REVIEW OF ADVOCACY NEEDS

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Literature Review On Sexual Reproductive Health And Rights, Family Planning and CAC

1.1 DEFINITIONS

Sexual and Reproductive Health Rights (SRHR)
Reproductive health and rights

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes." (Programme of Action, Paragraph 7.2)

"Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents."
(Programme of Action Paragraph 7.3)

Sexual rights

Although there is no standard definition of sexual rights, WHO has come up with the following working definition: "Sexual rights embrace human rights that are already recognized in national laws, international human rights document and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- The highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- Seek, receive and impart information related to sexuality;

1.2 INTRODUCTION

What are sexual and reproductive health rights?

Simply defined, sexual and reproductive health rights are the right for all people, regardless of age, gender and other characteristics, to make choices regarding their own sexuality and reproduction, provided that they respect the rights of others. It includes the right to access to information and services to support these choices and promote sexual and reproductive health (SRH).

SRH rights are a relatively new concept. Reproductive rights were first officially recognized at the International Conference on Population and Development (ICPD) in Cairo in 1994. Prior to this, reproductive health programming had focused on family planning, fertility control and safe motherhood, having emerged from concern about population control. The definition of SRH agreed in Cairo moved beyond this, and was notable for being broad and comprehensive, and for placing reproductive health in the context of human rights and the right to health. This included rights to sexual health, and focusing not only on problems and diseases, but on what should be positive experiences around pregnancy & parenthood, sexuality & relationships. The key outcome of the conference was a programme of action for universal access to SRH by 2015, which was agreed by 179 countries. This commitment was later reaffirmed in various other international meetings, such as the 1995 World Conference on Women in Beijing.

However, despite this international commitment, there has been slow progress towards the ICPD programme of action; there have been varying interpretations of SRH rights at ground level, and lack of resources (Resource Flows, 2006),[3] with the result that some countries have seen modest advances, while others have seen none (UNFPA 2004)[4] . There was huge disappointment in 2000 when the UN general assembly rejected inclusion of SRH in the Millennium Development Goals (MDGs) – four of the goals are related to SRH, but none explicitly address it, leaving key omissions such as violence, unsafe abortions and family planning. In addition, although the ICPD definition of reproductive rights is now generally accepted, the definition of sexual rights remains much less developed, mainly because it is a more sensitive area.

However, recently there have been signs of increasing recognition that the MDGs cannot be achieved without achieving the ICPD goal. In September 2005, world leaders at the World Summit reaffirmed

commitment to SRHR, and specifically to universal access to services And in September 2006, the UN General Assembly finally adopted the ICPD goal of universal access to SRH as a target of the MDGs as a result of advocacy by international & national NGOs. In Kenya, the focus has been on the risks of HIV and AIDS for our youth as was evident in 1999 when Kenya declared HIV/AIDS a national disaster and almost all resources were channelled towards responding to the disaster. A decade later, after a lot of successful awareness-raising on HIV/AIDS, development of sex education curriculum, and other actions the focus is swinging to a broader approach to youth development, including the pivotal issues related to sexual and reproductive health Rights (SRHR). Donors, government agencies, programs and service providers are increasingly moving towards such a holistic approach to addressing youth issues hence the need for a better coordination of the multiple SRHR youth programs being implemented by partners.

Kenya is faced with a rapidly growing population with an annual growth rate of 3% per annum[5] (2009 National Census). According to the recent Kenya Demographic and Health Survey – KDHS (2008-09) and the 2009 Census, Kenya has a broad based (pyramid shaped) population structure with 63% of the population below 25 years. Similarly, 32% of the population is aged between 10-24 years; also 41% of women and 43% of men of reproductive age (15-49) are below 25 years of age. The rapid population growth coupled with large proportion of young people in the country puts great demands on health care, education, housing, water and sanitation and employment. With inadequate attention to the SRHR needs of this age group of the population, Kenya is unlikely to achieve the Millennium Development Goals (MDG) or Vision 2030.

Youth are at a stage in their lives when they are exploring and establishing their identity in society. They need to develop life skills that prepare them to be responsible adults and socially fit in society. Due to their large population, poverty and inadequate access to health care some youth do not get an opportunity to acquire life skills and consequently involve themselves in risky behaviours that expose them to social, economic and adverse health events such as substance abuse, school dropout, crime, social unrest, unemployment, unintended pregnancy and life threatening sexually transmitted diseases and infections. A recent assessment conducted by the HIV Free Generation project in Kenya found that the top three fears of young people were unemployment, unintended pregnancy and HIV and AIDS[6]

Adolescents and youth have been perceived to have few health needs and little income to access to health services. As young people pass through puberty and adolescence, health needs related to sexual and reproductive health arise. In general the health system seems to neglect the group though all need information on reproductive health and some need specialized or targeted services. The health system should provide information on sexuality, pregnancy prevention, and prevention of HIV/AIDS and other sexually transmitted infections by providing information and skill-based approaches such as life planning that can lead to favourable reproductive health outcomes.

The negative outcomes such as unintended pregnancy, early childbirth, abortion, early marriage, sexually transmitted infections including HIV/AIDS and risky behaviours such as early sexual debut, substance abuse, sexual and gender violence, multiple sexual partners, and inadequate access to and use of contraceptives, curtail young people's ability to achieve their economic and social goals, which in turn affect the country's long-term development

[2]Source: WHO 2004, Working Definitions, www.who.int/reproductive-health/gender/sexual_health.html
[3]Resource flows project, 2006. 'Financial resources flows for population activities in 2004', UNFPA/UNAIDS/Netherlands Interdisciplinary Demographic Institute. This draft report is available at www.resourceflows.org,
[4]UNFPA, 2004. 'Investing in people: National progress in implementing the ICPD programme of action, 1994-2004. UNFPA, New York. Available online at www.unfpa.org/icpd
[5]Kenya National Bureau of Statistics (2009). National Population Census
[6]npublished HIV Free Generation presentation (2011). Creating partnership for a HIV-Free Generation in Kenya

1.3 What is universal access to SRH services?

WHO has come up with a working definition, which includes prevention, diagnosis, counselling, treatment and care services relating to:

- Antenatal, perinatal, postpartum & new-born care
- Family planning services including infertility and contraception
- Elimination of unsafe abortions,
- Prevention & treatment of STIs, HIV/AIDS, RTIs, cervical cancer etc.
- Promotion of healthy sexuality

1.4 Rights-based approach to SRH services mean?

Rights-based approaches to SRH represent a shift from policy-making based on population level rationales such as population growth, economic and environmental factors, to recognition of the needs and rights of individuals. This came about largely as a result of the women's rights movement, culminating in the Beijing conference, and consolidated by the work of other RSH-related pressure groups such as LGBT (lesbian, gay, bisexual and transgender) and treatment access groups. A rights-based approach means as well as providing to SRH services & information, paying attention to sexuality & sexual rights of different groups.

A rights-based approach also implies responsibilities: There is a requirement for the individual to behave responsibly – but this assumes they have the relevant knowledge, skills and resources to do so, which depends on responsibilities of others: researchers, health professionals, religious leaders, national governments, donor governments etc. (Shaw, 2006).[7]

1.5 Why SRHR

Although cheap, effective interventions are available for many SRH problems, according to WHO unsafe sex is the second most important risk factor leading to disability, disease or death in developing countries and the ninth most important in developed countries (Glasier, 2006).[8]

Key SRH problems include:

Maternal mortality is the leading cause of death for women of reproductive age in many developing countries, and is largely preventable. This indicator shows the widest disparity in human development between north & south. Maternal mortality is declining in some Asian countries but not in Africa (Horton, 2006).[9]

There are now almost 40 million people infected with HIV across the world, 24.7 million in sub-Saharan Africa and 7.8 in South & South-East Asia (UNAIDS, 2006).[10]

Other STIs are often the second most important cause of healthy life years lost in women in developing countries (after maternal mortality).

1.6 Overview of broad context of sexual & reproductive health & rights

SRH policy and access to services are heavily influenced, often negatively, by sociocultural and political factors in the local and national context.

1.7 Sociocultural factors

Sociocultural factors are crucial in determining the nature of sexual relationships, sexuality and sexual behaviour, and vary hugely across and within countries. Issues around sex and sexuality are taboo in most cultures, which leads to a reluctance to discuss and address sexual health issues. It also leads to stigma of those who do not conform to socially accepted norms of behaviour, for example adolescents who have sex before marriage, and men who have sex with men. This in turn reduces access to SRH services by these groups.

1.8 Gender Norms

Gender norms in most societies tend to make men

[7]Shaw D, 2006. 'Sexual and reproductive health: rights and responsibilities', Lancet, published online Nov 1. DOI:10.1016/S0140-6737(06)69487-7
[8]Glasier A, Gulmezoglu AM, Schmid GP, Moreno CG & Van Look PFA, 2006. 'Sexual and reproductive health: a matter of life and death', Lancet, published online Nov 1, DOI: 10.1016/S0140-6736(06)69478-6.

macho, women passive, making them vulnerable in different ways to SRH problems and inhibiting access to services. For example, men may take risks in their sexual relations that expose them to HIV and STIs, and may be reluctant to seek services (which are often focused on women). Women are often economically dependent on men, and have limited power to claim their SRH rights, for example through condom use. It is also often culturally unacceptable for women to express sexuality, which for example could make them unwilling to seek condoms. Violence against women has direct effects such as increased risk of STIs/HIV, as well as indirect such as fear of accessing services, requesting use of condoms (Amnesty International, 2005).[11]

Religion has had a major influence in the field of SRHR, most notably the Catholic Church. The church has led what is being described as a "backlash against human rights" and in particular sexual & reproductive rights. The Vatican's stance against contraception has compromised the promotion of condoms for STI/AIDS prevention and with significant financial power, has wielded political power and influence. And there conservative attitudes towards sexuality have led to skewed funding for sex education programmes for young people focusing on abstinence as opposed to more comprehensive approaches, particularly in Africa. Pro-life movements linked to both have hampered efforts to reduce unsafe abortions. These religious groups have used concepts of "culture" and "tradition" to oppose sexual and reproductive rights (Long, 2005).[12]

1.9 Political factors

Political factors are themselves often influenced strongly by the socio-cultural context at national & international levels. As previously mentioned, the international policy context is clear on issues of reproductive health (ICPD programme of action) (less so on sexual health). However, there is a general lack of national & international political will to act to implement international policy, especially on sensitive issues such as abortion, and services for marginalized groups and adolescents (Langer, 2006).[13] The local legal framework is also important – repressive laws can prevent people's access to services, but others can enable access when enforced (Cook 2006).[14]

In many countries systems are not in place for the population to demand accountability of the government to provide quality services, and there are limited opportunities for civil society groups to participate in policy debates. However, there are examples of where social mobilization has been successful in pushing issues onto the political agenda, and helped to achieve increased access to services, for example on issues such as HIV/AIDS, FGM.

1.10 Economic & structural factors

Lack of political will has led to a corresponding absence of financial commitment for SRH (outside of HIV) by both international donors and national governments, and a lack of funding for improved access to services leads to national governments facing competing priorities for resources.. In most developing countries, resources will be insufficient and universal access will not be achieved, leading to rationing of resources (Rosen 2005).

[9]Horton T, 2006. 'Healthy motherhood: an urgent call to action', Lancet,published online Sept 28. DOI: 10.1016/S0140-6736(06)69389-6.
[10]UNAIDS, 2006. 'AIDS epidemic update: December 2006', UNAIDS, Geneva. Available at http://www.unaids.org/en/HIV_data/epi2006/default.asp
[11]Amnesty International, 2005. 'Women, violence and health'. London. Available online at www.amnesty.org/actforwomen.
[12]Long S, 2005 'Anatomy of a backlash: Sexuality and the "cultural" war on human rights'. Human Rights Watch.
[13]Langer, 2006. 'Cairo after 12 years: successes, setbacks, and challenges'. Lancet, published online Nov 1, DOI: 10.1016/S0140-6736(06)69486-5.
[14]Cook RJ & Ngwena CG, 2006. 'Women's access to health care: the legal framework', International Journal of Gynecology & Obstetrics, 94, 216-225.

A key strategy for expanding coverage of SRH services is their integration into existing health services. Integrated services are believed to promote more efficient use of resources, and be better from the service user's perspective. For example, a recent study analysing data from 18 African countries has shown that condom use by single people is mainly motivated by contraceptive desire not as protection for HIV, highlighting the need to promoting condoms as dual protection which will require integrated FP and HIV services (Cleland, 2006).

The most important barriers to integrating services now lie in international policy, institutional & financial arrangements. This is particularly notable in the case of HIV/AIDS, and has led to an increasing divide between HIV-related services and other health services including SRH. Politically, HIV/AIDS has become the key SRH international priority, which is reflected in policy and financing: since 1994, the proportion of donor SRH funding has increased substantially for HIV/AIDS and dropped for other areas, in particular family planning (Resource Flows, 2006).

A central principle of a rights-based approach to access is that of equity. A huge challenge in attaining universal access is overcoming the existing inequity in access to services. Currently there is much evidence to suggest that although access may be increasing at a national level in some countries, access is not equal across different social groups. Poverty is a key factor excluding many from accessing services. For example, studies have found that access to a skilled birth attendant at delivery is over 3 times higher for women in the richest quintile than those in the poorest in sub-Saharan Africa, and 8 times higher in South Asia (Greene 2005).

People who in some way do not conform to societal norms, face stigma, discrimination and violence, often backed up by repressive laws. This can limit their access to services, for example for fear of persecution or abuse, or by pushing groups underground so that it is hard to access them with programmes (Berger, 2005). This is compounded by the fact that it is often hard for marginalized groups to lobby for increased access, for example in Kenya currently gay rights organization finding it difficult to operate. Adolescents on the other hand face many barriers accessing services. These include: legal barriers, for example requirements for parental consent, or age limits for providing contraception; refusal of health workers to provide services to adolescents, or judgemental attitudes which prevent adolescents from seeking services in the first place (e.g. Kenya & Zambia, Wareniu 2006).

People living with HIV/AIDS face problems in accessing appropriate services which meet their specific sexual health needs, which are rarely understood or addressed by health service providers (Guttmacher Institute). Women in particular may have to deal with pressure from their families to have or not have children, challenges in negotiating safer sex and issues around disclosure. They can also be confronted with fear and judgemental attitudes of health workers, who may pressure them to abort, be sterilized, or use contraception because they think that people with HIV should not have children due to the possibility of vertical transmission (ICS SRHR factsheet). A study in Zambia found that people with disabilities, specifically women, faces various social, attitudinal and physical barriers to accessing reproductive health services. For example, health workers may assume that people with disabilities are not sexually active and so not offer them services (Smith, 2004).

A huge challenge in supporting expanded access is finding the necessary increased resources. In addition, the resource supply must be sustainable. The private sector has often stepped in to fill the gap where government services are failing to meet demand. Private health services are sometimes preferred for SRH by clients because they are perceived to afford greater privacy, or they provide services not provided by the state (such as abortion). The private sector is also increasingly being actively engaged by governments; in what are collectively known as public-private initiatives (PPIs). Apart from meeting the unmet demand for services, it has been argued that engagement of the private sector can improve access for the poor, since wealthier people will seek private services, freeing up public resources for free services (Sharma 2005). In Ghana, for example the government provides logistical and technical support to private providers in areas with no government services, and has in this way increased access to family planning (Dmytraczenko 2003). However, there is some evidence that the opposite can happen, increasing inequity between the wealthy and the poor, both in terms of access to services and quality of treatment (Rights & Reforms,

2005).

Social marketing involves using marketing principles and techniques to "sell" products and behaviors to the target population, and has been used in many countries to expand access to products such as condoms, and services such as voluntary counselling & testing (VCT).

A key debate within SRH has been that of SRH rights vs family planning. Family planning programmes emerged from concerns about population growth, and were based on ideas about state control for future social good. By contrast, reproductive health rights are based on concepts of individual control for current quality of life. However, more recently efforts have been made to bring the two together as complementary approaches, fulfilling individual rights to fulfil greater social aims (Cleland, 2006).

With the debate now ranging of whether the state should advocate for smaller families, raises questions over whether individual rights should sometimes be sacrificed for greater good. Another example is male circumcision, which has recently been shown to be effective in reducing HIV transmission but can easily be challenged by some as compromising men's rights.
The concept of SRHR emerged from the women's movement, and has focused on women's control of their bodies and women's rights. It has unfortunately tended to place blame on men, which has alienated them rather than engaging them, and resulted in the SRH needs of men often not being addressed. The women's rights movement is still a strong player in SRHR, but there is increasingly a call for men's rights. In the middle is a gender equity approach, which aims to achieve equitable access to SRH rather focus on either women's or men's rights alone. Examples of such groups include the "Maendeleo ya Wanaume" in Kenya a rights group in Kenya advocating for male rights and the Khululeka Men's Support Group in South Africa is a group of HIV positive men working to support each other to adopt responsible lifestyles. Several issues have been described above, including unsafe abortion and violence, that are present in current debate but absent in policy and programming for various reasons. Another example is family planning, which in recent years has been largely neglected. This is partly for historical reasons – it is seen by some as irrelevant (since fertility rates have dropped in many areas), and coercive (for example China's one-child policy); and partly because HIV has taken over as the key international SRH issue (Glasier 2006, Cleland 2006).

However there is evidence of ongoing and increasing need for family planning efforts – there is a large unmet need, especially in Africa; population continues to rise (in sub-Saharan Africa the population is predicted to more than double by 2050, and even in Asia will increase by 34%; Cleland 2006); it is missing from the MDGs but would make achieving them much more feasible, for example by contributing to decreasing poverty in many countries, as well as health benefits (less safe abortion & maternal, neonatal & child mortality), and supporting environmental sustainability (Cleland 2006).

Reproductive rights, embracing certain basic human rights that are already recognized in Kenyan law and in international human rights conventions. These include the right of the youth to appropriate and relevant information and services. Denial of reproductive rights to young people negatively affects their general wellbeing.

Unsafe abortion contributes significantly to maternal morbidity and mortality. The majority of women seeking care for unsafe abortion complications are below 25 years of age. Effective advocacy and service provision to reduce the need for unsafe abortion are not adequate. The promotion of knowledge and adoption of appropriate attitudes towards abortion related issues is what has been sighted in the policy as the way to reduce discrimination and stigma. This includes correct and adequate information where adolescents are found, as well as improved access to contraceptive and post-abortion care services.

Safe motherhood aims at assisting all women to go through pregnancy and childbirth with the desired outcome of a live and healthy baby and mother. Current safe motherhood programmes include preventive and health promoting activities encompassing family planning, antenatal care, safe delivery, postpartum care and maternal nutrition. However, these services are not equitably accessible to female adolescent users in all parts of the country. At the current estimate of 590/100,000 live births; Kenya's maternal mortality rate is unacceptably high. Adolescents are more likely to suffer pregnancy related complications than older women owing to their relative immaturity as well as preventable

causes such as malnutrition, infectious diseases and haemorrhage, malaria, and inadequate health care and supportive services, particularly in rural areas.

The Family Planning Programme, started in 1967 by the Ministry of Health, has contributed considerably to the decline in fertility rates in Kenya. The TFR estimated at 8.1 in 1977/78 declined to 4.7 in 1998, but increased to 4.9 in 2003. The contraceptive prevalence rates (CPR) for all methods and modern methods were estimated in 2003 at 39 per cent and 32 per cent, respectively. Although the 2003 CPR estimate for modern methods indicates a two-fold increase since 1989, the 1998-2003 trend data reflect stagnation at 32 per cent. The Kenya Service Provision Assessment (KSPA) survey indicates that only 73 per cent of all health facilities are offering temporary methods of family planning services.

Unmet need for family planning among married women in Kenya has remained high, at about 24 per cent since 1998. On the other hand, the population projections show that the number of couples of reproductive age together with sexually active unmarried individuals in need of family planning information and services will grow by about 200,000 per annum in the 2005-2015 periods. [15]

Key challenges sighted include: wide regional and socio-economic disparities in CPR; lack of security for contraceptive commodities; lack of sustained demand creation for family planning services; relatively low community and private sector participation in family planning service provision and low involvement of males; method mix that does not permit wide method choice and cost-effectiveness; inadequate family planning training for service providers; and low level of integration of family planning with HIV/AIDS services.

The age-specific fertility rate among young women aged 15-19 and 20-24 years is 103 and 238 per 1000 women (KDHS, 2008/9)[16] respectively. Age-specific fertility in Kenya peaks at ages 20-24 years and then starts declining from age group 25-29 onwards. The median age at first birth is 19.9 years. Pregnancies and births to adolescent girls are high risk since girls are not yet fully developed physiologically to carry a pregnancy. Young girls are more likely to develop complications of pregnancy and childbirth leading to higher rates of maternal morbidity and mortality. Limited access to youth and young mother friendly MCH/FP and SRH services29[17] exacerbates the problem. Under-five mortality rate (the probability of dying between birth and the fifth birthday) is notably higher among children born to mothers below 20 years (100 deaths per 1000 live births) compared to mortality among children born to mothers 20 years and above (77 deaths per 1000 live births).

Even though contraceptive prevalence rate (CPR) has been on the rise among sexually active young women, unmet need for contraception remains high. According to the KDHS 2008-09, CPR for any modern method is 25% for sexually active women aged 15-19 years and 37% for those aged 20-24 years. Among unmarried sexually active women of the same age groups (15-19 and 20-24 years) CPR for any modern method is 23% and 59% respectively. Condoms are the most commonly used method among young people. The unmet need for family planning among currently married 15-19 and 20-24 years is 30% for both age groups, which is higher than the unmet need of 26% among all currently married women. A study conducted by Nzioka (2004)30[18]in Makueni District found that contraceptive use among adolescent girls was hampered by inaccessibility to services, fear of side effects and religious beliefs. Most girls used untested traditional methods of contraception, and they did not have skills to resist sexual advances or negotiate condom use.

A study conducted recently in Kenya Service Provision Assessment explored the general provision of services for child health, family planning, maternal and new-born care, and HIV/AIDS but did not specifically examine the provision of services to young people in spite of the increased interest in providing information and services to this age group

[15]CBS (2002). Analytical Report on Population Projections, Volume VII, Nairobi: Government Press
[16]Kenya National Bureau of Statistics and Macro International (2009). Kenya Demographic and Health Survey 2008/9
[17]Makona et al. (2008). 2008 National youth shadow report: Progress made on the 2001 UNGASS Declaration of commitment on HIV/AIDS, Kenya New York Global Action Network, Global Youth Coalition on HIV/AIDS
[18]Nzioka, C. (2004). Unwanted pregnancy and sexually transmitted infection among young women in rural Kenya. Culture and Health 6(1): 31-44

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