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What are the Population-level Impacts of Enabling People to Exercise their Reproductive Rights?

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A. INTRODUCTION

Sixty years ago, the Universal Declaration of Human Rights laid the foundations for the right to the highest attainable standard of health. This right is central to the creation of equitable health systems. More recently, in the 19 years since 179 governments adopted a 20-year Programme of Action (PoA) at the International Conference on Population and Development (ICPD) in 1994 (Earth Negotiations Bulletin, 1994), much has been done to ensure that population concerns are not just about counting people, but about making sure that every person counts, and that the Universal Declaration of Human Rights is used to promote health and wellbeing (Osotimehin, 2013). The delegates to that conference brought about a sea change in the rhetoric around the population debate – agreeing unanimously that a woman's ability to access reproductive health and rights is a cornerstone of her empowerment, and the key to sustainable development for everyone on the planet (United Nations, 1995).

Despite the momentum generated by the ICPD, Millennium Development Goal 5 remains one of the most off-track of the international aspirations for a better world. Goal 5b which addresses reproductive health services and family planning was added late to the framework in 2007. Only 13 countries are poised to reach the targeted reduction in maternal mortality (Centre for Reproductive Rights, 2013). Since 2005 there has been a proliferation of World Health Reports (World Health Organization, 2005, 2006 and 2008; UN Millennium Project Task force on child health and maternal health, 2005) MDG acceleration frameworks (UNDP, 2010; Ghana Ministry of Health and United Nations, n/d), Global Strategies (Partnership for Maternal, n/d) and accountability mechanisms (Hunt and Gray, 2013) to tackle the continuing lack of achievement. The headline figures published in 2012 at last showed some improvement for reproductive health (WHO et al., 2012), and there have been some very notable positive case studies (Mbizvo and Say, 2012). The same time, adolescent childbearing, which is risky for both mother and child, remains at very high levels in many developing regions, with African countries showing particularly wide disparities in maternal and reproductive health, including the need for family planning (United Nations, 2013).

While a large body of research has focused on the importance of a human rights-based approach, there is limited evidence examining the extent to which rights related to reproductive health have been realised. The likely population level impacts of enabling people to benefit from their reproductive rights are unknown. This paper brings together a framework through which to analyse population impacts with a focus on fertility, as well as considering the constraints, challenges and opportunities to the positive developmental consequences of fuller exercise of reproductive rights in the future.

In essence, the reproductive rights approach adopted at Cairo is intended as an instrument to promote policies and development that result in improvements in women's health, their autonomy in reproductive decision-making and the health of their babies and children. The recent emphasis on accountability is an attempt to build on the Cairo consensus, but to also accelerate progress by holding key actors to account. In some contexts there are clearly constraints to

B. Human rights, reproductive rights and the right to health

Human rights provide an internationally recognized, legally binding code of conduct (Bilder, 1992). Human rights are those activities, conditions, and freedoms that all human beings are entitled to enjoy, by virtue of their humanity. They include civil, political, economic, social and cultural rights. Human rights are inherent, inalienable, interdependent, and indivisible, meaning they cannot be granted or taken away, the enjoyment of one right affects the enjoyment of others, and they must all be respected. Human rights are thus fundamentally about securing entitlements of people and empowerment in a context of respect and accountability defended by recourse mechanisms (Committee on Economic Social and Cultural Rights, 2000).

1. The Right to Health

Human rights are concerned with the empowerment and entitlements of people in certain aspects of

to health and to regulate private and public practices that impact individuals' enjoyment of those rights, we therefore consider national Governments ("States") as the guarantors, or violators, of human rights.

The Right to Health however also requires that education, information and services are provided for together. Implementing a human rights-based approach involves strengthening the capacities of both rights-holders to make their claims and duty-bearers to meet their obligations (Human Rights Council 20th Session, 2012). In short, in the sexual and reproductive health (SRH) context, clients and providers must become aware of their rights and to expect more from those that have the duty to deliver on those rights. This translates into claiming the Right to Health care as clients; or as providers, to be given the conditions in which to work effectively. Likewise, it requires the providers and managers in the health system recognize their obligation as duty-bearers to ensure that a client's Right to Health is respected, protected and fulfilled by the system and by them themselves as primary actors within the system.

2. Reproductive rights: a key subset of human rights which underpin development

Reproductive rights relate to an individual woman's or man's ability to control and make decisions about her or his life which will impact their sexual and reproductive health. They are not new rights but rather a constellation of human rights that together constitute reproductive rights. Reproductive rights relate to the functions of reproduction and related health or healthcare and refer to a broad range of issues linked with both healthcare and sexual relations. For example, persons who are in need of healthcare related to reproduction have rights related to non-discriminatory, respectful, confidential, accessible and quality healthcare that responds to their needs. As applied to sexual relations, the rights extend to the ability to lead a healthy and satisfying sexual life of choice, free of coercion, rape, violence and discrimination.

One of the first articulations of reproductive rights was at the United Nations 1968 International Conference on Human Rights. The resulting non-binding Proclamation of Teheran was the first international document to recognize one of these rights when it stated that: "Parents have a basic human right to determine freely and responsibly the number and the spacing of their children."

In the next decade, autonomy in decision-making about fertility regulation as a sexual and reproductive right began to include a broader range of sexual and reproductive health issues as well as some of the underlying structural conditions that constrain reproductive and sexual decisions (that is, maternal and infant mortality, infertility, unwanted sterilization, malnutrition of girls and women, female genital mutilation, sexual violence and sexually transmitted infections). During this time, the issue surrounding rights was enlarged to address the social needs that erode reproductive and sexual choices of poor women (Correa and Petchesky, 1994).

While the developing concept of reproductive rights gained momentum in some circles, population control policies and programmes were pervasive, emerging out of Malthusian concerns that high population growth rates hamper economic growth, destroy the environment, overstretch public services and result in greater poverty. These concerns led to drastic measures where States, localities and even lone providers took fertility control into their own hands using coercive methods to meet family planning goals (Sen et al., 1994). Reproductive rights in countries such as China and India and others were

opportunity.

The historic consensus reached in Cairo in 1994 at the ICPD was a landmark agreement that put the reproductive rights of women at the centre of the debate. Fertility control was out and choice, empowerment, and resources (to create the conditions for self-determination) were in (Finkle and McIntosh, 2002). Nearly 20 years later, the Cairo Programme of Action is still relevant as countries try to make those historic promises a reality. Today, there is recognition that reproductive rights necessarily include a variety of rights (see Figure I) as well as responsibilities that can only be achieved through integrated approaches to services as

outcomes improve, what is the magnitude of the fertility impact? And third, how do these population impacts in turn influence broader wellbeing? The evidence on these links needs to be drawn from separate sets of literatures.

Examining the effect of reproductive rights approaches is a fairly recent endeavour and has been tried, for example, by using country case studies and interviewing key actors as in a study in Nepal (Bustreo and Hunt, 2013) claiming large impacts on contraceptive rates. Other case studies presented in the same monograph on Brazil, Italy and Malawi examine the rights focus of various programmes and policies and track outcomes – seeking to link the two by analysing in-depth interviews with key decision-makers active during the time of policy and programme implementation. However, given the breadth of the field, mixing the impacts of upholding rights in HIV care with abortion, contraceptive services, sexual health and maternal healthcare may add up to an impressive set of effects, but the pathways to impact vary considerably.

The right to decide the number and spacing of children is at the heart of the impact of reproductive rights on fertility. Collated survey estimates suggest that in 16 countries, the excess fertility over desired family size is 0.5 or less children per women, in 22 countries the excess fertility is between 0.6 and 0.9 and in 19 countries, the excess fertility is one child or more. In these contexts women and couples are in need of contraception. It is also in these same contexts where very young girls are married too early and adolescent fertility remains high. In contrast, amongst 27 European countries the opposite situation prevails whereby women are on average having 0.7 children less than they would desire.

The following sections examine specific reproductive health rights and their likely fertility impacts: 1) reducing the unmet need for family planning by satisfying demand for family planning, 2) increasing fertility rates in more developed countries with lowest-low achieved family sizes, and 3) reducing early marriage especially where adolescent fertility rates are high.

1. Meeting unmet need for family planning - impacts on fertility

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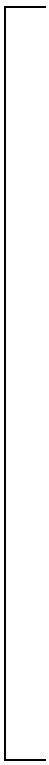

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for methods) together constitute another 23 per cent of the reasons for non-use. In some countries these reasons can account for a relatively high proportion of non-use (see Table 1).

TABLE 1: PER CENT OF WOMEN THAT GIVE REASONS FOR NON-USE OF CONTRACEPTIVES RELATED TO AGENCY OR HEALTH SYSTEMS

Country	Partner or other is opposed	Unawareness of method	High cost	No source/access problems
Burkina Faso	11	5	12	19
Benin	6	12	5	15
Ethiopia	8	11	2	15
Madagascar	6	13	4	13
Mozambique	8	4	3	13
Uganda	14	5	7	13
Mali	10	10	4	11
Peru	5	0	3	11
Nepal	11	1	1	10
Chad	4	15	3	9
Mauritania	9	13	1	9
Nigeria	7	9	3	9
Cameroon	5	12	4	8
Ghana	3	7	8	8
Guinea	7	5	3	8
Tanzania	11	2	1	8
Bolivia	6	12	4	7
Cambodia	1	5	4	7
Zambia	6	1	1	7
Kenya	11	2		

Figure IV: The evolution of unmet need for contraceptives (2000-2010) from DHS surveys with two time points

NOTES: Country selection criteria were based on 1) the availability of data at or around [+/- 2 years] 2000 and 2010 and similar time period between the two surveys (9-11 years). When a survey was carried out over a two-year time period, the older time point was used as a reference.

2. Bridging the gap between low fertility and desired family size

Low fertility and desired family size have been amongst the key socio-demographic issues on the agendas of most European countries. With the overall fertility (TF) of 1.6 (Eurostat, 2013), the EU nations are projected to experience potential challenges in terms of their future labour force as well as healthcare and welfare provisions. Higher life expectancy combined with shrinking working-age populations and often unfavourable economic climate imply that more resources will be needed to care for the aging while the supply of these resources is at risk. In some countries, such as Italy, Austria and Greece, the TF is as low as 1.4 children per women (Eurostat, 2013). Comparatively, between 2005 and 2010, in Japan and the Republic of Korea the TFs were respectively 1.3 and 1.2 (UN, 2010). The reasons for these trends have been researched extensively and include changes in social norms and values, lack of stable employment prospects, higher educational attainment and labour participation of women as well as deficiency of policy responses at the state level (Kohler, 2006; Kohler et al., 2002; Morgan, 2003; Ní Bhrolcháin and Beaujouan, 2012; Gauthier, 2006).

Analysing the 2011 Eurobarometer on Fertility and Social Climate data, Testa found that around 30 per cent of men and women exit their reproductive age with less children than they initially intended (Testa, 2012). While in extreme cases, such as that of Cyprus, the difference between the actual family size and the personal ideal family size is more than one child, in all other EU nations the personal ideal family size is greater than the actual family size. In almost all these countries, the personal ideal family size is two or more children (Testa, 2012). Similarly, a recent study of desired family size in Hyogo, Japan found that the desired TF was almost 2.6 as compared to the actual TF of 1.8 reported in the sample under investigation (Matsumoto and Yamabe, 2013). In addition, the study found significant rural-urban differentials, with rural families showing a greater desire for larger families as compared to their urban counterparts.

From the human rights perspective, two key questions arise: 1) what are the reasons behind the gap between the actual low fertility and couples' desire for more children, and 2) are the ways in which governments try to incentivise couples to have more children fully compliant with individuals' reproductive rights? Regarding the first issue, analysis of longitudinal household data from Spain found that unemployment and temporary contracts were negatively associated with the fertility gap, while women working in public sector were more likely to achieve their desired fertility (Adsera, 2005). Within a context of rising unemployment and job insecurity, inadequate institutional infrastructure is likely to exacerbate the existing fertility gap. Research on the reasons for discrepancies in Europe and the United States found that in addition to a different ethnic composition of the United States, a more flexible job market paid a key role in allowing couples to satisfy their reproductive choices (Kohler, 2006). However; while there is a broad debate around the type of support that States should provide in order for individuals to reach their desired family size, the other side of the coin is the risk of States' policies preventing couples from exercising their low fertility choices.

3. Reducing early marriage – effects on adolescent fertility

Any marriage before the age of 18 is considered by international human rights standards as child marriage yet the right to marry and found a family is a rights of adults not children or adolescents (Cook, 1994) . Although in decline worldwide, a substantial proportion of girls in sub-Saharan Africa and South Asia will be married early, and if marriage patterns remain the same, it is estimated that more than 100 million young women will be married before age 18, and roughly 14 million will be married by age 15 in the next 10 years (Bruce, 2005).

Early marriage has been associated with elevated fertility rates and all the morbidities and mortality associated with early pregnancy (Raj et al., 2009). A review conducted by the Population Reference Bureau (2007) found that complications of pregnancy and childbirth are the leading causes of death among females aged 15 to 19, and girls who have a child before 15 years of age are more than twice as likely as older mothers to die of pregnancy-related causes (Murphy and Carr, 2007). According to a review of the DHS from 51 countries, more than 90 per cent of first children born to mothers under 18

Civil and Political Rights), early and forced child marriage is universally recognised by the international community as a violation of the rights of children and adolescents (Center for Reproductive Rights, 2013).

The Convention on the Rights of the Child recognised that children are rights-holders, and the United Nations treaty-monitoring bodies that have explicitly noted that adolescents have the same human rights, including reproductive rights, as adults have. However, as children or even adolescents, they lack the autonomy necessary for decision-making, and are often in a situation of social and economic, and even physical vulnerability that makes the exercise of their rights nearly impossible. Thus in the case of early marriage we see the negative population level impacts when reproductive rights are violated. To illustrate this impact, Figure V presents the macro level association between child marriage and adolescent fertility rate, while Figure VI allows for further disentangling of this association by different world regions. Concerning the first graph, one can notice a strong linear relationship between the two factors. Complementarily, the results of an unadjusted regression modelling show that, at the country level, an increase in child marriage is associated with significantly higher adolescent fertility rate (+0.32, R2=0.66). The most visible patterns can be observed in Africa and Asia (Figure 6), despite a number of outliers in the second region.

Figure V: Association between child marriage and adolescent fertility rate

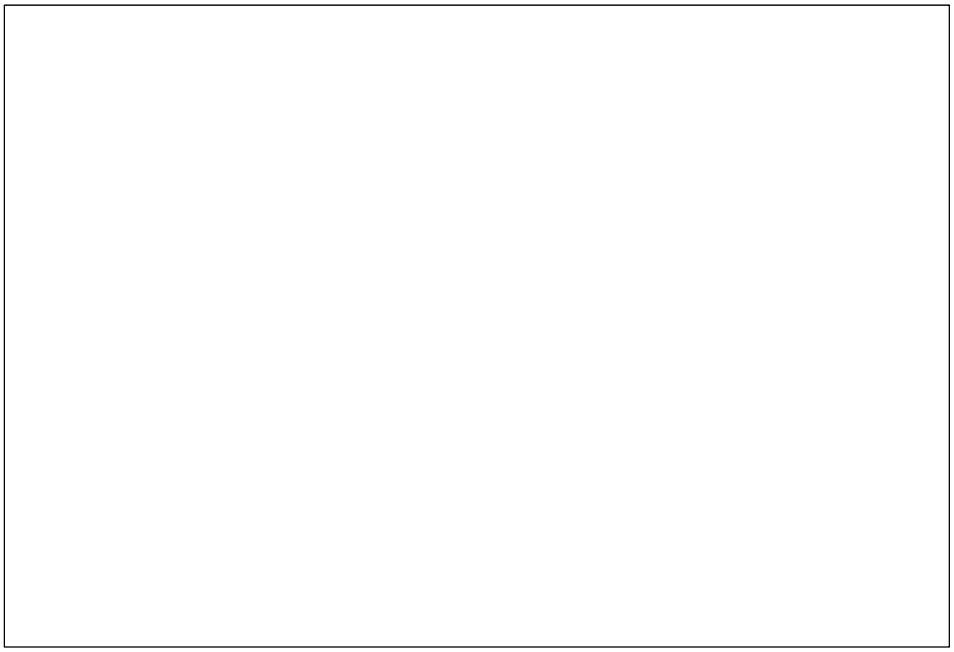

Figure VI: Association between child marriage and adolescent fertility rate by region

D. HYPOTHESISING BROADER IMPACTS ON POVERTY—TOWARDS A CONCEPTUAL FRAMEWORK

Various literature reviews have examined the further links between reproductive health and broader impacts on fertility and economic wellbeing. Greene and Merrick (2005), for instance, concluded that "poor reproductive health outcomes can undermine a household's chance as well a country's chance of reducing poverty". Various authors (Hobcraft, 2003; Matthews and Falkingham, 2008) posit a range of conceptual frameworks linking population growth, reproductive health and poverty via population impacts (both at macro and micro levels) using extensive literature reviews. Matthews and Falkingham (2008) suggest the 'population dividend' (Bloom and Williamson, 1998; D.E. Bloom et al., 2003) as a way of changing a cycle of poor reproductive health and poverty into a virtuous cycle leading to economic wellbeing. More recently, Grepin and Klugman (2013) concluded that "investments in reproductive health are a major missed opportunity for development".

Commentators and experts are now asserting with increasing confidence that people are in poverty because of their lack of capacity to achieve reproductive health and rights (Leete and Shoch, 2003), and that the growth rate of poor people can be more than twice the overall growth rate of the population, thus raising enormous challenges for poverty reduction (DFID, cited in All Party Parliamentary Group, 2007; United Kingdom All Party Parliamentary Group on Population Development and Reproductive Health, 2007). One of the first advocates to put the macro perspective back into the policy discussion around fertility, health and mortality reduction and to understand the consequences of these population issues was Jeffrey Sachs in 2001. His Report of the Commission on Macroeconomics and Health examined the possible economic benefits that could result from reducing mortality generally—and reducing avoidable mortality from HIV/AIDS and other communicable diseases, maternal complications and newborn conditions in particular—thus adding economic clout to the moral imperatives enshrined in the Millennium Development Goals (Sachs, 2001). The Guttmacher Institute estimates that each dollar spent to move from current levels of modern method use to the full-needs-met scenario would save $1.40 in the costs of maternal and newborn health care.

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tertiary education are similarly an opportunity to foster a better enabling environment for extending women's agency and increasing their participation in the workforce.

Accountability mechanisms are still in their infancy, but many advances in holding responsible actors (duty-bearers) to account both at local and national levels are likely to help to close the gap between the rhetoric on improving health systems and the realization of extending effective quality coverage. The recently established Commission for Information and Accountability for Women's and Children's health has focussed on accountability mechanisms such as maternal death reviews, and the availability of data down to local levels (WHO Commission on Information and Accountability for Women's and Children's Health, 2011). There is some way to go – but many countries are taking up the opportunities related to improved data management and transparency,

around the world, puberty — the biological onset of adolescence — brings not only changes to their

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