



Institute of  
**Development Studies**

**Women's sexual  
and reproductive  
health – increasing  
the evidence base**

**Hewlett/PRB 2<sup>nd</sup> Annual  
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# OUTLINE

## *Headline trends on SRH*

- Maternal health
- Contraception
- HIV
- Unsafe abortion
- Gender based violence
- Reproductive cancers
- Nutrition
- Missing “invisibles”

## *Some health sector responses*

## *Useful framings for policy influence*

## *Methodological challenges*

## **Caveats**

- Large and varied region – economy, society, culture
- Significant wealth/poverty, urban/rural differences
- Between/within countries
- Data limitations – scarcity, quality, reliability

## Headlines – maternal health

- Half the global number of maternal deaths in SSA. Increase from 205,000 to 261,000 between 1990-2005
- MMRs shockingly high in some countries
  - Chad 1,099/100,000
  - South Africa 150/100,000

### *Factors*

Poverty

High fertility

HIV infection?

Health systems failure

### *Morbidities*

Multiple morbidities for every death – near misses and chronic outcomes

Very difficult to get data on these

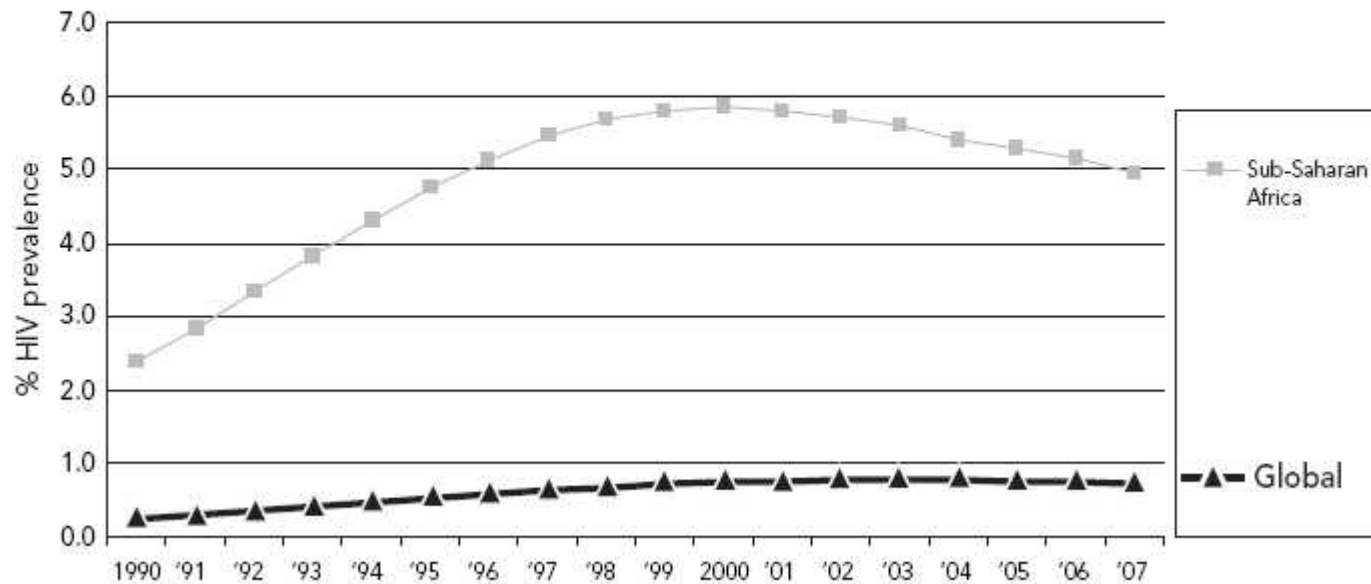
## Contraception

- High fertility compared to other regions (around 5 per woman)
- Low rate of use of modern contraceptives SSA CPR
- SSA average 27% for married women
  - LDCs average 59%
- High unmet need for contraception
  - Early age of sexual debut with very young women vulnerable to unplanned pregnancy
  - high levels of pregnancy in under 20 year olds
  - Some evidence of increase in use of condoms by young single women in 18 countries, but not for young married/cohabiting women (Cleland 2006)
  - Socio-cultural determinants of fertility change

# HIV prevalence in SSA – the latest UNAIDS update

Figure 2

Estimated adult (15–49) HIV prevalence (%) globally and in sub-Saharan Africa, 1990–2007



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# HIV and AIDS in SSA – a gendered epidemic

- Women are 61% of adults living with HIV
- South Africa sero-prevalence survey of 12,000 15-24 age group
  - Young women 15.5%
  - Young men 4.8%
- A very gendered public health crisis

## **Female adolescents reporting forced sexual initiation, as a percent of those reporting having had sex**

- Cameroon 37%
- Republic of Tanzania 29%
- South Africa 28%
- Ghana 21%
- Mozambique 19%

**Source:** Population-Based Surveys 1993-1999.

All figures cited in Jewkes, Sen, and Garcia Moreno, 2002.



## Unsafe abortion

- Recent estimates:
  - SSA 680 per 100,000
  - DCs 330 per 100,000
  - OECD 1 per 100,000
- 12% of estimated 40m unplanned pregnancies result in abortion (mostly unsafe)
- 76.7% of admissions in a major hospital in Nigeria due to unsafe abortion
- Serious morbidities include uterine perforation, chronic pelvic infection and infertility

## Gender Based Violence

*“any act of GBV that results in or is likely to result in sexual or mental harm or suffering to women, including threats of such acts as coercion or arbitrary deprivations of liberty, whether occurring in private or public life”* (UN Declaration on Elimination of Violence against Women 1993)

- A data limited area, although some small-scale studies

## Results from WHO multi-country study on intimate partner violence

<b>Place</b>	<b>Sexual violence (ever) % of informants</b>	<b>Physical violence (ever)</b>	<b>Physical violence (last 12 months)</b>
Ethiopia (province)	59	49	29
Tanzania (province)	31	47	19
Tanzania (Urban)	23	33	15

## Impact of GBV

- Increases long term risk of health problems, including drug and alcohol abuse and depression
- Unwanted pregnancies often result in unsafe abortions and injuries
- Violence an important risk factor in vulnerability to HIV

## Strategies on several fronts

- Role of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa
- Legislative reform
- Multi-sectoral approaches
- Partnerships between government and non-government agencies
- Efforts to address norms and attitudes sanctioning GBV
- Focus on young people

## Reproductive cancers

- A growing public health issue but poorly documented
- SSA has world's highest rates of cervical cancer
  - 67/100,00 Harare 1997
  - 40.8/100,000 Kampala 1997
- Prevalence of high risk types of HPV infection 18% in SSA compared to 5% in Asia and 4% in Europe
- In 1998-9, 84% of South African women diagnosed with cervical cancer were black
- Rates of breast cancer rising in some urban contexts

## Nutrition

- Important factor in pregnancy outcomes
- Cross-links with HIV infection
- From underweight malnutrition to overweight malnutrition
- WHO estimates one-third women and a quarter men overweight in SSA
- South Africa – 65% of women overweight or obese, teenage girls 25%

## The even less visibles

- Other STIs
- Infertility
- Maternal morbidities
- Sexual problems/anxieties



## Health system challenges

- Programmatic and vertical responses rather than joined up working
- Disparate funding streams, often dominated by big outside donors
- Dominance of HIV and AIDS funding over other SRH
- Ambiguous institutional positioning of SRH
- Complex challenges of integration – what to integrate and how?
- Skilled personnel shortages
- How to provide and resource services for adolescents/ young with complex SRH needs
- Filling the gaps in commodity requirement and ensuring security
- Tackling taboos around sex and sexuality
- Troubling influence of US policy (as largest SRH donor)
- Addressing the most serious violations of SRH rights (e.g. violence in conflict zones)
- Planning for future needs

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# Responses: promising technologies and services

- Effective low cost medical technologies for eclampsia and post partum hemorrhage
- Safe abortion technologies – MVA, medical abortion – offer new service modalities
- Self-diagnostics, e.g. syphilis tests
- HIV prevention technologies – microbicides, circumcision??
- Repackaging existing technologies, e.g. condoms for pregnancy prevention
- New vaccines – possible rollout of HPV vaccine
- Building on successful market based mechanisms, recognising major role of private/informal providers
- Promoting positive images of/approaches to sex and sexuality

## Responses continued

### *Human resources*

- Training new paramedic cadres for complex obstetric care
- Increased incentives for staff to work in rural areas
- Initiatives to improve provider attitudes

### *Monitoring systems*

Botswana – functioning maternity monitoring system, internal and external

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## SRH and Economic development – the broader policy challenge

*How to tackle the low priority to SRH and R to contribute to poverty reduction and economic development*

- Maputo Plan of Action for the Operationalisation of the SRH and R Continental Policy Framework (Sept 2006)
  - Integration of sexual and reproductive health (SRH) services into PHC, including nutrition and reproductive cancers
  - quality safe motherhood,
  - repositioning family planning as key to MDGs,
  - involving men in SRH
  - SRH of adolescents and youth-friendly services,
  - Addressing unsafe abortion,
  - commodity security
  - monitoring and evaluation
  - increasing domestic resource mobilisation

## Areas of action – Maputo Plan of Action

- Integration of sexual and reproductive health (SRH) services into PHC, including nutrition and reproductive cancers
- quality safe motherhood,
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## Rights framing

### *Protocol To The African Charter On Human And Peoples' Rights On The Rights Of Women In Africa*

- adopted in Maputo in July 2003, ratified in 2005 and by May 2007 has been signed up to by 21 countries.
- Creates obligations on States Parties to respect SRHR and provide services
- Another strong statement on safe abortion services

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## Supporting SRH priorities with research evidence

- Economic and social costs of poor SRH to individuals, households and economies
- Links between poverty and SRH ill-health

### *Methodological challenges*

- Dealing more creatively with data gaps and limitations
- Expanding methodological horizons – asking questions in different ways

## SRHR as a “hard to research” area

- Many conditions are source of shame, guilt due to links with sexuality - high level of “moral framing”
- Stigma very prevalent, leading to fear of disclosure
- Laws punishing the condition or its consequences
- Issues often neglected (e.g. maternal health morbidities) due to lack of policy profile and funding
- Major ethical issues entailed e.g. in gender based violence

### *Methodological consequences:*

- Under reporting (but occasionally overreporting), access and ethical issues, finding sensitive, reliable methodologies – alternatives to surveys
- “vicious circle” of lack of concern or legal impediments leading to neglect of basic data collection

### *There are also empirical consequences*

- E.g. “costs” of SRH to individuals and households intangible such as shame, stigma, secrecy etc which are both adverse for good public health and very hard to measure.



## Unsafe abortion

### *Disaggregating costs*

- Distinguishing direct versus indirect costs, real v notional costs, economic v fiscal costs
- Costs to health systems of treatment and management
- Loss of livelihood to individual, household - which welfare and productivity losses should count?
- Social costs, e.g. orphaning, stigma
- Loss to national economies (productivity, sector costs)
- Costs of implementing changes in law and providing services

## Unsafe abortion

### *Finding proxies where data and approaches are limited*

- Other health conditions which share common characteristics,
- Other ways of measuring women's non-market productivity drawn from agricultural labour market studies

### *Methods to extrapolate poverty impacts*

- Adapting existing household-level cross sectional and longitudinal data on wealth status and maternal deaths and recent methodologies developed for measuring the relationship between maternal mortality and poverty (cf IMMPACT study) for unsafe abortion-poverty links.

## Towards more methodological pluralism

- Participatory approaches can produce numbers
- Example of “Voices of the Poor”
- Adding innovative qualitative approaches to surveys

