limit access to and information about contraceptives and safe abortions, and neglect the complexities and realities of peoples' lives, for example the prevalence of rape (including marital rape) and sexual coercion of unmarried girls [4]. Similarly, the Vatican's stance against contraception has compromised the promotion of condoms for STI/HIV prevention, and "pro-life" movements linked to both have hampered efforts to reduce unsafe abortions, for instance by blocking access to emergency contraception.

Conversely, some religious groups have taken action to improve access to SRH services and information. Catholics for a Free Choice (see: **www.catholicsforchoice.org/**) advocate the use of condoms (**www.condoms4life.org**); and Christian Aid has adopted an approach to HIV prevention which promotes safer practices, available medications, voluntary counselling and testing, and empowerment as an alternative to abstinence strategies (see: **www.christianaid.org.uk/news/media/pressrel/060321p.htm**).

See also: Social and cultural issues in the health topic guide on sexual and reproductive health: **www.eldis.org/health/sexrepro/soccul.htm**
See also: Sexual and reproductive health and rights key issues guide section on obstacles to realising sexual and reproductive health and rights:
www.eldis.org/health/srhr/debates.htm

Recommended readings: [**2**], [**3**], [**4**], [**15**], [**16**], [**18**], [**24**], [**26**], [**30**]

Political factors

Whilst reproductive health targets and rights have been agreed in international negotiations and universal access to reproductive health services incorporated into the MDG5, many countries do not recognise sexual health as being distinct from reproductive health and the need for sexual health services and information as going beyond those concerning reproduction and HIV. Sexual health services have generally been neglected because providing them requires governments to acknowledge sexual rights including sexual pleasure and sexual orientation; and address issues such as gender roles and power imbalances within relationships.

At national levels, there is a general lack of political will to implement international policy and amend laws to improve access, especially on sensitive issues such as abortion, and services that are not related to reproductive health, such as facilities for MSM or transgender people. Recently, some countries have implemented regressive laws which further restrict women from accessing safe abortions. For instance, in 2006 Nicaragua passed a law forbidding abortion under any circumstances, including cases where women's lives are at risk from continuing pregnancy (see: **http://news.bbc.co.uk/1/hi/world/americas/6161396.stm**).

National laws concerning SRH issues often remain ambiguous and inconsistent. For example, in Zimbabwe whilst 16 and 17 year olds are legally capable of consenting to sex, they are not permitted to use services and information regarding contraception and STI prevention [**6**]. Such ambiguities can provide a foundation for service providers to use their discretion and restrict access to some groups of people based on personal prejudices.

In many countries accountability mechanisms are not in place to ensure an acceptable quality of services, and there are limited opportunities for civil society groups to participate in policy debates. However, there are examples where social mobilisation has been successful in pushing issues onto the political agenda and helped to achieve increased access to services. In South Africa women's activists and health advocates successfully campaigned for abortion services to be legalised (see: **www.ipas.org/english/press_room/2005/releases/05122005.asp**). As a result of this legalisation, it is estimated that access to safe abortions has reduced abortion deaths by over 90 per cent.

Recommended readings: [**2**], [**6**], [**13**], [**19**]

Economic and structural factors

Lack of political will has led to a corresponding lack of financial commitment to SRH (outside of HIV) by both international donors and national governments. Whilst HIV and AIDS has become an international priority, reflected in policy and funding programmes (PEPFAR, the Global Fund to Fight AIDS, TB & Malaria, and the World Bank's MAP), the proportion of donor funding has been reduced in other areas of SRH, in particular family planning. In Malawi, health workers ceased to provide general SRH services in order to offer voluntary counselling and testing for HIV [**27**].

In many developing countries, governments do not have the capacity to provide universal access: there are not enough human resources (trained doctors, nurses and midwives) to provide services; supplies of drugs and contraceptives are often erratic; and there is a lack of technical expertise in some areas. Poor communications and transport infrastructure can prevent access to services in rural areas, especially in maternal health care where transport to referral services with adequate facilities is an essential component of dealing with emergencies and preventing mortality.

Featured article:

Mobility and health: the impact of transport provision on direct and proximate determinants of access to health services

The role of mobility and transport in public health remains neglected both in terms of research and inclusion in development agendas. This paper examines the relationship between mobility and access to health services in low income countries, and assesses the impacts of transport interventions on access to health. Poor mobility and accessibility of maternal services has a major impact on excluding poor rural women from maternity facilities in low-income countries. [20]

Photo: Panos Pictures / Tim Dirven (**www.panos.co.uk**)

Poverty is a major barrier to accessing services and treatment in many countries, and the introduction or expansion of user fees (where people pay directly for services), has prevented many poor people from utilising health services [23]. This is especially the case for family planning services which are often considered less important than treating life-threatening diseases. There is evidence in India that user fees discourage women from giving birth in formal institutions, accessing antenatal care and seeking treatment for reproductive tract infections. The cost of transport to visit regional hospitals which can be far away from rural areas also prevents many poor people from accessing the appropriate facilities [20].

See also: Health service delivery section in the health systems resource guide:
(**www.eldis.org/healthsystems/delivery/index.htm**)
See also: Dossier on meeting the health-related needs of the very poor in the health systems resource guide: (**www.eldis.org/healthsystems/vp/index.htm**)

Recommended readings: [20], [23], [27], [29]

Approaches for expanding access to services

Integrated services

Integrating reproductive health, family planning and STI/HIV prevention and treatment services is critical for achieving universal access. Integration requires that health care workers can provide an appropriate comprehensive package of services under one roof, and refer patients to other services if required. Linking STI/HIV with SRH services improves access to HIV/STI services for women who might otherwise not visit them because of issues of stigma [1]. It also improves access to reproductive health services for people living with HIV and AIDS whose reproductive health needs and rights are often overlooked [12].

Integrating services into mainstream existing primary health care facilities makes them more accessible for non-traditional users of family planning services such as men and adolescents. In Tanzania, linking of youth friendly SRH services with public health facilities meant that adolescents were able to use services and get information without fear of being stigmatised by adults [24]. In Bangladesh, integration of reproductive health services for men in family welfare centres increased their access to and acceptance of services to address their specific SRH needs. This initiative also led to a substantial rise in the number of women using services [25].

Integrating SRH services into public facilities provides greater potential for scaling up services and maintaining them on a long-term basis as networks are already in place across countries. Successful integration necessitates political commitment towards providing a comprehensive package of primary health care services and technical and financial support towards achieving this. Many attempts to integrate SRH services have encountered problems at the programme and service level. These include difficulties in: allocating and coordinating responsibilities; ensuring effective communication between staff in programmes; training staff with appropriate skills to meet a broader range of demands; strengthening referral services.

Recommended readings: [1], [11], [12], [24], [25], [26]

Featured article:

Strengthening linkages for sexual and reproductive health, HIV and AIDS: progress, barriers and opportunities for scaling up
This review, produced by the DFID Health Resource Centre, explores the policy, financing and institutional factors that enable or constrain the integration of sexual and reproductive health and rights programmes with policy programmes for HIV prevention and AIDS treatment and care. It discusses the main constraints to developing linkages and strategies and opportunities for engagement. [11]

Photo: Panos Pictures / Giacomo Pirozzi (**www.panos.co.uk**)

Targeting marginalised groups

Many people are unable to access mainstream SRH services or programmes for reasons of poverty, language, disability and geographical inaccessibility; or are denied access because of stigma, discrimination or restrictive laws and policies. Overcoming inequalities in access requires that the SRH needs of marginalised people are identified, and interventions are targeted towards meeting their needs in a culturally considerate manner.

Mobile health facilities which bring services directly to people are one method of addressing physical barriers to access for the most isolated and often the poorest populations. The

International Planned Parenthood Federation (IPPF) has used mobile health units, sometimes in the form of canoes and planes, to reach isolated populations across countries in Latin America and the Caribbean, and provide them with education, supplies and services. The initiative resulted in a reduction of total births and increase in births attended by a trained professional (see **www.ippfwhr.org/publications/download/serial_issues/spotaccess1_e.pdf**).

Mobile health units have also been used to deliver free condoms, STI testing and treatment, and prenatal care to sex workers in Brazil. The clinics are based in red-light districts so that workers do not have to lose earnings as a result of time spent travelling to clinics. In India, an NGO called SANGRAM (Sampada Grameen Mahila Sanstha) uses a peer based model to reach out to sex workers. Peer educators, who are themselves sex-workers, undertake a variety of activities including raising awareness about HIV and AIDS, distributing condoms, and assisting people in accessing medical care (see: **www.id21.org/insights/insights64/art05.html**).

Identifying groups that have unmet needs for SRH services can be difficult because there are often a number of simultaneous factors that prevent access. Also, targeting services towards specific groups can be difficult because people may not identify themselves as belonging to these groups. For instance MSM who do not consider themselves as being gay or bisexual are unlikely to respond to HIV/STI services designed for these communities. With this in mind, Profamilia, an NGO in Columbia, launched an initiative to increase access to quality services and information for MSM. It provided sexual health services in environments sensitive to all sexualities, and used a variety of media to promote messages including vouchers at clinics, advertisements in magazines, and websites.
(see: **www.ippfwhr.org/publications/download/serial_issues/spothivsti3_e.pdf**).

See also: Dossier on meeting the health-related needs of the very poor in the health systems resource guide: (**www.eldis.org/healthsystems/vp/index.htm**)
See also: Vulnerable groups section in the health systems resource guide: (**www.eldis.org/healthsystems/poverty/index.htm**)

Strengthening participation and accountability

Actively involving marginalised groups in decision making processes at all levels, and providing them with the opportunity to hold service providers and policy makers accountable for discriminatory practices, corruption or poor quality services, helps to redress inequalities in access to SRH services and ensure that they are acceptable and appropriate.

In practice, representation in the planning processes for SRH services has been limited. A review of community participation and (public) SRH service accountability across developing countries found that participation was restricted to service delivery, and was not extended to the design of policies, legislation and allocation of budgets. Marginalised groups including adolescents, the elderly and the very poor, were not consulted as much as mainstream health organisations. This may be because, even within the forums for participation, they lack the skills, information or representation to have a voice amongst more powerful participants [**22**].

To improve their influence on SRH legislation, policy and spending decisions at all levels, it is necessary to strengthen the capacity of marginalised people and of other civil society organisations concerned with SRH including women's groups, health and human rights groups and elected representatives so they can better negotiate for their demands. Civil society groups should collect evidence to support these demands, support marginalised people to express their concerns, and form alliances to strengthen their representation. The creation of more opportunities and spaces for people to engage in policymaking processes such as independent courts, media and councils can also strengthen participation and accountability.

Recommended readings: [**21**], [**22**], [**29**]

Improving quality of care

Perceived quality of care is an important factor that determines whether people choose to utilise SRH services. Evidence from Bangladesh, Senegal and Tanzania suggests that in areas where women felt that they were receiving a high standard of care, they were more likely to use contraceptives than in areas with lower quality health facilities [7].

Improving quality of care requires that patients' perspectives and levels of satisfaction are taken into account when evaluating services, and are incorporated into policy decisions. This means that in addition to clinical factors (safe procedures, accurate information and reliable products), providers need to be aware of their patients' cultural values, social concerns and individual needs. Factors that patients often consider important in determining quality of care include: acceptable waiting times; convenient opening hours; confidential relationships; availability of gender-sensitive services; continuity of services; choice of contraceptive method; and being treated with dignity and respect.

EngenderHealth, a non-profit organisation that works in reproductive health, has devised a "client-orientated, provider-efficient" (COPE) approach to improve quality of care and motivate staff. COPE offers guidance for providers to assess their services, interview patients, and examine the time that they spend at clinics. This gives staff a better understanding of patients' perspectives, and enables them to develop a plan of action to improve quality. In some clinics, COPE has resulted in staff staggering their lunch breaks to reduce patients' waiting time. The approach empowers providers to have more control over their activities and resources, and motivates staff to identify their own training needs
(see: **www.engenderhealth.org/ia/sfq/qcope.html**).

See also: Quality improvements section in the health systems resource guide:
www.eldis.org/healthsystems/delivery/index.htm

Recommended readings: [7], [17], [26]

Sustainable financing

To achieve universal access, it is essential that SRH services are affordable even for the poorest people in societies. In many instances, this means that services must be free. Reductions in donor funding mean that providing free services is becoming increasingly difficult to sustain, especially in countries with limited resources. In Turkey, the government has dealt with the phase-out of free contraceptives from donors by requesting wealthier clients to make a donation for the commodities they use, and subsidising contraceptives for those most in need [28].

Non-state providers including commercial firms, not-for-profit organisations and faith-based organisations often provide services when governments are unable to meet people's SRH needs. Social franchising, or networks of private providers who offer a standard set of services and share training, referral systems, quality standards and brands is one such example. The high volume of patients that these networks can provide for enables them to reduce costs of treatment for poor people. However, as with many commercial providers there is a tension between sustaining services by collecting revenue and providing services for most poor people. Those who cannot afford to pay the fees are excluded. Also, when services exist outside the realms of government regulation and monitoring, it is difficult to ensure that services are of adequate quality, and that people are not financially exploited.

Developing partnerships between government agencies, the private sector and non-governmental organisations through public-private partnerships or contracts can help sustain facilities and improve access for the poor. For instance, in Ghana private providers were given logistical and technical support by the government to operate family planning services in remote areas [9]. In Pakistan, the NGO Marie Stopes International formed a partnership with a district health department to renovate and upgrade obstetric services in rural health centres (see **www.mariestopes.org.uk/pdf/ppp.pdf**).

See also: Health service delivery section in the health systems resource guide:
www.eldis.org/healthsystems/delivery/index.htm
See also: Key issues guide on market development approaches in the health systems resource guide: **www.eldis.org/healthsystems/mda/index.htm**
See also: Public-private partnerships section in the health systems resource guide:
www.eldis.org/healthsystems/global/index.htm

Recommended readings: [**9**], [**10**], [**28**], [**29**]

Drawing on international human rights legislation and advocacy

Human rights legislation and documents have been used by NGOs, civil society organisations and marginalised groups to influence policy and challenge restrictive laws that prevent access to SRH services. In Nepal, women and reproductive rights organisations succeeded in introducing a law that decriminalises abortion during the first 12 weeks of pregnancy. The bill was part of a set of amendments intended to redress discriminatory laws that exist against women (see: **www.feminist.org/news/newsbyte/uswirestory.asp?id=7027**). In Columbia, the NGO Profamilia successfully advocated for emergency contraception to be classified as a method for preventing pregnancy. It argued that denying women access to treatments that are the product of scientific advances is discriminatory and limits a women's right to protect her health and life (see: **www.ippfwhr.org/publications/download/serial_issues/spotEC1_e.pdf**).

Human rights advocacy has also been used by civil society organisations to fight stigma and discriminatory practices which prevent people from seeking care or deny them access to non-judgemental information and services. While advocacy has occurred most visibly in international and national arenas, important activity has also taken place in local communities in response to particular issues such as stigma against women and girls seeking HIV and family planning services, or poor quality of local facilities (see: **www.icw.org/node/233**).

Making people aware of their rights increases the likelihood that they will use services, and also mobilises demand for improved access. For example, activists in Namibia informed a group of HIV positive women about PAP smear tests and breast examinations to check for cancer, and where to access these services. These women independently approached the Ministry of Health (MOH), and succeeded in compelling the MOH, in collaboration with private providers, to make available these services and improve the supply of information about cancer to local communities (Mallet, ICW).

See also: Rights and advocacy in the health topic guide on sexual and reproductive health:
www.eldis.org/health/sexrepro/rights.htm

Recommended readings: [**13**], [**14**], [**15**], [**19**], [**29**], [**30**]

References and summaries

1. Study of the integration of family planning and VCT/PMTCT/ART programs in Uganda

Barriers to and successes of integration in Uganda
Asiimwe, D.; Kibombo, R.; Matsiko, J. / Makerere Institute of Social Research (MISR), Uganda (2005)

This paper examines the integration of family planning (FP) services with HIV and AIDS services (voluntary counselling and testing (VCT), prevention of mother-to-child-transmission (PMTCT) and anti-retroviral therapy (ART)) in Uganda. The paper finds that: FP service integration is more evident in VCT and PMTCT settings where counselling, provision of contraceptive methods other than condoms, and information is available in varying degrees. Implementation of integrated services remains a challenge because under the public healthcare system, FP and VCT services are controlled by different divisions within the Ministry of Health.

The paper also finds that overwhelmingly, people living with HIV and AIDS (PLWHA) reported a need for FP but were reluctant to access these services outside HIV/AIDS centres because they fear stigma and discrimination. Policymakers and providers were also supportive of integration as a means to cut costs and reduce duplication of services. The authors make several recommendations for improving integration. These include: policymakers should be sensitised to the desire among PLWHA to access contraception; policy on and implementation of HIV/AIDS and FP services need to be harmonised to enhance joint planning and inter-service coordination; FP providers need to be sensitised to serving HIV-positive clients without judgement.

Available online at:
www.policyproject.com/pubs/corepackages/Uganda%20TOO%20Final%2012%2020%2005.pdf

2. Reproductive health supplies in Central and Eastern Europe

Political will to prioritise reproductive and sexual health needed in central and eastern Europe
Astra Network / ASTRA - Central and Eastern European Womens Network for Sexual and Reproductive Health and Rights (2007)

This ASTRA network paper examines barriers to accessing reproductive health services and supplies in Central and Eastern Europe (CEE). The paper finds that reproductive health is not prioritised in government policies: they lack a commitment to recognise reproductive health supplies as an important component of public health and human rights and there is no adequate legislation and policy in this area. Condoms are widely available, but their cost is often high, especially for young people. HIV testing is accessible, but testing for other sexually transmitted infections including Chlamydia is rare – tests are suggested by doctors only after symptoms have occurred.

The paper finds that non-state providers in the region fill the gap left by governments especially in education and counselling services. Private sector organisations subsidise contraceptives, and UN bodies distribute free condoms in some countries. The paper highlights other barriers to access including a lack of adequate sex education and low awareness of reproductive health in many societies. The authors suggest that people need to be made more aware of their rights, and better dialogue is required with politicians, policymakers and government officials.

Available online at: www.astra.org.pl/CEE_RH%20Supplies.pdf

3. Young men and the construction of masculinity in sub-Saharan Africa: implications for HIV/AIDS, conflict and violence

Both women and men are made vulnerable by ideas of masculinity and gender hierarchies
Barker, G.; Ricardo, C. / World Bank (2005)

In the literature on conflict and HIV/AIDS, African men are often presented in simplistic and explicitly negative terms. It is generally taken for granted that those who use weapons are men whilst those who suffer the consequences of conflict are women, and that men always hold power in sexual relationships whilst women are always powerless. Certainly, African women and girls have been made vulnerable by the behaviour of men and boys in conflict settings and in sexual relationships. Yet the fact that gender hierarchies also oppress some men is seldom discussed. What of the men who are survivors and victims of violence, or who are displaced or orphaned due to conflict? What of the men who are brothers or husbands of women who have been sexually abused during conflict?

This paper argues that applying a more sophisticated gender analysis as it relates to conflict and HIV/AIDS is essential in order to understand how both women and men are made vulnerable by rigid ideas of masculinity and by gender hierarchies. References are made to alternative, non-violent forms of masculinity in Africa and to elements of traditional gender socialisation (the process by which individuals learn and teach others about the roles and behaviours that are expected of a women or man in a given society) which promote more gender-equitable attitudes on the part of young men. Included are examples of young men whose stories reveal ways in which men can question and counter prevailing norms of masculinity. A summary is also provided of promising programmes for including men in the promotion of gender-equity.
[Summary adapted from Siyanda **www.siyanda.org**]

Available online at:
www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2005/06/23/000012009_20050623134235/Rendered/PDF/327120rev0PAPER0AFR0young0men0WP26.pdf

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4. HIV/AIDS: sex, abstinence, and behaviour change

Abstinence programmes do not address broader factors in sexual behaviour
Barnett, T.; Parkhurst, J. / The Lancet Infectious Diseases (2005)

This opinion piece, published by Lancet Infectious Diseases, argues that an abstinence approach to HIV does not take into account the balance between contextual and environmental factors and individual choices in determining why and how people have sex. The article reviews the case of Uganda, where many claim that the ABC approach (abstinence, be faithful, condoms) helped to maintain low HIV prevalence rates early in the epidemic. The authors highlight that this was only one of many messages and there is no evidence of any causal link between any single message and the behaviour change observed.

The authors argue that abstinence-based prevention messages fail to engage with diversity and the social and economic contexts of sex. Focusing on education alone may not be appropriate as sex in poor country contexts is more often tied to livelihoods, duty and survival. In order to address the HIV epidemic, sex must be seen for what it is, rather than what we assume it to be from the assumptions of our own cultural standpoint. Continued misunderstandings of the nature of the problem, based on incorrect assumptions about the drivers of other people's sex lives will result in a waste of resources on inappropriate policy recommendations and interventions.

Please note: To read this article, you will first need to register with The Lancet. This process and access to the article is free of charge.

Available online at:
www.thelancet.com/journals/laninf/article/PIIS147330990570219X/abstract

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5. Public choices, private decisions: sexual and reproductive health and the Millennium Development Goals

How family planning services can save lives and help meet the MDGs
Bernstein, S.; Hansen, C.J. / Millennium Project (2006)

This report, published by the UN Millennium Project, examines the global burden of diseases and risks related to sexual and reproductive health (SRH), analyses the implications for the Millennium Development Goals, and asks what needs to be done. Key findings include that millions of women lack access to family planning services they need and want. The unmet need for contraception is especially acute among adolescents in the developing world. One in 16 women in sub-Saharan Africa dies from complications of pregnancy and childbirth, compared with one in every 2800 in highly- developed countries.

The report argues that providing safe, effective, voluntary family planning services prevents death and disability, spurs development, and fights poverty. It calls for a massive expansion of family planning, maternal health, and AIDS prevention efforts by mobilising political will, institutional capacity, and technical and financial resources. It estimates that US$36 billion per year will be needed in order to meet the developing world’s SRH needs. Recommendations to integrate SRH into development strategies include: incorporating SRH in both national poverty reduction strategies and strengthened health systems; allocating enough funds for commodities, supplies and logistics while strengthening health systems; and meeting the needs of special populations, particularly young people, the poor and victims of humanitarian crisis.

Available online at: www.unmillenniumproject.org/documents/UNMP_QA_SRH.pdf

6. State of denial: adolescent reproductive rights in Zimbabwe

Legal and administrative reform needed to secure adolescent reproductive rights in Zimbabwe
CRLP / Center for Reproductive Rights, formerly known as the Center for Reproductive Law and Policy (CRLP), New York ([2002])

This report, produced by the Center for Reproductive Rights, documents the legal, policy and social barriers which prevent Zimbabwean adolescents from accessing dual protection methods and information. The investigation reveals a systematic denial of this right, which is the product of several interacting factors: an inconsistent and ambiguous national legal and policy framework, which creates a grey area for 16-17 year olds; insufficient provision for adolescents in national anti-discrimination law; restrictive interpretations of the framework by public health providers; the requirement for parental consent for access to reproductive health services and information for those under 18; and unreceptive attitudes towards adolescents seeking such services, particularly those who are unmarried or living in rural areas.

The paper calls for the Zimbabwean government to take steps to provide adolescents with dual protection methods and information. This should include simplifying the legal framework to promote the ability of young people to obtain methods of contraception and sexually transmitted infection (STI) prevention. The government must also examine the way current policies relating to adolescents are being implemented, and enact changes to ensure that their human right to access dual protection methods and information is being upheld.

Available online at: www.crlp.org/pdf/zimbabwe_report.pdf

7. Overview of quality of care in reproductive health: definitions and measurements of quality

What is quality of care?
Creel, L. C.; Sass, J. V.; Yinger, N. V. / Population Reference Bureau (PRB) (2002)

This policy brief from the Population Council and Population Reference Bureau discusses various definitions of quality of care in the context of reproductive health. The brief focuses on a client-centred approach to improving quality of care, where the needs and perspectives of patients are placed at the centre of the concept of quality of care. It discusses several factors that contribute to quality of care including: follow-up and continuity; considering gender relations both in the population service and between providers and clients; considering clients access including distance travelled, the cost of services and the attitudes of providers.

The brief also discusses tools for measuring quality of care and improvements in quality of care. The authors recommend a list of quality care indicators for providers, staff (other than providers), clients, facility. Indicators for clients include: active participation in discussion and selection of method of contraception; receives his/her method of choice; believes the provider will keep his/her information confidential. The brief concludes that increased efforts must be made to understand and motivate providers, improve their performance, and help make them partners in improving access to and quality of family planning and reproductive health care services.

Available online at: www.prb.org/pdf/NewPerspQOC-Overview.pdf

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8. Sexual and reproductive health and rights: a position paper

DFID policy on supporting rights-based approaches to sexual and reproductive health
DFID / Department for International Development (DFID), UK (2004)

In this paper, the UK Department for International Development (DFID) sets out its position on sexual and reproductive health and rights, reaffirming its commitment to realising the goals of the International Conference on Population and Development (ICPD). New challenges are highlighted, including the HIV/AIDS pandemic, threats to international consensus, increasing demand for reproductive health services, and weak or failing health systems, alongside a shortage of skilled health workers.

The paper recommends the effective integration of sexual and reproductive health services (including those for HIV/AIDS) to improve maternal and newborn health, deliver family planning choices, eliminate unsafe abortion and reduce sexually transmitted infections and risky behaviour. It also calls for increased access to sexual and reproductive health services and non-judgemental information for poor women, men, young people, and specific vulnerable groups such as sex workers and displaced people, highlighting the importance of gender equality. Four areas of action are identified: advocacy and partnership; strengthening sexual and reproductive health services; addressing social, cultural and economic barriers to access; and generation and application of evidence based research. The paper concludes by advocating a rights based approach to sexual and reproductive health, to build momentum in policymaking, backed up by legal and political frameworks.

Available online at: www.dfid.gov.uk/pubs/files/sexualreprohealthrights.pdf

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9. Health sector reform: how it affects reproductive health

Reproductive health managers need to play larger role in health sector reforms
Dmytraczenko, T.; Rao, V.; Ashford, L. / Population Reference Bureau (PRB) (2003)

This brief discusses the steps that health managers need to take to ensure that reproductive health objectives are met within the wider aims of health sector reforms. Produced by the Population Reference Bureau (PRB), it provides an overview of health sector reform, discussing its potential impact on reproductive health services and ways to incorporate reproductive health priorities into evolving health care systems.

The brief finds that alternative financing approaches can influence the demand for and use of health services. With decentralisation, to avoid the potential problem of inequitable distribution of health care, central governments could provide grants, or use weighted formulas to help districts with higher concentrations of "at-risk" or poor populations. It concludes that in order to influence reforms, reproductive health managers need to familiarise themselves with the objectives, principles and strategies of health sector reform and to take part in policy discussions at both national and local levels. In particular, they need to engage in a continuous dialogue with health planners and participate at the local level in public debate.

Available online at: www.phrplus.org/Pubs/HealthSectorReformColor.pdf

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10. Public-private interactions: lessons for sexual and reproductive health services

Involving the private sector in sexual and reproductive health services: the need for caution

Doherty, J.; Initiative for Sexual & Reproductive Rights in Health Reforms / Initiative for Sexual & Reproductive Rights in Health Reforms [School of Public Health, University of the Witwatersrand] (2005)

This policy briefing, produced by the Initiative for Sexual & Reproductive Rights in Health Reforms, asks how governments can best draw on private resources to support the achievement of sexual and reproductive health (SRH) service objectives. It reports that, while interactions between the public and private sectors may expand coverage and improve services for some, there is evidence that they can also worsen inequity, provide poor quality care, create inefficiencies and undermine the coherence and sustainability of the health system, especially in the realm of SRH. It argues that public and donor subsidies to public-private interactions (PPIs) risk diverting funds away from the poorest and hardest to reach populations, towards urban centres and higher income groups.

The briefing argues that public-private interaction (PPI) should be approached in a cautious and planned manner. Governments should be guided by clear principles for engagement, and supported by strong regulatory frameworks and contractual arrangements. They also need the capacity to implement and monitor PPIs appropriately. The briefing emphasises that responsibility for meeting international targets such as the Millennium Development Goals, still lies in the hands of the public sector. The strengthening of the public sector must not be compromised by parallel efforts to extend private sector involvement.

Available online at: www.wits.ac.za/whp/rightsandreforms/docs/RRpolicyPublic.pdf

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11. Strengthening linkages for sexual and reproductive health, HIV and AIDS: progress, barriers and opportunities for scaling up

Summarising the main obstacles to jointly addressing sexual and reproductive health, HIV and AIDS

Druce, N.; Dickinson, C.; Attawell, K.; et al / Department for International Development (DFID) Health Resource Centre (HRC) (2006)

This review, produced by the DFID Health Resource Centre, explores the policy, financing and institutional factors that enable or constrain the integration of sexual and reproductive health and rights programmes with policy programmes for HIV prevention and AIDS treatment and care. Based on a review of the literature, key informant interviews and policy and programme analysis, it discusses the main constraints to developing linkages and the possible strategies and opportunities for engagement. Key challenges to scaling up include: downward trends in donor financing for reproductive health and family planning and weak international leadership for the promotion of linkages. Institutional arrangements and support for targeted disease specific programmes also create incentives that weaken synergistic approaches.

The review provides examples of enabling processes to promote linkages. These include improved government and donor coordination and cross programme working groups and task forces. Finally, the authors suggest potential opportunities for engagement. These opportunities fall into four categories; civil society and private sector engagement, actions on commitments, opportunities among multi and bilateral donors, and support to harmonised country processes with key stakeholders. [adapted from authors]

Available online at:
www.dfidhealthrc.org/publications/HIV_SRH_strengthening_responses_06.pdf

12. Women and girls living with HIV/AIDS: overview and annotated bibliography

Challenges faced by women and girls living with HIV and AIDS
Esplen, E.; International Community of Women Living with HIV/AIDS (ICW) / BRIDGE (2007)

HIV/AIDS is both driven by and entrenches gender inequality, leaving women more vulnerable than men to its impact. This report - consisting of an overview, annotated bibliography, and contacts section - considers the specific challenges faced by women and girls who are living with HIV and AIDS. Women's social, economic, and legal disadvantage is exacerbated by a positive HIV status, and vice versa. Violations of women's social, economic, and legal rights in turn obstruct their ability to seek care, treatment and support, and to realise their sexual and reproductive health and rights (SRHR).

In many contexts, social and cultural values surrounding the importance of female purity mean that women and girls living with HIV and AIDS are also subject to greater discrimination than men. Sex workers, drug users, prisoners and migrants may face additional stigma. Women and girls living with HIV/AIDS are calling for recognition of their fundamental human rights, including their SRHR and the right to decide whether or not to have children; their meaningful involvement at all stages of the policy-making process; and government provision of accessible and equitable healthcare.
[Summary adapted from Siyanda **www.siyanda.org**]

Available online at: http://www.bridge.ids.ac.uk/reports/BB18_HIV.pdf

13. Sexual and reproductive health for all: a call for action

Sexual and reproductive health for all is still an achievable target
Fathalla, M. F.; Singing, S. W.; Rosenfield, A.; Fathalla, M. M. F. / The Lancet (2006)

This article is the final paper in a series on Sexual and Reproductive Health published in the Lancet. It outlines what needs to be done to achieve universal access to sexual and reproductive health services by 2015 -- a goal set out at the United Nations International Conference on Population and Development in Cairo in 1994. It notes that whilst most countries are now focusing more attention on sexual and reproductive health and are working to create better policies and improve access to information and services, progress has been uneven across countries and across different components of sexual and reproductive health. The article reviews experiences since 1994 focusing on three areas: know-how, the political commitment, and the resources to improve sexual and reproductive health.

The authors conclude that sexual and reproductive health for all is an achievable goal if cost-effective interventions are properly scaled up; political commitment is revitalised; and financial resources are mobilised, rationally allocated, and more effectively used. They emphasise that sustained effort is the responsibility of all actors including governments, the donor community, non-governmental organisations, civil society groups, the health profession and the research community.

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Available online at:
http://www.thelancet.com/journals/lancet/article/PIIS014067360669483X/fulltext

14. Sexual and reproductive health: a matter of life and death

Progress in sexual and reproductive health is threatened by conservative political, religious, and cultural forces around the world
Glasier, A.; Gülmezoglu, A. M.; Schmid, G. P.; et al / The Lancet (2006)

This article is the first in a series of papers on Sexual and Reproductive Health published by the Lancet. The article notes that worldwide, the burden of sexual and reproductive ill-health remains enormous: unsafe sex is the second most important risk factor for disease, disability and death in the poorest communities. The authors identify core components of sexual and reproductive health care. These are: improvement in maternal and newborn care, provision of high-quality services for family planning, elimination of unsafe abortion, prevention and treatment of sexually transmitted infections (STIs), and promotion of healthy sexuality. The article provides an overview of these components and discusses trends and accomplishments in the fields.

Men’s sexual and reproductive health is examined and the authors observe that men can also be the subject of sexual and reproductive ill-health, for instance they acquire STIs and can be victims of non-consensual sex. Finally, the article investigates why sexual and reproductive health, with the exception of HIV and AIDS, has failed to capture broad support from the donor community. One explanation given is that funding and policy decisions concerning sexual and reproductive health are being increasingly influenced by conservative political, religious and cultural forces which have undermined recent progress in the field.

Please note: To read this article, you will first need to register with The Lancet. This process and access to the article is free of charge.

Available online at:
www.thelancet.com/journals/lancet/article/PIIS0140673606694786/abstract

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15. Sex and the rights of man

Examining the sexual rights of men
Greig, A. / Institute of Development Studies (IDS), Sussex, UK (2006)

This paper explores the subject of sexual rights and the claims about such rights as they are made by and for men. It asks: what can men's interest be in the social and sexual revolution being proposed by advocates of sexual rights? The first answer to this question is to recognise that some men's sexual rights have long been violated. Those men who have sex with other men are especially vulnerable to such violation. But what about men who do appear to conform to dominant stereotypes of masculinity? What can be said of their sexual rights? Even these men may suffer sexual violence, as shown by figures on non-consensual heterosexual experiences reported by boys and men.

Furthermore, gender socialisation (the process by which individuals learn and teach others about the roles and behaviours that are expected of them as a women or man in a given society) may inhibit men's ability to experience joy, dignity, autonomy and safety in their sexual lives. For example, gender socialisation dictates that men should be confident and take control in sexual relations, leaving no space for admission of the anxieties that many feel. However, it is also important to consider the privileges that ensue to men who conform to prevailing ideas about masculinity and sexuality. It is crucial both to recognise the gender constraints that shape men's sexual attitudes and behaviours, at the same time as holding men accountable for the choices and decisions that they do make within their sexual lives.
[Summary adapted from Siyanda **www.siyanda.org**]

Available online at: www.siyanda.org/docs/Sex_and_the_Rights_of_Man-Greig.doc

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16. Provision of reproductive health services in sub-Saharan Africa: lessons, issues, challenges and the overlooked rural majority

A review of access to reproductive health services in rural areas
Haile, S.; du Guerny, J.; Stloukal, L. / Sustainable Development Department, FAO SD Dimensions (2000)

This paper by the Sustainable Development Department of the Food and Agricultural Organisation, explores the availability, accessibility and affordability of reproductive health services in sub-Saharan Africa. It reviews the current situation and proposes some solutions to respond to the unmet need for family planning. Barriers to available and accessible family planning services in Africa, especially in rural areas include: lack of strong government commitment; lack of communication between urban centres and rural areas; and lack of adequate resources. The paper also examines the relevance of existing reproductive health strategies to rural populations and highlights several questions that warrant further exploration. These include what can be done to redress the rural-urban imbalances in policies and programmes, and to what extent can the reproductive health needs of rural people be met by relying primarily on urban-centered strategies?

The paper concludes that the reproductive health needs of rural people should not be overlooked. To correct the existing rural-urban imbalances, policy-makers and service providers need to be more active in assessing the relative merits of different service delivery approaches, and developing effective strategies to specifically address the needs for rural inhabitants. There is no one model for delivery of reproductive health services and it is therefore necessary to look at what type of service is appropriate in a given socio-cultural context. [adapted from author]

Available online at: www.fao.org/sd/wpdirect/WPan0044.htm

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17. Family planning services quality as a determinant of use of IUD in Egypt

Assessing how quality of care influences contraceptive use in Egypt
Hong, R.; Montana, L.; Mishra, V. / Health-services-research (2006)

This article from BMC Health Services Research examines the relationship between the quality of family planning services and the use of intrauterine devices (IUDs) in Egypt. There is general agreement that the quality of family planning and reproductive health services positively affects contraceptive use and behaviour of patients; and that patients deserve to receive safe and high quality services with respect and dignity. The paper discusses indicators used to measure quality of care including: choice of methods; information given to clients; client-provider interpersonal relations; mechanisms to ensure follow-up and continuity; respecting client's privacy; and tailoring counselling to meet clients needs.

The paper finds that IUD use among women who obtained their contraceptive method from public sources was positively associated with quality of family planning services, and independent of distance to the facility, facility type, age, number of children, education level, household wealth status and residence. In particular quality of services related to counselling and examination room had strong positive effects on the use of IUD. The paper concludes that service quality is an important determinant of use of clinical contraceptive methods in Egypt. Improving quality of family planning services may help further increase use of clinical contraceptive methods and reduce fertility.

Available online at: www.biomedcentral.com/1472- 6963/6/79

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18. Mapping of experiences of access to care, treatment and support

Assessing access to health services in Tanzania, Kenya and Namibia
International Community of Women Living with HIV/AIDS (ICW) / International Community of Women Living with HIV/AIDS (ICW) (2006)

As a positive woman, how do you try to stay healthy? What barriers do you face in trying to access medication? In 2006, ICW mapped positive women's experiences of access to care, treatment and support in three countries - Tanzania, Kenya and Namibia. Treatment is meant to be free in all three countries, yet focus group discussions with HIV positive women and health care workers revealed a number of factors that negate women's ability to access and use antiretrovirals (ARVs) to improve their health.

Partner control can make it impossible for women to access health services. Partners may refuse to let women go to the hospital or deny them the money for treatment. In other cases women faced pressure from partners to share their medications with them. Having to bribe health care workers to ensure access to care, treatment and support was reported by all focus groups. Other problems included the financial and time costs of travelling to clinics or health centres; lack of confidentiality; unavailability of treatment; and poor nutrition leading to ill-health, problems with adherence, and pressure to sell medications. Changes needed to improve treatment, care and support include better transport services, health services near villages, income generation opportunities, and improved nutrition.
[Summary adapted from Siyanda **www.siyanda.org**]

Available online at:
www.siyanda.org/search/summary.cfm?nn=2713&ST=SS&Keywords=access%20to%20care%2C%20treatment%20%26%20support&SUBJECT=0&Donor=&StartRow=1 &Ref=Sim

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19. Cairo after twelve years: successes, setbacks and challenges

More activism and barriers for sexual and reproductive health and rights
Langer, A. / The Lancet (2006)

This Lancet paper describes the achievements, setbacks and challenges that have been faced since the UN International Conference on Population and Development (ICPD) in Cairo. The conference placed sexual and reproductive health and rights (SRHR), choice, women's empowerment, a life- cycle approach, and gender equity at the centre of the international agenda; and set out a goal to achieve universal access to safe, affordable, and effective reproductive health care and services, including those for young people. The paper shows that since Cairo, visibility of SRHR on the international development and political landscape has decreased. This is a consequence of reduced funding and ideological resistance to the SRHR paradigm in an increasingly conservative environment.

However, the SRHR community has come a long way since Cairo: SRHR is now a mainstream notion among activists, programmers, policymakers, and academics; and there is better awareness of the complex interactions between social, political, cultural, and health factors that shape reproduction and sexuality. The paper concludes that to achieve real impact, a comprehensive approach that improves access to services and their quality, supports functional health systems, community participation, and an enabling environment is mandatory.

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Available online at: www.thelancet.com/journals/lancet/article/PIIS0140673606694865/fulltext

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20. Mobility and health: the impact of transport provision on direct and proximate determinants of access to health services

Mobility is key for many rural communities to accessing health services
Molesworth, K. / Swiss Tropical Institute (STI) (2005)

The role of mobility and transport in public health remains neglected both in terms of research and inclusion in development agendas. This paper examines the relationship between mobility and access to health services in low income countries, and assesses the impacts of transport interventions on access to health. The paper finds that distance and time taken to travel to health facilities prevents many people from accessing services and the direct costs of transport contribute a substantial proportion of expenditure on health care. Poor mobility and accessibility of maternal services has a major impact on excluding poor rural women from maternity facilities in low-income countries. This in turn impacts negatively upon broader initiatives towards safer motherhood and reducing maternal and neonatal mortality.

The paper concludes that mobility is key for many rural communities to accessing available preventive and curative services, and also supports indirect determinants of health including livelihoods and education. An integrated approach to transport development and health has the potential to indirectly enhance health through non-medical aspects of improved mobility, as well as through more direct health access routes.

Available online at: www.ifrtd.org/new/issues/Molesworth2005.doc

21. Negotiating sexual and reproductive health: culture matters

How culture can be an entry point, rather than obstacle, to sexual and reproductive health
Molesworth, K. / Medicus Mundi Switzerland (2006)

This article, published in the Bulletin of Medicus Mundi Schweiz, examines the new approach to sexual and reproductive health (SRH) being developed by the United Nations Population Fund (UNFPA), whereby cultural issues are regarded as challenges and opportunities rather than obstacles to rights-based SRH programmes. It emphasises the need for agencies to understand cultural context in order to reduce harmful practices, legislation and beliefs, and to support equitable, rights-based development in some of the most intimate and sensitive domains of human life.

The article argues that listening and learning from communities can be a more effective and appropriate way of achieving change than attempting to impose alien views and cultural values from above. In this way, cultural issues can be seen as entry points rather than obstacles to be surmounted. The article also sets out operational recommendations emerging from a series of UNFPA case studies. These include the need for cultural awareness and sensitivity; engaging religious institutions and local power structures; and using the emerging knowledge base on cultural issues in staff training. Finally, the author explains how conflict can be minimised by emphasising points on which consensus can be achieved, for example between religious texts and development goals.

Available online at:
www.medicusmundi.ch/mms/services/bulletin/bulletin200602/kap1/01Molesworth.html

22. Strengthening accountability to sexual and reproductive health and rights and community participation in the context of reforms

The need for genuine accountability in sexual and reproductive health services
Murthy, R.K.; Initiative for Sexual & Reproductive Rights in Health Reforms / Initiative for Sexual & Reproductive Rights in Health Reforms [School of Public Health, University of the Witwatersrand] (2005)

This policy brief, published by the Initiative for Sexual & Reproductive Rights in Health Reforms, examines the ways in which community participation and accountability have been implemented in developing country health sector reforms, focusing on sexual and reproductive health services. Findings include that community participation has usually been restricted to health programme management and service delivery, and has not been extended to the design of policies, legislation, and allocation of budgets. Community representatives have at best been consulted, but have not had decision-making powers. Marginalised groups, and sexual and reproductive rights groups, have not been consulted as much as mainstream health organisations.

The brief argues that the World Bank, national governments and donors need to move beyond paying lip service to issues of community participation and service accountability in health sector reforms. It recommends setting up new structures to strengthen participation and accountability mechanisms within policy, planning and implementation. Such structures could be either independent commissions, which might have more scope for promoting participation and accountability, or task forces within governments, which would be easier to set up. Participants should include women's health and rights groups – especially those led by marginalised groups; health researchers; progressive members of professional associations; consumer rights groups; and health policy makers.

Available online at: www.wits.ac.za/whp/rightsandreforms/docs/RRpolicyAccounta.pdf

23. Gender dimensions of user fees: implications for women's utilization of health care

User fees prevent many poor women from accessing health services in Africa
Nanda, P. / Reproductive Health Matters (RHM) (2002)

This article, published in Reproductive Health Matters, looks at the implications of user fees for women's utilisation of health care services in Africa. The article shows that a lack of access to resources and inequitable decision-making power means that many poor women are put out of reach of health care when they face out-of-pocket costs such as user fees. The fact that user fees may be low does not preclude other informal or hidden costs that women experience, which together can add up to amounts beyond their means. The trade-offs that women may make in order to pay for health care can lead to debt, use of ineffective treatments of neglect of their health and other needs.

The paper concludes that in order to mitigate the negative effects of current policies on the health of poor women more efforts are required to examine the budgetary implications of user fees at the household level, the health consequences of delays in care seeking or recourse to affordable but ineffective care, and the tradeoffs that women make to pay for health care. Issues around women's ability to pay are also pertinent to thinking about other methods of cost-recovery, including pre-payment schemes and health insurance mechanisms.

Available online at: www.muhef.or.tz/articles/ref%20369.pdf

24. Integrating youth-friendly sexual and reproductive health services in public health facilities: a success story and lessons learned in Tanzania

Improving access to sexual and reproductive health facilities for young people
Pathfinder International, Tanzania / Pathfinder International (2005)

This Pathfinder International report shares successes and lessons learned from integrating youth-friendly services (YFS) into public health facilities in Tanzania. In this country young people are often prevented from accessing sexual and reproductive health (SRH) information and services, and their SRH needs often fall through the cracks of many health and development plans and programmes. Integrating YFS into existing health facilities is seen as a way of overcoming this problem. The report highlights successes arising from integration. These include: strengthened capacity for national-level coordination of YFS; provision of services to youth where existing policy does not yet stipulate support for access; development of monitoring and evaluation tools and systems; strengthened management information systems (MIS).

The report concludes that it is possible to integrate youth-friendly SRH services into public health facilities. This is contrary to the popular perspective that non-governmental organisations are always better placed to offer youth-friendly SRH services. The report recommends that the government should provide funds for scaling-up the initiative and make use of existing technical capacities to scale-up initiatives to new sites. Integration of YFS should no longer be treated as a project, but rather as a routine service that is provided by the health facilities.

Available online at:
www.pathfind.org/site/DocServer/Tanz_case_study_FINAL.pdf?docID= 5161

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25. Integration of reproductive health services for men in health and family welfare centres in Bangladesh

Including men's reproductive health in family planning services proves cost-effective in Bangladesh
Frontiers in Reproductive Health / Population Council, USA (2004)

This paper from the Population Council reports on a project in Bangladesh which integrated male reproductive health services into traditionally female-focused health and family welfare centres. Training was given to service providers on male reproductive tract infections (RTIs) and sexually transmitted infections (STIs). This involved general awareness raising, guidance on the use of behaviour change communications materials, and adopting the syndromic (clinical diagnosis) approach to delivering RTI and STI services. Findings showed that the intervention increased the number of male STI and RTI clients from one per month to five per month. The number of male clients attending the clinic for all health problems increased threefold. There was also a substantial increase in the number of female RTI and STI clients.

The paper concludes that incorporating male reproductive health services into female-focused family planning programmes does not discourage women from attending clinics, and actually increases take-up of services from both sexes. An added benefit was that service providers increased their technical knowledge about male reproductive health problems, particularly with regard to STIs and RTIs. Overall, the intervention increased usage of facilities which in turn decreased the costs of treatment, thereby enabling more effective use of resources.

Available online at:
www.popcouncil.org/pdfs/frontiers/FR_FinalReports/Bangladesh_Male%20Involvement.pdf

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26. Introducing client-centered reproductive health services in a Pakistani setting

Addressing women's barriers to accessing and using services through a client-centered approach.
Sathar, Z.; Jain, A.; RamaRao, S.; et al / Studies in Family Planning (2005)

Poor quality of existing public reproductive health services in Pakistan deters many women from using services and contributes to poor reproductive health outcomes. This paper reviews an intervention designed to improve the quality of services by training health care providers to help clients meet their needs and eliminate barriers to service access and use. The training encouraged clinic staff and community workers to become aware of clients' circumstances and to respond accordingly; to expand discussion beyond clients' immediate needs to a wider array of their reproductive health concerns; and to engage clients in discussion and negotiation regarding reproductive health-care solutions.

The paper finds that the providers who had participated in the training had significantly better interactions with clients compared with providers in the control group. However, deficiencies remain in provider's assessment of clients' needs and in helping clients to find appropriate solutions. For instance, providers do not seem to pay adequate attention to assessing a client's reproductive health needs or to providing her with enough information to encourage her to choose a solution or option on her own. The authors conclude that scaling-up the intervention can have a potentially major impact on the quality and use of reproductive health services and that the training is not prohibitively expensive.

Available online at: www.popcouncil.org/pdfs/councilarticles/sfp/SFP363Sathar.pdf

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27. Effects of the global fund on reproductive health in Ethiopia and Malawi: baseline findings

Assessing the impact of the Global Fund to Fight AIDS, tuberculosis and Malaria
Schott, W.; Stillman, K.; Bennett, S. / Partners for Health Reformplus (PHRplus) (2005)

This report by Partners for Health Reformplus, assesses the effects of the Global Fund to Fight AIDS, tuberculosis and Malaria (GF), and the activities it supports on reproductive health and family planning programmes in Ethiopia and Malawi. The paper considers the effects of the GF on policy processes, human resources, the public/private mix, pharmaceutical and commodity procurement and management with relation to reproductive health and family planning services. It finds that reproductive health players have not participated extensively in GF planning processes, and GF activities are not integrated with reproductive health, family planning, or other preventative care services.

In Ethiopia, health workers are shifting out of the public sector in search of better working conditions at non-governmental organisations, and in Malawi, there is evidence of resource shifts away from community reproductive health programmes in favour of activities related to AIDS, tuberculosis and malaria. The paper concludes that in order to bolster reproductive health and family planning services in future GF activities, reproductive health advocates and providers should make a case for integrating services for AIDS, tuberculosis and malaria with reproductive health and family planning, and become more involved in the planning process of GF activities. [adapted from author]

Available online at: www.phrplus.org/Pubs/Tech074_fin.pdf

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28. Policy issues in planning and finance: creating conditions for greater private sector participation in family planning/reproductive health: benefits for contraceptive security

Mobilising the private sector to achieve contraceptive security
Sharma, S.; Dayaratna, V. / Policy Project, Futures Group, Washington (2004)

This policy brief provides an overview of processes, strategies, and tools that developing countries can adopt to foster complementary public/private sector roles that enhance the private sector’s contribution to contraceptive security. Specifically, it examines the roles of the public and private sectors in the provision of contraceptives and condoms; and describes strategies/mechanisms used at both the policy and operational levels to mobilise the private sector. The paper outlines steps to mobilise the public and private sector to achieve contraceptive security. These are: understanding the market and policy environment; creating a policy environment conducive to private sector involvement; and balancing public/private roles in achieving contraceptive security.

The paper concludes that achieving contraceptive security in an environment of rapidly increasing demand, lagging donor support, and scarce public resources requires a comprehensive and integrated approach that finds solutions that go beyond the public sector. Within this context, stimulating private sector involvement in the contraceptive environment becomes increasingly important. It is essential that all major stakeholders, including governments, NGOs, civil society, the commercial sector, and donors, actively participate in developing and implementing a strategic plan for achieving contraceptive security. [adapted from author]

Available online at: www.policyproject.com/pubs/policyissues/PF4English.pdf

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29. The right reforms? Health sector reforms and sexual and reproductive health

Accountability, participation and good governance critical to health sector reform and sexual and reproductive health services
Sundari Ravindran, T. K.; de Pinho, H. / Initiative for Sexual & Reproductive Rights in Health Reforms (School of Public Health, University of the Witwatersrand) (2005)

This publication, from the Initiative for Sexual and Reproductive Rights in Health Reforms, pulls together available information on how health sector reform has impacted on sexual and reproductive health services (SRH), and identifies information gaps and advocacy issues. It draws on findings from Africa, Asia and Latin America on financing, public-private interaction, priority-setting, decentralisation, integration of services and accountability in health sector reform.

The authors argue that four principles need to be applied in response to the impact of neo-liberal health sector reform and to promote the provision of quality SRH services based on an equity and rights approach. These are: strengthening state legitimacy and reinforcing good governance; building political will and commitment to a discourse of equity and rights that ensure an inclusive health system; strengthening health systems through the provision of adequate resources and the capacity to manage these resources; and developing constructive accountability and participative mechanisms that facilitate meaningful involvement and advocacy from even the most vulnerable groups. The authors also highlight knowledge and research gaps that need to be addressed, including: context and actors in health sector reform and SRH services; assessing the impact of reform on health systems; and methods and tools for research. [adapted from author]

Available online at: www.wits.ac.za/whp/rightsandreforms/globalvolume.htm

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30. Promoting young people's sexual and reproductive health: stigma, discrimination and human rights

Addressing stigma and discrimination to improve young people’s sexual and reproductive health
Wood, K.; Aggleton, P. / Safe Passages to Adulthood (2004)

This document, produced by Safe Passages to Adulthood, examines the experiences of projects working to challenge stigma and discrimination and to promote human rights as they relate to young people’s sexual and reproductive health. It draws on a meeting held in 2003 in which participants from a wide variety of countries described their experiences. The document provides a background and definitions of the issues of stigma, discrimination and human rights, and presents several case studies in order to identify principles for effective practice that might inform future work.

The authors outline several lessons which emerged from the projects reviewed during the meeting. They recommend changing social norms in relation to HIV and AIDS, sexual diversity and gender, in order to address the stigma and discrimination experienced by many young people. Young people need to be involved centrally and respectfully in the design, implementation and evaluation of programmes aimed at them. Other recommendations include: creating spaces in which coalitions of marginalised groups can be developed; challenging the language of stigma and discrimination; conducting sensitive and participatory research to understand the contexts of stigma and discrimination; using a human rights framework; using the mass media and innovative methods such as theatre; recognising the diversity of young people.

Available online at: www.safepassages.soton.ac.uk/pdfs/Stigma.pdf

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