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World Health Organization statement

to the Standing Committee on Foreign Affairs and International Development of the House of Commons of Canada, on the sexual and reproductive health and rights of women globally

Introductory disclaimer

WHO is pleased to provide a written briefing in reply to the request from the Standing Committee on Foreign Affairs and International Development of the House of Commons of Canada for its study of sexual and reproductive health and rights of women globally. This briefing is informal and provided on a voluntary basis without prejudice to the privileges and immunities of WHO and its officials, and as a technical contribution.

The World Health Organization (WHO) is a key ally to Canada's 10-year Commitment to Global Health and Rights to advance the health and rights of women and girls around the world (2020–2030) and agrees that a focus on sexual and reproductive health and rights across the life course, as well as addressing violence against women and harmful practices (for example, child, early and forced marriage and female genital mutilation) is fundamental to making progress on gender equality, women's health and well-being, and to fulfilling the Sustainable Development Goals commitments. This is reflected in the WHO's Thirteenth General Programme of Work and through the work carried out at all levels of the Organization.

The Human Reproduction Programme, created in 1972 following a World Health Assembly (WHA) Resolution, is based at the WHO headquarters in Geneva, Switzerland, in the department of Sexual and Reproductive Health. It supports and coordinates research on a global scale, synthesizes research through systematic reviews of literature, builds research capacity in low-income countries and develops dissemination tools to make efficient use of ever-increasing research information.

Governed by a sub-set of member states, HRP is a Special Programme co-sponsored by five United Nations agencies (WHO, UNDP, UNFPA, UNICEF, World Bank) that brings together policymakers, scientists, health care providers and civil society to focus on research, training and implementation research on SRHR.

Progress in sexual and reproductive health and an unfinished agenda

Over the course of the past 50 years, HRP has had a distinguished record of supporting and coordinating research on a global scale and conducted research in partnership with countries to provide the high-quality information needed to achieve universal access to effective services and to enable people to protect and promote their own sexual and reproductive health across the life course. This includes decades of groundbreaking research on safe and comprehensive abortion care, access to and safety of contraception, violence against women, sexual health and respectful and quality care during and after pregnancy.

HRP also provides key data and estimates for global use, such as current trends on maternal mortality, the only international comparable data on the prevalence of violence against women, and the world's first estimates on infertility prevalence. In addition, HRP synthesizes evidence through systematic reviews of the literature, builds research capacity in low-income countries and develops tools to facilitate access to the latest research information by the people who need it.

While great advancements have been made on women's sexual and reproductive health and rights since HRP was established, huge challenges remain. This, despite the many important commitments made by governments in the 1994 Programme of Action of the International Conference on Population and Development (ICPD), the 1995 Beijing Declaration, the SDGs and international human rights treaties.

The slow progress towards ensuring universal access to SRHR is an outcome of lack of political will and action, insufficient funding, restrictive laws and policies, harmful gender norms, restrictions on women's and girls' autonomy, and health systems constraints, including insufficient integration of comprehensive sexual and reproductive health services in national health benefit packages and primary health care. The data we collect and present on sexual and reproductive health consistently point to deep gaps in rights and justice, gender equality, human dignity and broader social well-being.

A substantial proportion of women remain unable to plan whether and when to have children and how many to have, and 270 million women have an unmet need for contraception (1). Gender inequalities and gender norms, roles and stereotypes keep determining women's health and rights. For example, 43% of women (15-49 years) report lack of agency in decisions on sexual relations, use of contraceptives and health care (2). The United Nations only collects the above data for married and in-union women, so the real numbers are much higher.

Infertility has significant and negative societal and health consequences including poor mental health, social stigma, and economic hardship. Most recent data from the WHO shows that one out of every 6 people of reproductive age, experience infertility in a lifetime (3). However, despite its magnitude and burden, infertility has not been a focus in global agendas on sexual and reproductive health and rights.

Preventable deaths continue to occur during pregnancy, childbirth and in the period following childbirth. Maternal mortality remains unacceptably high: every two minutes a woman dies during pregnancy or childbirth, with almost all deaths (95%) occurring in LMICs; most of these deaths could have been prevented (4). Excessive bleeding or postpartum haemorrhage is a leading cause of maternal mortality, responsible for one maternal death every six minutes (5). Globally, a leading cause of death among girls aged 15-19 years is complications during pregnancy and childbirth (6). And the rates of stillbirths and neonatal deaths are also unacceptably high.

Violence against women and girls – including harmful practices – remains a pervasive human rights violation. Almost 1 in 3 (30%) of women have been subjected to either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime. We estimate that as many as 38% of female homicides globally were committed by a male intimate partner (7). More than 200 million girls and women alive today have undergone female genital mutilation with treatment of health complications costs amounting to 1.4 billion USD per year, a cost that is expected to rise due to population growth *(8)*. Child marriage, estimated to occur in one in five girls today, continues to impact the health and wellbeing of adolescent girls and their life trajectories into adulthood (9).

Many individuals and couples are still unable to access information and services to ensure their sexual, reproductive, maternal and perinatal health, putting their well-being and lives at risk. Globally, 45% of all abortions are unsafe (10). In countries that allow abortion on request, nearly 87% of abortion are safe; in countries that prohibit abortion or allow it only to save the life of the woman or protect her physical health, only 25% of abortions are safe[1] (11).

Humanitarian crises and disease outbreaks threaten lives, livelihoods, health and access to sexual and reproductive health services for millions. The risks of gender-based violence are exacerbated during humanitarian and public health emergencies. COVID-19-related disruptions including delivery of health services and essential medicines and products, resulted in lost access to family planning services to millions of women particularly in LMICs . Consequently, there was an estimated 1.4 million unintended pregnancies – including teenage pregnancies (12).

Menstruation is a normal biological function; global estimates put the figure of women and girls of reproductive age at approximately 1.8 billion. That notwithstanding, millions of those who menstruate have limited or no access to information, resources, services, and products they need for their monthly cycle in a dignified and healthy way (13). In addition, there are now more adolescents than ever before – about 1.3 billion or 16% of the global population – who are in need of adolescent-friendly services at a unique stage of human development (14).

We know Universal Health Coverage (UHC) is essential for healthier populations, but almost 2 billion people face catastrophic health spending. Fully meeting the contraceptive, maternal, and newborn healthcare needs of all women in LMICs would cost an estimated US $9 per person annually, and would result in 67 million fewer unintended pregnancies, 2.2 million few newborn deaths, and 224.000 fewer maternal deaths (15). Return on investment data tells us that every $1 invested in meeting the unmet need for contraceptives yields in the long-term $120 in accrued annual benefits: $30-50 in benefits from reduced infant and maternal mortality and $60-100 in long-term benefits from economic growth (16).

Priorities going forward

Without continuing investments in research, and in improving the capacity of countries to conduct and use research, it is unlikely that national primary health systems will be able to effectively implement globally agreed, and locally implemented best practices and standards of care, or to achieve the goal of UHC.

Access to rights-based safe, effective, quality, affordable and acceptable contraceptive information and services, together with the prevention and treatment of infertility, supports people to decide if and when to have children, the number of children they would like, and their preferred timing and spacing. There is a need to take forward innovative research and development on new and repurposed contraceptive methods that better meet the needs of women, ways in which women and adolescents are empowered to exercise choice and autonomy over their fertility decisions and support implementation research to improve programs and support scale-up of infertility and integrated contraception services.

Abortion is a common health intervention and is safe when carried out in accordance with WHO guidelines and standards. Comprehensive abortion care includes the provision of information, abortion

[1] The WHO defines unsafe abortions as: The persons, skills and medical standards considered safe in the provision of abortion are different for medical and surgical abortion and also depend on the duration of the pregnancy. What is considered ‘safe’ should be interpreted in line with current WHO technical and policy guidance.

management and post-abortion care. There is a need to conduct research and development of newer abortion medications that can expand options for women and increase commodity security. It would be important to generate evidence on the level of uptake and implementation of WHO recommendations on abortion care and understand how abortion-related policies are implemented in different settings and the impact they have on women and societies. Documenting and developing strategies to counter misinformation related to abortion is equally important.

Adolescence is the unique period of life that encompasses the transition from childhood to adulthood. An individual's behaviour and the choices they make during this time can determine their future health and well-being. Enormous progress has been made in adolescent sexual and reproductive health over the past two decades, but it has been uneven across different health issues, geographic areas and groups. Research led by HRP has shown that gender norms are established during puberty and are key drivers of SRH in adolescence and into adulthood. Going forward, it would be important to explore optimal service provision across separate health services for adolescents on the one hand and ensure existing health services are adolescent-friendly on the other. We must expand contraceptive access to adolescents and invest in comprehensive sexuality education in schools and outside of school settings, with a focus on building more gender-equitable norms, and healthy and respectful relationships.

Violence against women and girls constitutes a major public health concern and is a grave violation of human rights, rooted in gender inequality. Violence against women and girls takes multiple forms, including intimate partner violence, sexual violence, femicide and trafficking. The health sector has an important role in a multisectoral response in preventing and responding to violence against women and girls (VAW). WHO has the mandate to implement a global plan of action on strengthening the health systems in addressing violence against women and girls and against children, championed by Canada and endorsed by all Member States (17). Research led by HRP has established the magnitude and health impacts of VAW, and contributed to the evidence base for health sector interventions. WHO's guidelines on the health sector response to VAW are widely used by countries and partners, including in humanitarian emergencies. We have had strong collaborations with Canadian researchers and practitioners in this field, including in the development of domestic guidelines on family violence. Going forward we must continue to strengthen the health response to VAW, data collection and measurement of different forms of VAW, research on effective health sector interventions, and work with partner agencies to strengthen evidence on prevention.

How to invest for sustainable solutions – generating evidence, strengthening health systems, impacting lives

Further investing in efforts that strengthen evidence-based policy making and processes that provide human rights accountability for women's sexual and reproductive health is more important than ever. A focus on sustainable and longer-term solutions could prioritize the below investments.

Investing in research and evidence-generation on sexual and reproductive health, its determinants and pathways is an investment in women's sexual and reproductive rights. Through building the best evidence and recommendations based on rigorous research, and clinical and community interventions, human rights-based approaches to sexual and reproductive health can be supported, and social norms, values and systems detrimental to health can be challenged.

The following considerations are important to highlight:

- Promote study designs and analytical approaches beyond determining efficacy and efficiency to identify how integrating human rights and gender equality in sexual and reproductive health programmes and policies can improve health outcomes;
- Strengthen a focus on research that addresses intersecting forms of discrimination and rights violations that affect the sexual and reproductive health of persons made vulnerable through these intersections;
- Support national research governance mechanisms to ensure the independence and accountability of researchers and research funders to those most affected by structural gender inequality and human rights violations;
- Promote community-driven research agendas and value different forms of knowledge and research that better reflect the priorities of people most affected by sexual and reproductive injustice (18-20).

Investing in strengthening primary health care services as a crucial component of universal health coverage and comprehensive sexual and reproductive health and rights. Progressing towards UHC and improved access to sexual and reproductive health services, including digital solutions, requires shifting the burden of financing away from individuals, especially women and girls, towards increased domestic public funding that combines tax revenue and prepayment schemes.

Improvements in the use of existing public resources for service delivery are important for efficiency, quality and equity gains, even where the context constrains funding for sexual and reproductive services. Further, improved measurement and tracking of the resource flows for sexual and reproductive health services, and products are needed to monitor financial contributions from governments, donors, insurance companies and households and document returns on investment, further building the economic case for strengthening sexual and reproductive health services (21-22).

An increased focus on supporting good and inclusive governance for sexual and reproductive health. An enabling legal environment is crucial for successfully implementing rights-based sexual and reproductive health services. Prohibitive or restrictive national laws and policies are important barriers to seeking and accessing essential sexual and reproductive health services. Alongside these institutional barriers, deep-rooted inequalities and power asymmetries in gender and social norms may also influence how policy makers and governments address sexual and reproductive needs.

To move from evidence to policy and action that impact lives, it is important to

- Support research to understand how certain laws and political decisions affect sexual and reproductive health policies and programming that seek gender equality and human rights;
- Make efforts to always “side with science” and find ways to counteract misinformation and promoting the right to sexual and reproductive health evidence and information;

- Invest in political alliance building for a rights-based approach to sexual and reproductive health and celebrating mutual progress and achievements;
- Invest in civil society organizations as important actors balancing government action or inaction, supporting human rights accountability, and supporting action that promotes and safeguards civic space (23-24).

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