

Literature review on Sexual and Reproductive Health Rights: Universal Access to Services, focussing on East and Southern Africa and South Asia

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A. OVERVIEW OF THE RESEARCH

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). Various definitions of sexual and reproductive health and rights are included in Annex 1.

SRH rights are a relatively new concept. Reproductive rights were first officially recognised 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 focussing 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), with the result that some countries have seen modest advances, while others have seen none (UNFPA 2004). 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 (see Annex 2). 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.¹

¹ 'UN General Assembly adopts target', IPPF press release, 5 October 2006, available at <http://www.ippf.org/Content Controller.aspx?ID=14844>.

What is universal access?

There is no universally accepted definition of what is meant by '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 & newborn 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

What does a rights-based approach to access mean?

The current focus on rights-based approaches to SRH represents 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 SRH-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).

Why is SRHR important now?

It is recognised that the MDGs will not be achieved without improving access to SRH rights (Population Action International, 2005). 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). 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).
- 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).
- Other **STIs** are often the second most important cause of healthy life years lost in women in developing countries (after maternal mortality).

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 international context.

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.

Gender norms in most societies tend to make men macho, women passive, and transgender people marginalized – making all of 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 focussed on women). Women are often economically dependent on men, and have limited power to claim their SRH rights, for example through condom use, or determining resource use for accessing services. 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).

Many studies have documented how **traditional practices and beliefs** also affect access to services. For example, in many countries it is standard practice to seek the services of traditional healers over public health service providers, in particular for SRH issues; a study in India found that many pregnant women preferred services of a lay attendant to those of a midwife (Matthews, 2005).

Religion has had a major influence in the field of SRHR, most notably the US Christian right and the Catholic church (and to lesser extent Islam). These groups have led what is being described as a “backlash against human rights” and in particular sexual & reproductive rights (Long, 2005), and with significant financial power, have wielded political power and influence. Conservative attitudes towards sexuality have led to US government funding restrictions for services for sex workers, and a promotion of narrow sex education programmes for young people focussing on abstinence as opposed to more comprehensive approaches, particularly in Africa. The Vatican’s stance against contraception has compromised the promotion of condoms for STI/AIDS prevention, although this may be about to change.² 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).

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). 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).

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 mobilisation** 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,³ and sexuality (gay rights movement).⁴

² ‘Vatican concludes study on condoms’, IPPF News, 23 November 2006.

³ ‘South Africa: AIDS treatment gets green light’, *AfricaFocus Bulletin*, Nov 23, 2003

⁴ ‘Gay rights win in South Africa’, BBC News, 9 October 1998.

Box 2: Ideology vs evidence-based policy

Socio-cultural, religious and political factors have led to the emergence in recent years of an ideological approach to SRH which is in opposition to evidence-based policy, and which is influencing SRH rights globally.

Unsafe abortion

Unsafe abortion causes an estimated 13% of all maternal deaths globally, and 20-30% result in RTIs, many of which result in infertility (WHO 2004); an estimated 220,000 children lose their mothers each year due to unsafe abortions (Vlassoff 2004).

Practically all of these deaths are avoidable by providing women with access to legal, safe abortion. The public health arguments for promoting safe abortion, as well as provision of post-abortion treatment and care are strong – for example in South Africa, abortion-related deaths dropped by 91% from 1994 to 2001, during which period abortion was legalised and made available on request (Grimes, 2006).

However, mainly due to the influence of the US Christian right and the Vatican, abortion remains illegal or highly restricted in 72 countries, and is punishable by prison in many. The US government in 2001 reintroduced a policy stating that recipients of US family planning funds may only receive funding if they do not engage in most abortion-related activities, even with their own funds (Grimes, 2006). In Kenya this has led to the closure of 8 reproductive health clinics, leaving at least 9,000 people with little or no access to services (Access Denied, 2006).

Even in countries where abortion has been legalised, women may still not use services due to stigma, lack of services, and uncertainty about the law, for example in India (Hirve 2004 and Ganatra 2006) and Mozambique (Gallo 2004).

Abstinence-only HIV prevention

The US government is the leading bilateral international donor for HIV prevention. However, for their major HIV funding scheme, PEPFAR, 1/3 of prevention funds must go to abstinence-only programmes (Lancet editorial, 2004). Although some have defended this decision, for example using Uganda as a 'success story' based on abstinence (eg. Alonso, 2004), there is increasing and overwhelming evidence to the contrary (Slutkin 2006). Many studies have found that for HIV education to be effective it must be comprehensive, providing information on a variety of prevention strategies (including condom use) to enable people to take informed decisions (Santelli 2006). The US has been accused of being behind current changes in Uganda, involving heavy promotion of abstinence messages and restriction of condom availability (Tuncalp 2005).

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 (Resource Flows, 2006). In most developing countries, resources will be insufficient and universal access will not be achieved, leading to rationing of resources (Rosen 2005). National governments face competing priorities for resources. The impact of US funding policy changes under the current Bush administration has been felt across the world (eg. Busza 2006), although other donors have stepped in to some extent where the US has withdrawn funds (for example the UK has led the creation of a safe abortion fund)⁵.

⁵ Bosely S, 'Britain defies US with funding to boost safe abortion services', *The Guardian*, 6 February 2006. <http://politics.guardian.co.uk/development/story/0,,1703082,00.html>

Weakened health systems resulting from conflict and chronic under-investment mean there is limited government capacity to provide universal access in most developing countries. There is a lack of health infrastructure, including human resources for service provision; RSH supplies such as drugs and contraceptives are often erratic (see Sevine, 2005 for case study of Mozambique & Zimbabwe); and there is a lack of technical expertise in some areas.

Poor **communications and transport infrastructure** can be important in preventing access to services in rural areas, especially in maternal health care where transport to referral services is an essential component of dealing with emergencies and preventing mortality (Molesworth 2005).

Health sector reform: Neoliberal policies such as the structural readjustment policies promoted by the IMF and World Bank have led to increasing **privatisation** of services in some countries, and promotion of **user fees** as a strategy for sustainable financing of health services. These approaches have been seen to increase access to services in some countries, but have been demonstrated to increase inequity between the wealthier and poorer segments of the population, as the poorest are denied access to services (Raberg 2002). It has also raised issues of service quality, as the private sector has been in some places allowed to explode with relatively little regulation (see Ravindram, 2005)

Current policy & programming issues

Research has raised issues about two key aspects of achieving universal access: coverage and quality. Increasingly, issues specific to working within the framework of sexual and reproductive rights are emerging. Finally, the development of new technological and scientific advances research is providing hopes, and sparking some fears.

Expanding coverage of services

Various policy and programme initiatives have attempted to widen access to SRH health services. The following are some of the strategies that have been used and the key issues emerging.

Challenge of integrated services

A key strategy for expanding coverage of SRH services is their integration into existing health services. Integrated services (as opposed to vertical programmes such as stand-alone HIV treatment 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).

However, the category of RSH is not always clear, and can create tension when it is not clear organisationally where it fits. For example, although provision of SRH services falls mainly within the remit of health ministries, the ICPD programme of action is often monitored by women's affairs ministries. Within ministries of health, different components of SRH programmes may be included under different departments, for example maternal health is often grouped with neonatal and child health, separate from sexual health. In other cases SRH programmes are run vertically, and are not well linked in to others.

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). Targeted AIDS funding mechanisms, such as PEPFAR, the Global Fund for AIDS, TB & Malaria, and the World

Bank's MAP, encourage vertical programmes with 'quick wins' for AIDS but can have negative impacts on other programme areas and parts of health system. For example, in Malawi health workers have ceased to provide general SRH services in order to provide VCT services, and a parallel procurement system has been set up for HIV-related drugs, leading to duplication and inefficiency (Abt Associates PHR Plus, 2005).

Some attempts to overcome barriers to integration include the creation of cross-programme working groups and task forces in Zambia and Malawi which bring together key members of different departments (such as reproductive health and HIV/AIDS) to work on developing guidelines and programmes (Druce 2006).

Inequity of access to services

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).

Another major factor contributing to unequal access to services is **stigma and marginalisation**. People with alternative sexual identities, or 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 the government in Nepal has attempted to shut down the Blue Diamond Society, a gay rights organisation.⁶ Some examples of marginalised groups include:

- **Commercial sex workers** are often penalised by the law, and in India and Nepal are subject to violence and police harassment. For example in India sex workers reported frequent arrest by the police, who would then force them to have sex with them to secure their release (Amin 2004). Their illegal or stigmatised status prevents them from accessing services (Seshu 2006).
- **Injecting drug users** with HIV have reported limited access to ARV treatment programmes, mainly due to repressive laws which force them away from services or into prison (Jurgens, 2006).
- **Adolescents** 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 (eg Kenya & Zambia, Wareniu 2006)
- **Men who have sex with men** are highly stigmatised in many countries, and often face violence and restricted access to services (Greig 2006). For example, in Bangladesh they face violence from the police and the *mastan*, powerful street criminals (HRW, 2003).
- There are established communities of **transgender people** in South Asia such as the Hijra in India, but they are often stigmatised and harassed (HRW, 2003). In Cambodia, transgender people are discriminated and abused, and so are driven underground, away from SRH services (Greig 2006). Apart from in South Africa, transgender people tend to be made invisible in most African societies.
- **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

⁶ Singh KM, 'Nepal gay rights group fights possible ban', *Agence France Presse*, July 26, 2004.

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).

Sustainable financing of expanded access

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, the government provides logistical and technical support to private providers in areas with no government services, and have 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). Other concerns of involvement of the private sector are around regulation and maintaining quality control.

Social marketing involves using marketing principles and techniques to “sell” products and behaviours 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). For example, a study in Tanzania concluded that condom social marketing contributed to an increase in condom use from 15% to 43% over 3 years (Eloundou-Enyeque 2005).

Improving quality of services

Increasing coverage is often the primary aim of programmes aiming to increase access to services, but equally as important is the quality of services. This has the potential to create tension, as rapid expansion and scaling up of service provision could lead to compromised quality, which can in turn lead to poor uptake of services.

Traditionally, frameworks for assessing quality of care have focussed on biomedical outcomes, and to what extent clinical guidelines are followed. However, it is also crucial to take into account patient perspectives. In some cases patient’s and provider’s perspectives of quality are not the same – for example, women in Brazil request Caesarean sections as they see them as a modern intervention, even when they are not medically indicated (Pittrof 2000).

Working within a rights framework

Addressing access to SRH services within a rights framework has raised many challenges and debates. In particular, rights at different levels and of different groups can often conflict with each other.

Rights at different levels

Rights can be claimed and defended at many different levels – individual, couple, community, social – which can lead to tensions and trade offs.

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 aim to promote 'complete physical, mental and social wellbeing', and are based on concepts of individual control for current quality of life (ref). In the past this has caused conflict, partly due to cases in some countries (such as China and India) when family planning programmes involved coercion (Coale 1994). 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). Still, the debate sometimes re-emerges. For example, in West Africa, where population growth remains a huge problem, meeting the unmet need for FP would only bring fertility down to 4.8 (unlike in East and Southern Africa where unmet need remains high). Some are advocating for the right of states to advocate for smaller families in these circumstances, raising 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 in South Africa (Auvert 2005), but is being challenged by some as compromising men's rights.⁷

Rights of different groups

The concept of SRHR emerged from the women's movement, and has focussed 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. 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 (Robbins 2006). A project in Bangladesh aimed to integrate RSH services for men into existing women-focussed government services (NIPORT 2004)

Rights are used to defend various different standpoints. There have been instances where moral conservatives in the US and in the Catholic church have used the right to religion, or community rights to enforce morality, as a counter-argument to those defending individual sexual rights, for example of homosexuals (HRW, 2005). Women's rights and foetal rights are commonly brought in to defend each side of the debate around abortion.

Sexuality & sexual rights

Traditionally SRH programmes have problematised sex, seeing it as something that needs to be controlled in order to avoid negative consequences such as STIs, HIV and unwanted pregnancy. Positive aspects of sex and sexuality, such as pleasure and fulfilment, have been ignored. This has partly resulted from the public health perspective, but also from discomfort in seeing sex for procreation not reproduction. The concept of sexual rights brings together both aspects of sexuality, including both protection against negative aspects such as disease and discrimination, and promotion of positive aspects (see WHO definition in Annex 1). It also recognises multiple sexualities, encouraging a move away from rigid, western categorisations such as MSM (men who have sex with men) and transgender, which are seen by some to promote heterosexuality as the unchallenged norm against which 'sexual minorities' are compared (Baudh 2006).

There are potential public health benefits of addressing sexual rights in SRH programmes. For example, it has been argued that sexuality education can make people more comfortable with their bodies, and so more able to communicate wishes to others including safer sex, and to resist coercion (Ingham 2005). However, most SRH services and policies do not adequately address sexual rights. People with sexual identities different from the perceived 'norm' may be denied access to health services, and health education, and services continue to focus on negative consequences of sexuality mentioned above.

⁷ 'Male Circumcision: Is it time to act?', XVI International AIDS Conference 13-18 August 2006, Toronto, Track E session summary TUAC02, at http://www.aids2006.org/PAG/Summary.aspx?summary_id=187.

Promotion of sexual rights faces fierce opposition, in particular from religious fundamentalist groups, many of which only consider certain forms of sexuality to be acceptable – usually heterosexual and within marriage. On the other hand, there are examples of religion engaging positively, such as the ‘Coalition for Sexual and Bodily Rights in Muslim Societies’, which brings together organisations in the Middle East & South East Asia. Some SRH programmes have started to address sexuality, for example in relation to safer sex. Sexuality has been used to promote use of condoms in some settings (see Pleasure Project, 2006 for an example from Sri Lanka).

What’s new on the horizon

Science and technology clearly have a key role to play in promoting SRH (see MDGs), and recently several promising new technologies and scientific advances have been developed. There are various concerns relating to this.

There is a risk of technological solutions being seen as ‘magic bullets’ that will solve highly complex problems, when in reality they will only work effectively as part of broader, complex interventions that address contextual factors as well as biomedical ones. For example, a controversial study has found a 44% reduction in pregnancy-related mortality when women in Nepal were given Vitamin A (West, 2004), but further trials are underway to assess the effectiveness of the intervention in other settings, and it is likely that it will be most effective as part of a comprehensive strategy of skilled birth attendants and emergency obstetric care.

There have been significant efforts to develop female-controlled prevention methods for STIs and HIV. **Female condoms** have been introduced in many countries including most of Southern Africa, but have had limited supply and uptake due mainly to sociocultural factors (UNFPA & PATH 2006), although there are some examples of positive experiences (such as Zimbabwe, where high uptake was achieved through social marketing; DfID, 2006). New female condom products are being developed which may overcome some barriers to use, as well as bring down costs. Similar issues are likely to apply when **microbicides**⁸ come onto the market – several studies are currently underway to test them (McGowan 2006).

The development and promotion of new technologies has raised questions about how these advances will translate into interventions that will meet the needs and concerns of poor people at a local level (IDS 2006). Economic and political factors influence the promotion of new technologies, as opposed to local needs. A vaccine has recently been approved in the US against HPV (Human Papilloma Virus), a main cause of cervical cancer. The **HPV vaccine** is the only realistic strategy for preventing cervical cancer in developing countries where organised screening programmes are too expensive. However, the vaccine is being tested in developed countries, since that is where the market for the vaccine is expected (Dailard 2006).

Within a rights framework, new technologies can be seen to both help and hinder people to realise their SRH rights. When they are available and appropriate, technologies can help women to assert their right to control their fertility and protect their sexual health. However, women in developing countries are considered by some to be treated as passive recipients in initiatives primarily driven by commercial gain in the West where they are usually developed. They can also increase inequity where they are not available to all, for example due to cost (AWID 2004).

⁸ Microbicides are compounds that can be applied topically to prevent the sexual transmission of HIV and other STIs. Various products are under development including creams, gels and sponges. See http://www.global-campaign.org/about_microbicides.htm.

Other examples of new technologies being promoted or under development include: an AIDS vaccine,⁹ male contraceptives (Amory 2006), and misoprostol for prevention of post-partum haemorrhage (Derman 2006).

Neglected issues

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 unsafe abortion & maternal, neonatal & child mortality), and supporting environmental sustainability (Cleland 2006).

Other issues are largely absent from both policy and debate for various reasons. Issues such as **pelvic pain** (Latthe 2006), urinary and faecal **incontinence**, **menstruation problems** including dysmenorrhoea (for example in India, see Patel 2006) and absence of facilities for girls, and **infertility** are important issues affecting women's lives but are not prioritised by health programmes & policy (Glasier et al). Similarly **mental health** problems can be closely related to SRH (such as post-natal depression) and affect many women, but mental health services are often absent or not linked to SRH services (Patel, 1999).

Menstrual regulation involves vacuum extraction of contents of uterus without confirming pregnancy status; it is not legally classified as abortion since pregnancy status is unknown. It is used in some countries to circumvent abortion laws, and legal in Bangladesh (where abortion is illegal).¹⁰ Although it started to be used in the early 70s in the US, it is little talked about in policy and programming today. Emergency contraception is another intervention that has long been proven effective but is not much promoted, mainly for ideological reasons (Bergman, 2004).

In maternal health, there has been a focus on maternal mortality (eg. MDGs), neglecting **maternal morbidity**, which contributes hugely to women's ill health world wide. The focus on maternal mortality has also been prioritised over **perinatal mortality**, which is only recently coming to the forefront as a key public health issue (Martines, 2005), for example with the recently created Partnership for Maternal, Newborn and Child Health. This recent recognition raises challenges for service provision, since maternal health interventions are largely curative, while community-based prevention interventions can be effective in improving perinatal health. An example of this is training traditional birth attendants, which is generally agreed to be ineffective in reducing maternal mortality, but could be effective in reducing neonatal mortality, as well as improving maternal health and increasing communities' confidence in health services.

⁹ See for example the website of the International AIDS Vaccine Initiative, <http://www.iavi.org/>, for details of ongoing trials.

¹⁰ Henshaw SKm Singh S & Haas T, 1999. 'The incidence of abortion worldwide', *International Family Planning Perspectives*, 25(Supplement):S30–S38

B. SEXUAL AND REPRODUCTIVE HEALTH RIGHTS ANNOTATED BIBLIOGRAPHY

General (SRH rights and access to services)

Shaw D, 2006. 'Sexual and reproductive health: rights and responsibilities', *Lancet*, published online Nov 1. DOI:10.1016/S0140-6737(06)69487-7

This article considers at the role of SRH rights in addressing public health problems relating to sexual & reproductive health.

Jolly S & Cornwall A, 2006. 'Sexual and reproductive health and rights', *IDS Health & Development Information Team*, Brighton. Available online at www.eldis.org/health/srhr/

Long S, 2005 'Anatomy of a backlash: Sexuality and the "cultural" war on human rights'. *Human Rights Watch*.

This essay highlights the growing alliance of conservative forces which is threatening progress in defending sexual rights and sexual freedom, in particular the right to express homosexual orientation. It cites examples from various countries including India, Zimbabwe and Namibia.

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.

This paper reviews current evidence demonstrating the global impact of SRH problems, and some of the causes behind them including gender and the influence of ideological groups.

UN Millennium Project (2006) 'Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals'

http://www.unmillenniumproject.org/documents/MP_Sexual_Health_screen-final.pdf

This report critically analyses progress towards achieving universal access to SRH rights, and highlights their link with the MDGs. It also discusses the policies, interventions and investments needed to ensure access to SRH rights.

Bergman Y (editor), 2004. 'Breaking through: A guide to sexual and reproductive health and rights', *Swedish Association for Sexuality Education*, Stockholm.

This guide is a good introduction to the ICPD and the debates and controversies that surrounded it, in particular those around reproductive rights and abortion.

Coale AJ & Bannister J, 1994. 'Five decades of missing females in China', *Demography*, 31(3):459-79.

This study analyses census and fertility data from China, noting the shortage of females in relation to males, and attributing this to sex-selective abortion.

International policy

UN, 1995. 'Report of the International Conference on Population and Development, Cairo, 5-13 September 1994', *UN*, New York.

This is the report of the ICPD 1994 conference, and includes the Programme of Action, which includes definitions of reproductive health and access to services.

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

Provides context on ICPD and related international agreements. Reports on progress towards ICPD based on a survey conducted with 151 countries. Referring to MDGs, puts positive spin on the fact that there is no specific goal or target on reproductive health. Describes what measures have been taken to improve various aspects of access to SRH services.

Resource flows project, 2006. 'Financial resources flows for population activities in 2004', UNFPA/UNAIDS/Netherlands Interdisciplinary Demographic Institute.

The Resource Flows Project is monitoring how much funding is going to the population activities in the ICPD programme of action, and how and where (by region) the money is being spent. This draft report is available at www.resourceflows.org, and the full report will be published in late 2006, complete with updated figures from 2005.

Langer, 2006. 'Cairo after 12 years: successes, setbacks, and challenges'. Lancet, published online Nov 1, DOI: 10.1016/S0140-6736(06)69486-5.

Population Action International, 2005. 'How access to sexual & reproductive health services is key to the MDGs', PAI, Washington DC.

This factsheet explains clearly and concisely why universal access to SRH services is essential to achieving the MDGs. It starts with an overview, then focuses on four of the goal: Eradication of poverty & hunger, Promotion of gender equality & empowerment of women, Combating HIV/AIDS, malaria & other diseases, and Ensuring environmental sustainability.

Simwaka B, Theobald S, Amekudzi YP & Tolhurst R, 2005. 'Meeting millennium development goals 3 and 5: Gender equality needs to be put on the African agenda', British Medical Journal, 331, 708-709.

This editorial highlights the links between reducing maternal mortality (Goal 5) and promoting gender equality (Goal 3), and how increasing access to SRH services is essential for both.

CHANGE, 2004. 'Debunking the myths in the US global AIDS strategy: an evidence-based analysis'. CHANGE.

Analyses the US Global AIDS Strategy, according to it's own stated objectives, in particular is it following evidence-based approaches? Does it promote equitable access to information and services? Resounding 'no' – eg. counters the claim that Uganda's success in controlling HIV is due to abstinence-only approaches.

Contextual factors affecting RSH rights

Amnesty International, 2005. 'Women, violence and health'. London. Available online at www.amnesty.org/actforwomen.

This report reviews different forms of violence and the consequences they can have on women's health, based on reports and studies from across the world.

Gyimah SO, Takyi BK & Addai I, 2006. 'Challenges to the reproductive-health needs of African women: on religion and maternal health utilization in Ghana', Social Science & Medicine, 62, 2930-2944.

Quantitative analysis of DHS data looks at association between religion and maternal health service utilisation in Ghana. A conceptual framework is presented which describes how traditional and religious beliefs can affect women's use of maternal health services.

Cook RJ & Ngwena CG, 2006. 'Women's access to health care: the legal framework', International Journal of Gynecology & Obstetrics, 94, 216-225.

Provides overview of how legal context affects women's access to health care, and suggests three key guiding principles: that laws should require care to be evidence-based; clear and transparent; and fair.

Sevene E, Lewin S, Mariano A, Woelk G, Oxman AD, Matinhure S, Cliff J, Gernandes B & Daniels K, 2005. 'System and market failures: the unavailability of magnesium sulphate for the treatment of eclampsia and pre-eclampsia in Mozambique and Zimbabwe', British Medical Journal; 331, 765-769.

This paper describes problems with the registration, approval, acquisition and distribution of magnesium sulphate, a cheap and efficient drug for treating and preventing eclampsia and pre-

eclampsia, important causes of maternal and infant mortality and morbidity. It is based on qualitative data collected in **Mozambique** and Zimbabwe and review of policies.

Molesworth K, 2005. 'The impact of transport provision on direct and proximate determinants of access to health services', *Swiss Tropical Institute*

This paper reviews research on the link between availability of transport and access to health services, and looks particularly at barriers faced by women in accessing emergency obstetric care. A case study looks at the impact of improved transport facilities on access to health services. Available at: <http://www.ifrtd.gn.apc.org/new/issues/Molesworth2005.doc>

Bruce N, Dickinson C, Attawell K, White AC & Standing H, 2006. 'Strengthening linkages for sexual and reproductive health, HIV and AIDS: progress, barriers and opportunities for scaling up', *DfID Health Resource Centre, London.*

A critical look at the integration of SRH and HIV services, and the role of international financing, policy and institutional arrangements in inhibiting integration. Includes a case study of Kenya.

Raberg M & Jeene H, 2002. 'Selling out rights: How policy affects access to health services in East and Central Africa', *Save the Children UK, London.*

*This policy document describes how cost-recovery mechanisms (such as user fees) can deny access to health care for the poorest, based on field experiences from **Tanzania, Uganda** and other African countries.*

Ravindran STK & de Pinho H (eds), 2005. 'The right reforms? Health sector reforms and sexual and reproductive health', *Women's Health Project, University of the Witwatersrand, South Africa.*

This book looks in depth at how health sector reform has impacted on SRH services, drawing on research from Africa, Asia and Latin America on financing, public-private interactions, priority-setting, decentralisation, integration of services and accountability in health sector reform.

Nanda P, 2002. 'Gender dimensions of user fees: implications for women's utilization of health care', *Reproductive Health Matters*, 10(20), 127-134.

*This paper looks at how user fees can limit women's access to health services and increase inequity in access, based on a review of studies in various African countries including **Uganda, Swaziland, Kenya** and **Tanzania**.*

Maternal health & mortality

Horton T, 2006. 'Healthy motherhood: an urgent call to action', *Lancet*, published online Sept 28. DOI:10.1016/S0140-6736(06)69389-6.

*This article introduces the *Lancet* series on maternal survival, commenting on the lack of progress in reducing maternal mortality in developing countries, and calling for action, in particular to address human resource issues.*

West KP Jr, 2004. 'Vitamin A deficiency as a preventable cause of maternal mortality in undernourished societies: plausibility and next steps', *International Journal of Gynaecology & Obstetrics*, 85 Suppl 1:S24-7.

This article discusses evidence from Nepal suggesting that Vitamin A supplementation could play a role in reducing maternal mortality, and challenges and opportunities in implementing such an intervention.

Campbell OMR & Graham WJ, 2006. 'Strategies for reducing maternal mortality: getting on with what works', *Lancet*, published online Sept 28, DOI:10.1016/S0140-6736(06)69381-1.

This paper describes interventions for reducing maternal mortality and their evidence base, although it notes that the evidence is not considered strong by some since experimental study designs are rarely used.

Costello A, Azad K & Barnett S, 2006. 'An alternative strategy to reduce maternal mortality', *Lancet*, 368, 1477-1479.

The authors argue against the prevailing exclusive focus on increasing access to skilled birth attendants to reduce maternal mortality, using evidence to support community-based strategies such as Vitamin A supplementation, work with women's groups, and support to traditional birth attendants.

HIV/AIDS

UNAIDS, 2006. 'AIDS epidemic update: December 2006', *UNAIDS*, Geneva. Available at http://www.unaids.org/en/HIV_data/epi2006/default.asp

This document provides up-to-date statistics on the HIV epidemic across the globe, including regional data and analysis.

Auvert B, Taljaard D, Lagarde E, Sobngwi-Tambekou JI, Sitta R & Puren A, 2005. Randomized, Controlled Intervention Trial of Male Circumcision for Reduction of HIV Infection Risk: The ANRS 1265 Trial', *PLoS Med* 2(11): e298.

This randomised control trial found a 60% reduction in HIV incidence in men who had been circumcised.

Unsafe abortion

Grimes DA, Benson J, Singh S, Romero M, Ganatra B, Okonofua F & Shah I, 2006. 'Unsafe abortion: the preventable pandemic', *Lancet*, published online Nov 1. DOI: 10.1016/S0140-6736(06)69481-6.

Comprehensive review of unsafe abortion, including prevalence, methods, consequences, legal aspects, cost, and prevention. It makes a clear and compelling case for urgent action based on public health and human rights grounds.

World Health Organization, 2004. 'Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000'. *WHO*, 4th edition. Geneva, Switzerland.

Describes and quantifies mortality & morbidity associated with unsafe abortion

Hessine L, 2005. 'Global progress in abortion advocacy and policy: an assessment of the decade since ICPD'. *Reproductive Health Matters*, 13, 88-100.

Advocacy efforts to increase access to unsafe abortion including examples from Mozambique, Kenya, Uganda.

Hirve SS, 2004. 'Abortion law, policy and services in India: a critical review'. *Reproductive Health Matters*, 12, 114-121.

Describes the lack of access to abortion services in India.

Ganatra B, Hirve s, 2006. 'Unsafe abortion in South and South-East Asia: a review of the evidence. In: Warriner IK, Shah IH, eds., 'Preventing unsafe abortion and its consequences: priorities for research and action';. *Guttmacher Institute*, New York. Pp. 151-186.

Describes barriers to seeking safe abortion in Asia.

Gallo MF, Gevreselassie H, Victorino MT, Dgedge M, Jamisse L & Bique C, 2004. 'An assessment of abortion services in public health facilities in Mozambique: women's and providers' perspectives', *Reproductive Health Matters*, 12, 218-226.

Provides an example of confidentiality fears driving Mozambican women to unsafe abortion providers.

Vlassoff M, Singh S, Darroch JE, Carbone E & Bernstein S, 2004. 'Assessing costs and benefits of sexual and reproductive health interventions. *The Alan Guttmacher Institute*, Occasional report No. 11, New York.

Describes and quantifies the direct and indirect effects of unsafe abortion globally.

Abstinence for HIV prevention

Anonymous, 2004. 'Is it churlish to criticise Bush over his spending on AIDS?', editorial, *Lancet*, 364, 303-304.

Alonso A & De Irala J, 2004. 'Strategies for HIV prevention: the A-B-C approach', correspondence, *Lancet*, 364, 1033.
Response to the editorial above defending the USG position.

Santelli J, Ott MA, Lyon M, Rogers J, Summers D & Schleifer R, 2006. 'Abstinence and abstinence-only education: a review of US policies and programmes', *Journal of Adolescent Health*, 38, 72-81.

This paper reviews the literature on the effectiveness of abstinence policies and programmes, concluding that the evidence points to them not being effective in promoting positive sexual behaviour outcomes for young people.

Muula AS, 2006. 'Condom and sexual abstinence talk in the Malawi National Assembly', *African Health Sciences*, 6(1), 21-26.

The researcher has analysed comments made by members of parliament in Malawi about condoms. Reveals negatives attitudes and resistance to promotion of condoms for HIV prevention.

Inequity & Marginalised groups

Green ME & Merrick T, 2005. 'Poverty reduction: Does reproductive health matter?', HNP discussion paper, *World Bank*, Washington DC.

Examines the bi-directional link between poverty and reproductive health, including regional data for access to selected reproductive health services by wealth quintile.

Sheshu M, 2003. 'Absence of rights for women in prostitution in India: a major obstacle to improving their health', *Research for Sex Work*, 6, 27-28.

This article is based on project experiences in India, and looks at how the stigmatisation of sex workers in India and other denials of their rights negatively affects their access to health care.

Warenius LU, Faxelid EA, Chishimba PN, Musandu JO, Ong'any AA & Nissen EB-M, 2006. 'Nurse-Midwives' attitudes towards adolescent sexual and reproductive health needs in Kenya and Zambia', *Reproductive Health Matters*, 14(27), 119-128.

This study used a questionnaire to find out about health workers' attitudes towards adolescent SRH problems. It found that they were in general disapproving of adolescent sexual activity, in particular if they had not received training in providing adolescent-friendly services.

Greig A, 2006. 'Sex and the rights of man', in 'Sexuality Matters', eds. Cornwall A & Jolly S, *IDS Bulletin*, 37(5), 84-88.

Discussion paper on men's sexual rights. Describes how sexual rights have in the past tended to be framed around women's rights and argues that men's rights need to take into account hierarchies within the category of 'men', such as MSM who are in many settings denied their rights in similar ways that women are.

Samelius L & Wagberg E, 2005. 'Sexual orientation and gender identity issues in international development: A study of policy and administration', *SIDA*,

This report of the Swedish International Development Cooperation Agency, analyses the extent to which SIDA programmes address LGBT issues. It includes situation analysis of LGBT issues in India and South Africa, as well as annexes including useful background information and definitions of LGBT and intersex people.

Jurgens R & Cohen J, 2006. 'Human rights and HIV/AIDS: Now more than ever. 10 reasons why human rights should occupy the centre of the global AIDS struggle', *Open Society Institute*.

This paper highlights human rights issues relating to the AIDS epidemic, including the rights aspects of universal access to treatment.

IPPF & Global Network of People Living with HIV/AIDS, 2005. 'Fulfilling Fatherhood: experiences from HIV positive fathers', *International Planned Parenthood Federation, London*.

This report uses case studies from countries including Uganda, Kenya, South Africa, Sri Lanka and Nepal to highlight the positive role that HIV positive men can play as fathers.

Financing

Sharma S & Dayaratna V, 2005. 'Creating conditions for greater private sector participation in contraceptive security', *Health Policy*, 71, 347-357.

This paper advocates for an increased role of the private sector in ensuring adequate contraception supplies, and outlines ways in which this could be achieved.

Tania Dmytraczenko, Vijay Rao, and Lori Ashford, 2003. Health sector reform: how it affects reproductive health, *Population Reference Bureau, Washington DC*.

This policy brief provides a useful summary of the key aspects of health sector reform, including health financing strategies, and how they relate to reproductive health.

Quality of care

Pittrof R & Campbell O, 2000. 'Quality of maternity care: Silver bullet or red herring?', *London School of Hygiene & Tropical Medicine*.

Attempts to clarify and bring together various definitions of Quality of Care, with a focus on maternal health, including patient perspectives.

Sexuality

Berger J, 2004. 'Re-sexualizing the epidemic: Desire, risk and HIV prevention', *Development Update*, 5(3), 45-67, Johannesburg.

Paper arguing that there is a tendency to over-simplify the drivers of the AIDS epidemic, ignoring the diversity of sexual expression. Argues that HIV prevention programmes need to pay more attention to sex and desire, and that more needs to be done to address the barriers to access to HIV prevention services faced by groups that are marginalized due to their sexuality. Focuses on sub-Saharan Africa. Available at http://www.sarpn.org.za/documents/d0001195/2-Re-sexualising_the_Epidemic-Jonathan_Berger.pdf

Ilkkaracan P & Jolly S, 2007. 'Gender and sexuality: Overview report', BRIDGE Cutting Edge Pack, IDS, Brighton.

Highlights why gender and sexuality is an important issue for policy-makers in all areas of development, and looks at initiatives that have challenged existing norms.

Esplen E, 2007. 'Gender and sexuality: Supporting resources collection', BRIDGE Cutting Edge Pack, IDS, Brighton.

*Includes resources and case-studies, such as a project in **Zambia** training men as peer educators, and examples of political activism by lesbian, gay, bisexual, transgender and intersex groups in **Uganda, Zambia and Kenya**.*

Lane, T., Pettifor, A., Fiamma, A. & Rees. H. 2004a. Anal sex as a risk factor for HIV infection among young people aged 15-24 in South Africa: Data from a nationally representative household survey. Oral presentation, XV International AIDS Conference, abstract no.

LbOrC21, available online at

http://www.iasociety.org/abstract/show.asp?abstract_id=2175045

Results from this survey study suggest that condom use is lower for anal sex than vaginal sex, suggesting that by ignoring heterosexual anal sex, HIV prevention messages may be giving the false impression that anal sex is safer than vaginal sex.

Ingham R, 2005. “We didn’t cover that at school”: Education against pleasure or education for pleasure?’, *Sex Education*, 5(4), 375-388.

A review of the criteria used to evaluate school sex education interventions (mainly in the UK), noting that they focus exclusively on reduction of negative biomedical outcomes, and do not acknowledge the role that pleasure has in motivating people to have sex and could have in promoting safer sex. Uses the example of concerns about semen loss in India to illustrate how addressing pleasure (for example, masturbation) could promote sexual health.

Scott-Sheldon LAJ & Johnson BT, 2006. ‘Eroticizing creates safer sex: A research synthesis’, *Journal of Primary Prevention*, 27(6), 619-640.

“This meta-analytic review examined the effectiveness of sexual risk reduction interventions in 21 studies (N=5,015) that integrated a safer sex eroticization component. Compared to controls, intervention participants exhibited lower sexual risk on 6 dimensions: HIV-related knowledge, attitudes toward condoms, condom use, overall behavioral risk, communication with sexual partners, and sexual frequency. Additional analyses examined pre- to post-test outcomes and showed significant improvement in condom use in the intervention compared to the control groups. Overall, findings suggest that eroticizing safer sex leads to more risk-preventive attitudes, which in turn facilitates less risky sexual behavior.”

The Pleasure Project, 2004. ‘Global mapping of pleasure’, available at www.the-pleasure-project.org

*A resource including over 30 case-studies of projects and research that address sexual rights through focussing on pleasure. Includes a case study of a project in **Mozambique** which works with churches to improve couples’ sex lives, so decreasing partner infidelity; and others from South Africa, Kenya, India and Bangladesh.*

New technologies

IDS, 2006. ‘Science and Citizens: Global and Local Voices’, policy briefing, *IDS*, Brighton.

This policy briefing asks how scientific and technological advances – often played out on a global or corporate stage – can translate into innovations that will meet the needs of poor people at the local level. It includes a case study of South Africa’s Treatment Action Campaign, which has successfully engaged with government and drug companies to expand access to HIV treatment services.

PATH & UNFPA, 2006. ‘Female condom: a powerful tool for protection’, *UNFPA*, PATH, Seattle.

This review describes the unfulfilled potential role that female condoms can play in promoting sexual & reproductive health, and makes recommendations for scaling-up access.

DfID, 2006. ‘How Zimbabwe’s hairdressers are cutting HIV infection’, *DfID*,

<http://www.dfid.gov.uk/casestudies/files/africa/zim-hair.asp>.

This case study describes an innovative approach to condom promotion – social marketing of female condoms through hair salons.

McGowan I, 2006. ‘Microbicides: a new frontier in HIV prevention’, *Biologicals*, 34(4), 341-255.

Provides and overview of the development of microbicides and trials that are underway.

Amory JK, Page ST & Bremner W, 2006. ‘Drug insight: recent advances in male hormonal contraception’, *Nature Clinical Practice Endocrinology & Metabolism*, 2(1), 32-41.

This article reviews the current status of development of male hormonal contraceptive methods.

Derman RJ, Kodkany BS, Goudar SS, Geller SE, Naik VA, Belland MB, Patted SS, Patel A, Eldavitch SA, Hartwell T, Chakraborty H & Moss N, 2006. 'Oral misoprostol in preventing postpartum haemorrhage in resource-poor communities: a randomised controlled trial', *Lancet*, 368(9543):1216-8.

This is the report of a randomised controlled trial looking into the effect of misoprostol in preventing postpartum haemorrhage in rural India. The study found the drug to be effective in reducing PPH, and therefore recommends it as a strategy for reducing maternal mortality in resource-poor settings.

Neglected issues

Latthe P, Latthe M, Say L, Gulmezoglu M & Khan KS, 2006. 'WHO systematic review of prevalence of chronic pelvic pain: a neglected reproductive health morbidity', *BMC Public Health*, available online at www.biomedcentral.com/1471-2458/6/177.

A literature review that finds a high burden of pelvic pain, and highlights the need for more reliable research in this area.

Patel V & Oomman N, 1999. 'Mental health matters too: gynaecological symptoms and depression in South Asia', *Reproductive Health Matters*, 7(14), 30-8

Cleland J & Ali MM, 2006. 'Sexual abstinence, contraception, and condom use by young African women: a secondary analysis of survey data', *Lancet*, 368(9549), 1788-93.

Data was analysed from studies in 18 countries in sub-Saharan Africa to assess trends in abstinence, contraceptive use and condom use in women. Condom use rose significantly in most countries, and over half of women reported using condoms primarily for pregnancy prevention.

Country-specific research:

India

Matthews Z, Ramakrishna J, Mahendra S, Kilaru A, Ganapathy S, 2005. 'Birth rights and rituals in rural south India: care seeking in the intrapartum period', *Journal of Biosocial Science*, 37(4), 385-411.

This study involved surveys with women before and after birth, to collect information about women's health seeking decisions as their pregnancies unfolded.

Amin A, 2004. 'Risk, Morality, and Blame: A Critical Analysis of Government and U.S. Donor Responses to HIV Infections Among Sex Workers in India', *CHANGE*, Tahoma Park (USA).

The aim of this research was to assess the extent to which programmes targeting sex workers were effective at reaching them and addressing their concerns and vulnerabilities. The report, based on analysis of secondary data as well as collection of qualitative data from sex workers and service providers, raises many issues that need to be taken into consideration when targeting services for this group.

Hazra A, 2006. 'Enhancing sensuality for safer sex among men in India', in 'Sexuality Matters', eds. Cornwall A & Jolly S, *IDS Bulletin*, 37(5), 98-104.

Suggests ways of using sensuality in promoting safer sex, based on research experiences in West Bengal.

Mahendra VS, Sharma V, Gilborn L, George B, Samson L, Mudoi R, Jadav S, Gupta I, Bharat S, & Daly C, 'Reducing AIDS-related stigma and discrimination in Indian hospitals', *Horizons Final Report*. New Delhi: Population Council.

This study assessed the impact of a training programme to address AIDS-related stigma and discrimination in state and private hospitals in New Delhi. Questionnaires were used to assess health worker knowledge and attitudes, and results showed that stigmatising attitudes decreased

after training. Includes useful insight into how people with HIV/AIDS experience discrimination in hospital settings, including data from qualitative interviews that were conducted to design the training programme.

Prasad JH, Abraham S, Kurz KN, George V, Lalitha MK, John R, Jayapaul MNR, Shetty N & Joseph A, 2005. 'Reproductive Tract Infections Among Young Married Women in Tamil Nadu, India', *International Family Planning Perspectives* 31(2).

This study involved qualitative and quantitative interviewing of women to determine RTI rates and treatment seeking behaviour. It found that although RTIs were common, women rarely sought treatment due to stigma and lack of knowledge about RTIs.

Patel V, Tanksale V, Sahasrabhojane M, Gupte S & Nevrekar P, 2006. The burden and determinants of dysmenorrhoea: a population-based survey of 2262 women in Goa, India', *British Journal of Obstetrics & Gynaecology*, 113(4), 453-463.

This cross-sectional (survey) study found that more than half of women interviewed in Goa had experienced loss of menstruation, and that it was associated with other complaints such as violence and pelvic pain.

Bangladesh

Rashid SF, 2006. 'Small powers, little choice: contextualising reproductive and sexual rights in slums in Bangladesh', in 'Sexuality Matters', eds. Cornwall A & Jolly S, *IDS Bulletin*, 37(5), 69-75.

Description of factors that shape young women's sexual and reproductive health experiences, based on ethnographic research carried out in a slum in Dhaka, Bangladesh.

Human Rights Watch, 2003. 'Ravaging the vulnerable: Abuses against persons at high risk of HIV infection in Bangladesh', *HRW reports*, 15 (6C), New York.

This report is based on in-depth interviews with members of vulnerable groups (female sex workers, men who have sex with men and drug users), as well as key informants from NGOs, government etc. It describes the violence and discrimination faced by these groups, and how this interferes with HIV interventions. It includes many case studies of individuals from the three groups.

Khan SI, Hudson-Rodd N, Siggers S, Bhuiyan MI & Chuiya A, 2004. 'Rethinking Condom Use in the AIDS Era', *Sexual Health*" 1(4) 217-225.

This study in Bangladesh investigated the reasons for low condom use by men. Many cultural and psychological reasons were identified, and the authors conclude that the social dimensions of male sexuality, pleasure, eroticism and emotions have to be addressed for effective condom promotion.

Rob, Ubaidur, Sharif Mohammed Ismail Hossain, M.E. Khan, Ahmed Al-Sabir, and Mohammed Ahsanul Alam. 2004. "Integration of reproductive health services for men in health and family welfare centers in Bangladesh," *FRONTIERS Final Report*. Washington, DC: Population Council.

This 2-year study was designed to test the feasibility, acceptability, and impact of adding reproductive health services for men at rural Health and Family Welfare Centers (HFWCs), which are normally women-focussed. It compared 8 intervention sites with 4 control sites, and found increased uptake of services by both men and women. However, it found that the majority of men still did not seek STI services from a formal provider due to stigma, and that service quality was compromised by insufficient medicines and supplies.

Nepal

Borghi J, Thapa B, Osrin D, Jan S, Morrison J, Tamang S, Shrestha BP, Wade A, Manandhar DS, Costello AM (2005). Economic assessment of a women's group intervention to improve birth outcomes in rural Nepal. *Lancet* 366 (9500): 1882-4.

This cost-effectiveness study, linked to a randomised controlled trial, illustrated the feasibility of using community-level interventions to improve neonatal health.

Access Denied. (2006) *The Impact of the Global Gag Rule in Nepal.*

http://www.globalgagrule.org/pdfs/case_studies/GGRcase_nepal.pdf

This report highlights the impact of the Global Gag Rule in Nepal, in particular how it conflicts with the Nepalese government's attempts to address unsafe abortion having legalised abortion.

Pakistan

Sathar Z, Jain A, RamaRao S, ul Haque M, & Kim J, 2005. "Introducing client-centered reproductive health services in a Pakistani setting," *Studies in Family Planning* 36(3): 221–234.

This intervention study aimed to increase access to RH services by increasing their acceptability and quality, providing integrated services that recognised and addressed gender-related barriers to women seeking health care. Two intervention sites were compared with two control sites, through interviews with service providers and clients, observation of provider-client interactions, and inventories of services offered, staff and other resources available. Although quality of care was found to decline in both groups, the decline was less in the intervention group, leading the authors to conclude a positive effect.

Fikree FF, Saleem S & Sami N, 2005. "A quality of care issue: Appropriate use and efficacy knowledge of five contraceptive methods: Views of men and women living in low socioeconomic settlements of Karachi, Pakistan," *Journal of Pakistan Medical Association* 55(9): 363–368

A survey was conducted with married men and women in Karachi to determine their knowledge and use of contraception. It found that although general knowledge of FP methods was high, knowledge of correct use was low, and recommended that family planning programmes should aim to increase knowledge as well as focus on service provision.

Zambia

Denison JA, Lungu N, Dunnett-Dagg WA, McCauley A & Sweat MD, 2006. "Social relationships and adolescents' HIV counseling and testing decisions in Zambia," *Horizons Research Summary*. Washington, DC: Population Council.

Report of a study involving qualitative research with adolescents and a household survey, looking at factors influencing adolescent's decisions to seek HIV voluntary counselling and testing services. The study found that access to services was limited by fear of stigma, but that a supportive family environment led to increased access. It also found that adolescents who tested HIV positive were not accessing post-test care and support services (though reasons for this were not given).

Access Denied, 2006. 'The Impact of the Global Gag Rule in Zambia',

http://www.globalgagrule.org/pdfs/case_studies/GGRcase_Zambia_2006.pdf

This report describes the impact of the Global Gag Rule on abortion on the Planned Parenthood Association of Zambia and its service provision

Smith E, Murray SF, Yousafzai AK & Kasonka L, 2004. 'Barriers to accessing safe motherhood and reproductive health services: the situation of women with disabilities in Lusaka, Zambia', *Disability & Rehabilitation*, 26(2), 121-127.

In-depth interviews were carried out with women with disabilities and with service providers, revealing significant social, attitudinal and physical barriers to women with disabilities accessing services.

Kenya

Onyango-Ouma W, Birungi H & Geibel S, 2005. 'Understanding the HIV/STI risks and prevention needs of men who have sex with men in Nairobi, Kenya', *Horizons Final Report*. Washington, D.C.: Population Council.

This descriptive study used qualitative interviews, a survey and ethnographic observation to investigate the sexual health needs of MSM in Nairobi. It found that although many of the men were accessing services such as VCT and STI treatment, services were not appropriate since providers they did not discuss treatment and prevention issues relevant to MSM, and men did not feel able to ask for advice due to fears of stigma, lack of confidentiality, and the fact that homosexual behaviour is illegal in Kenya.

Birungi H & Onyango-Ouma W, 2006. 'Acceptability and Sustainability of the WHO Focused Antenatal Care package in Kenya', *Frontiers in Reproductive Health Program, Population Council.* *The aim of this study was to assess the feasibility of introducing an ante-natal care package in rural Kenya, and to assess how it affects quality of care received by pregnant women. It involved focus group discussions and interviews with service users and providers. It concluded that introduction was feasible, and that quality of ANC care improved, but that women were dissatisfied about waiting times and informal financial charges. Contextual and programmatic constraints to sustainability were identified, including non-integrated service delivery.*

Access Denied, 2006. 'The Impact of the Global Gag Rule in Kenya', http://www.globalgagrule.org/pdfs/case_studies/GGRcase_kenya_2006.pdf

Uganda

Asiimwe D, Hardee K et al, 2005. 'Study of the Integration of Family Planning and VCT/PMTCT/ART Programs in Uganda', Makerere Institute of Social Research and the POLICY Project for USAID.

This study used a combination of qualitative and quantitative methods to assess potential barriers and opportunities for integration of family planning and HIV-related services. Current programmes were found to be run mainly in a non-integrated way. Includes interesting results from focus group discussions with HIV-positive people, for example regarding their right to decide whether to have children.

McCauley A et al, 2004. 'Attracting Youth to Voluntary Counseling and Testing Services in Uganda', Horizons Research Summary. Washington, DC: Population Council.

This study compared findings from exit-servers with young clients of VCT services before and after a 'youth-friendly' initiative was introduced. It found that actions such as training providers and lowering prices increased uptake of services, particularly by girls.

Murphy EM, Greene ME, Mihailovic A, Olupot-Olupot P (2006) Was the "ABC" approach (abstinence, being faithful, using condoms) responsible for Uganda's decline in HIV? *PLoS Med* 3(9): e379. DOI: 10.1371/journal.pmed.0030379

This article is a debate between four researchers on whether the decline in HIV prevalence in Uganda was due to the ABC approach.

Slutkin G, Okware S, Naamara W, Sutherland D, Flanagan D, Crael M, Blas E, Delay P & Tarantola D, 2006. 'How Uganda reversed its HIV epidemic', *AIDS Behaviour*, 10(4): 351–360.

This paper is based on a review of policy documents, and assesses to what extent different strategies contributed to Uganda's reduction in HIV prevalence. It concludes that abstinence messages did not play a key role, since they were introduced after the upward trend in prevalence had begun to reverse.

Tuncalp O , 2005. 'US is accused of jeopardizing HIV prevention in Uganda', *British Medical Journal*, 331, 715.

Singh S & Prada P, 2005. 'The incidence of abortion in Uganda', *International Perspectives in Family Planning*, 31(4), 183-191.

A health facility survey was used to calculate abortion rates and compared with Demographic Health Survey data on contraception. The high rate of abortion found together with high unmet

need for contraception led the authors to conclude that family planning services should be urgently reinforced in order to reduce the abortion rate and its consequences.

Tanzania

Euloundo-Enyeque PM, Meekers D & Calves AE, 2005. 'From awareness to adoption: the effect of AIDS education and condom social marketing on condom use in Tanzania (1993-1996)', *Journal of Biosocial Sciences*, 37(3):257-68.

This retrospective study uses analysis of secondary data to conclude that education and social marketing programmes contributed to increased condom use in Tanzania in the early '90s.

Malawi

Abt Associates PHR Plus, 2005. Effects of the Global Fund on Reproductive Health in Ethiopia and Malawi: Baseline Findings, study for the System Wide Effects of the Fund (SWEF) research initiative.

This report examines the effect that Global Fund activities have had on RSH programmes in Malawi and Ethiopia. In Malawi, where data was collected through in-depth interviews with key informants, it was found that as well as some positive effects, Global Fund activities had negative effects on human resources, drug procurement, and policy processes.

C. RESEARCH ORGANISATIONS WORKING ON SEXUAL & REPRODUCTIVE HEALTH

Western Europe & US

London School of Hygiene & Tropical Medicine (LSHTM), UK

*Within LSHTM, the **Centre for Population Studies (CPS)** works specifically on health, population and development, including SRH. It is a member of the Realising Rights consortium, which conducts research relating to improving SRH of poor and vulnerable populations.*

Contacts: Susannah Mayhew (SRH rights and integrated SRH services; susannah.mayhew@lshtm.ac.uk), John Cleland, john.cleland@lshtm.ac.uk (family planning), Martine Collumbien, martine.collumbien@lshtm.ac.uk (sexual behaviour and masculinities), Charlotte Watts, charlotte.watts@lshtm.ac.uk (violence and health); Oona Campbell (proponent of universal access to skilled birth attendants).

Website: www.lshtm.ac.uk

Address: Keppel Street, London WC1E 7HT, UK.

Tel: +44 (0)207 6368636.

Institute of Development Studies (IDS), UK

IDS is also a member of the Realising Rights consortium, has done research on various aspects of health and development, and more recently HIV and development. The BRIDGE programme works on gender and development, and has recently carried out work on sexuality and SRH.

Contacts: Hilary Standing, h.standing@ids.ac.uk (reproductive health), Susan Jolly, s.jolly@ids.ac.uk (sexuality and gender).

Website: www.ids.ac.uk

Address: University of Sussex, Falmer, Brighton BN1 9RE, UK

Tel: +44 (0)1273 621202 / 691647.

Institute of Child Health, UK

Focuses mainly on childhood disease, but research area also includes maternal and perinatal health.

Contacts: Anthony Costello (community-based interventions to improve maternal & neonatal health)

Website: www.ich.ucl.ac.uk
Address: 30 Guilford Street, London WC1N 1EH
Tel: +44 (0)207 2429789

Alan Guttmacher Institute (AGI), USA

Non-profit organization for reproductive health research, policy analysis and public education, mostly US bias, but also covers international issues, including U.S. funding and policy towards the developing world.

Website: www.guttmacher.org
Address: New York Office: 120 Wall Street, New York, N.Y. 10005, USA
Washington, DC Office: 1120 Connecticut Avenue, N.W. Suite 460 Washington, D.C. 20036, USA
Email: NY: info@agi-usa.org|Washington: policyinfo@agi-usa.org
Tel: New York: 212-248-1111

Centre for Sexual Health Research, UK

The Opportunities and Choices research programme aims to provide evidence-based research to improve the availability, quality and efficiency of reproductive health services in resource-poor settings; particular focus on poverty and equity.

Contacts: Roger Inham, ri@soton.ac.uk (studies sexual behaviour of adolescents in the UK and elsewhere (eg Nepal), defends comprehensive sex education)

Website: www.socstats.soton.ac.uk/cshr/
Address: University of Southampton, Highfield, Southampton, SO17 1BJ, UK
Email: cshr@socsci.soton.ac.uk; choices@socsci.soton.ac.uk (Opportunities & Choices programme)
Tel: +44 (0)2380 597770

Royal Tropical Institute (KIT), Holland

Carries out epidemiological and action-orientated research on the integration of SRH services into existing health services.

Website: www.kit.nl/smartsite.shtml?id=2501
Address: Mauritskade 63, 1092 Amsterdam, Holland
Email: communication@kit.nl, k.d.koning@kit.nl (SRH programme)
Tel: +31 205688711

Population Council, USA

An international, not for profit, nongovernmental organisation that conducts biomedical, social science, and public health research. Conducts research into a wide range of HIV/AIDS and reproductive health issues.

Website: www.popcouncil.org
Address: One Dag Hammarskjold Plaza, New York 10017, USA
Email: pubinfo@popcouncil.org
Tel: +1 212 339 0500
[See also regional contacts under each region]

Center for Health and Gender Equity (CHANGE), USA

A research and advocacy organisation that seeks to integrate concern for gender equity and social justice into international health policy and practice. Research areas include violence and health, men's roles in reproductive health and rights, and monitoring impact of US policies, programmes & funding in developing countries and promoting accountability. In 2007 will publish a report based on field work in various countries in Asia & sub-Saharan Africa on the impact of the 'prostitution loyalty' clause.

Website: www.genderhealth.org/
Address: 6930 Carroll Ave., Suite 910, Takoma Park, MD 20912, USA
Email: change@genderhealth.org
Tel: +1 301 2701182

Ipas, USA

Ipas has worked for three decades to increase women's ability to exercise their sexual and reproductive rights and to reduce deaths and injuries of women from unsafe abortion. Ipas's global and country programmes include training, research, advocacy, distribution of equipment and supplies for reproductive -health care, and information dissemination.

Website: www.ipas.org

Address: PO Box 5027, Chapel Hill, NC 27514, USA

Email: research@ipas.org

Tel: +1 919 9677052

International Forum for Rural Transport and Development (IFRTC)

A global network of individuals and organisations interested in rural transport issues in developing countries. They currently have an internationally networked research project, Mobility and Health, which includes research into how lack of mobility places constraints on health and access to services.

Website: <http://www.mobilityandhealth.org/>

International Centre for Reproductive Health (ICRH), Belgium

ICRH seeks to improve the acceptability, accessibility and quality of sexual and reproductive health services globally, paying particular attention to the impact of gender inequalities on sexual and reproductive health.

Website: www.icrh.org

Address: Ghent University Hospital, De Pintelaan 185 P3, 9000 Ghent, Belgium

Email: info@icrh.org

Tel: +32 (0)9 240-3564

International Centre for Research on Women (ICRW), USA

ICRW promotes gender-equitable development. Conducting action-orientated research in collaboration with CARE International to create an innovative methodology to address gender and sexuality constraints in reproductive health and HIV/AIDS programming.

Contact: Sarah Degnan Kambou, skambou@icrw.org

Website: www.icrw.org/index.html

Address: 1717 Massachusetts Ave. NW, Suite 302, Washington, DC 20036, USA

Email: info@icrh.org

Tel: +1 202 797-0007

Center for Gender, Sexuality and Health (CGSH), USA

*CGSH promotes research and training on the social and cultural dimensions of sexuality, as well as policy-relevant research on issues related to sexual health, sexual rights and sexual education. Hosts the **International Working Group on Sexuality and Social Policy at the Center for Gender, Sexuality and Health (IWGSSP)**, which aims to play a key role in gathering and producing information and influencing policy around sexuality. Inspired by local and international initiatives, the IWGSSP 's mandate is to contribute to sexuality-related global policy debates through strategic policy-oriented research and analysis projects, and to promote more effective linkages between local, regional and global initiatives.*

Website: www.mailman.hs.columbia.edu/sms/cgsh.html

Address: Center for Gender, Sexuality and Health, Department of Sociomedical Sciences, Mailman School of Public Health, Columbia University, 722 West 168th Street, 9th Floor, New York, NY 10032, USA

Email: cgsh-msph@columbia.edu (CGSH), ssp_iwg@columbia.edu (SSPIWG)

Tel: +1 (212) 305-3286

World Health Organization (WHO), Geneva

*Within WHO, the **Department of Reproductive Health and Research** promotes optimal sexual health and an affirmative view of sexuality for women, men and young people.*

Contact: Iqbal Shah, shahi@who.int (adolescent sexual and reproductive health, unsafe abortion)

Website: www.who.int/reproductive-health/gender/

Address: 1211 Geneva 27, Switzerland

Tel: +41 (22) 791-3372

Africa

African Population and Health Research Centre, Kenya

An independent non-profit, non-governmental, pan-African, international organisation with headquarters in Kenya. Research focuses on urban health and poverty, adolescent sexual and reproductive health, health and social inequities in sub-Saharan Africa.

Website: <http://www.aphrc.org/>

Address: PO Box 10787, 00100 Nairobi, Kenya

Email: info@aphrc.org

Tel: +254 020 272 0400/1/2

Population Council, Kenya

Contact: Ian Askew

Address: General Accident House, Ralph Bunche Road, PO Box 17643, Nairobi 005, Kenya

Email: info@pcnairobi.org

Tel: +254 20 271 3480/1/2/3

Population Council, Zambia

Contact: Ian Askew

Address: Room 101, Pamodzi Hotel, P/Bag RW 319X, Lusaka, Zambia

Email: pcouncil@zamnet.zm

Tel: +260 1 255 035

Women's Health Project (WHP), South Africa

Through research, training and advocacy, the vision of the Women's Health Project (WHP) is to create a society respectful of economic, social, cultural, civil and political rights, in which all people, especially women, have access to, and control over, power and resources including internal psychological resources, enabling them to make decisions that contribute to optimal health and quality lives. Works in the areas of sexual rights, HIV/AIDS, violence against women and adolescent sexuality.

Website: www.wits.ac.za/whp/

Address: PO Box 1038, Johannesburg 2000, South Africa

Email: womenhp@sn.apc.org

Tel: +27 (0)11 489-9917 / 05

Health Economics and HIV/AIDS Research Division (HEARD), South Africa

Conducts research on the socio-economic aspects of public health, especially the HIV/AIDS pandemic. It is based in South Africa at the University of KwaZulu-Natal, but its operations are international in scope. The intent is to inspire health and development strategies that improve the welfare of people in and beyond Africa.

Website: www.ukzn.ac.za/heard/

Address: University of KwaZulu-Natal, Westville Campus, Private Bag X54001, Durban 4000, South Africa

Email: heard@ukzn.ac.za

Tel: +27 (31) 260 2592

Centre for Health Policy, South Africa

Aims to conduct research that promotes policies in support of equity and social justice in health; particular areas of focus are health systems, health financing and economics research, and HIV/AIDS and STIs.

Website: www.wits.ac.za/chp

Address: Centre for Health Policy (CHP), School of Public Health, Faculty of Health Sciences, University of the Witwatersrand, P.O. Box 1038, Johannesburg 2000, South Africa

Email: dudu.mlambo@nhls.ac.za

Tel: + 27 11 489 9936

Reproductive Health Research Unit, South Africa

A joint project of the Department of Obstetrics and Gynaecology, Baragwanath Hospital and the University of the Witwatersrand, and the Greater Johannesburg Metropolitan Council. Its primary goal is to contribute to the improvement of sexual and reproductive health, through carrying out research and community interventions on health and HIV. Specific areas include: microbicides, barrier methods including diaphragms, female and male condoms, HIV and STIs including HSV2/HIV and syphilis studies, contraception studies, adolescent health, voluntary counselling and testing, mobile populations (quality of life), acute HIV seroconversion studies including antiretrovirals (ARV) interventions, and studies on aspects of unsafe abortion and maternal health interventions. South Africa focussed.

Website: www.rhru.co.za

Address: Department of Obstetrics and Gynaecology, University of Witwatersrand, Chris Hani Baragwanath Hospital, Soweto, Gauteng 2013, South Africa

Email: enquiries@rhrujh.co.za

Tel: + 27 (0) 11 989 9200

Asia

MIRA (Mother & Infant Research Activities), Nepal

Collaborates with the Institute of Child Health conducting research into community interventions to promote maternal & neonatal health

Contact: Dr DS Manandhar, miraorg@wlink.com.np

Website: www.mira.org.np/research.htm

Address: 755 Praasuti Marg, Thapathali, P.O.Box No.: 921, Kathmandu, Nepal

Email: info@mira.org.np

Tel: (+977-1) 4266208

Centre for Health and Population Research, Bangladesh

International centre for health research, research areas includes community-based family health research, in cooperation with the Government of Bangladesh, in maternal and child health, communicable diseases, immunization, nutrition, reproductive health, and health-delivery systems.

Website: www.icddrb.org/

Address: GPO Box 128, Mohakhali, Dhaka 1212, Bangladesh

Email: info@icddrb.org

Tel: +880 (0)2 9899225

Community Advancement and Research Initiatives (CARI), Bangladesh.

Undertakes research in the following areas: HIV/AIDS/STI (including study investigating emotional, social and psychological reasons for low condom use), Women and Children issues, Health and population, Reproductive health & Family Planning, Human rights

Contact: Sharful Islam Khan, sikhan@icddrb.org.

Address: CARI, 7/E Siddeshwari Lane, Ground Floor, DHAKA 1217, Bangladesh

Email: cari-org@bdonline.com

Tel: +880-2-9355604

Centre for Operations Research and Training (CORT), India

Conducts policy-relevant reproductive health research, particularly relating to contraceptive use dynamics, abortion, operations research in reproductive and sexual health, adolescents, and HIV/AIDS and violence. CORT has collaborating centres in Nepal and Bangladesh.

Website: www.cortindia.com/index.htm

Address: Centre for Operations Research and Training 402, Woodland Apartment Race Course Course Vadodara - 390 007 Gujarat, India

Email: cort10@satyam.net.in, cortresearch@cortindia.com

Tel: +91-265-2341253, 2336875

Indian Council of Medical Research

Currently conducting a study in partnership with the Population Council (Frontiers programme) to assess usefulness and effectiveness of using female paramedics in educating and providing emergency contraception services to potential users, to overcome existing barriers to access.

Website: www.icmr.nic.in/

Address: V. Ramalingaswami Bhawan, Ansari Nagar, New Delhi 110029, India

Email: headquarters@icmr.org.in, icmrhqds@sansad.nic.in

Tel: 26588895, 26588980, 26589794, 26589336, 26588707

Population Council – India (Regional office)

Contact: Shereen Jeejeebohi (adolescent SRH)

Address: Zone 5A, Ground Floor, India Habitat Centre, Lodi Road, New Delhi 110003, India

Email: mbhalla@popcouncil.org, frontiers@pcindia.org (Frontiers project)

Tel: +91 11 2 464 2901/2, 464 4008/9, 465 2502/3, 465 6119

Population Council – Pakistan

Address: House No. 7, Street No. 62, Section F-6/3, Islamabad, Pakistan

Email: imran@pcpak.org

Tel: +92 051 227 7439

Health Services Academy (HSA), Pakistan

Academy established in Ministry of Health, Government of Pakistan in 1988 with the aim of improving the country's health care delivery. Its main areas of research are health systems, environmental and reproductive health.

Website: www.cortindia.com/index.htm

Address: Health Services Academy, 12-D West, Bewal Plaza, Blue Area, Islamabad, Pakistan

Email: hsaacademy@yahoo.com

Tel: +92(051)9221321

Annex 1: Definitions of Sexual & Reproductive Health & Rights

Reproductive health and rights

The ICPD definition of reproductive health and rights, that 179 countries signed up to in 1994, is:

“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.” ((PoA Paragraph 7.3)

Source: UN, 1995. ‘Report of the International Conference on Population and Development, Cairo, 5-13 September 1994’, *UN*, New York.

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;
- Sexuality education;
- Respect for bodily integrity
- Choose their partner;
- Decide to be sexually active or not
- Consensual sexual relations;
- Consensual marriage;
- Decide whether or not, and when, to have children; and
- Pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others”

Source: WHO 2004, Working Definitions, www.who.int/reproductive-health/gender/sexual_health.html

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