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Exploring inequities, inspiring new knowledge and action

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"*No one left behind*", the mantra of the Sustainable Development Goals (SDGs),[1] resonates in the global and development agenda and is being taken up by a myriad of organisations and agencies. It is an appealing, memorable and seductive phrase, beguilingly simple, yet immensely ambitious. Firmly embedded in the recognition of every individual's dignity, the aim is that the SDG targets be met globally, for all people, in all segments of society.[1] The idea of redressing inequities is implicit within the pledge of the SDGs, with concerns of exclusion, deprivation and denial of social and economic opportunities being highlighted, along with the need to confront the fundamental causes of why some are forgotten, disregarded or ostracised.[2]

Equity is a term grounded in the concept of fairness, implying that opportunities should exist for every person to attain their full potential.[3] Inequities arise when the unequal distribution of a resource is judged to be avoidable, unacceptable and indefensible. Inequity can result for many reasons, not least because of poor governance, corruption or societal exclusion.[3,4] Exploring inequities related to sexual and reproductive health and rights (SRHR) requires attention to intersecting political, legal, social and economic factors which influence people's knowledge, their access to rights and use of health and other public services. Inequities in SRHR may also be usefully considered in the context of specific population groups, especially those who are vulnerable, including, for example, younger and older populations, persons with disabilities, people living with HIV, transgender and intersex people, indigenous people, minorities and those who have been displaced. The papers in this themed issue do exactly these things, reflecting complex and multidimensional concerns from different populations *within* countries, as was the focus of our call, and from all corners of the globe.

Perspectives of different population groups

Adolescents belong to a population group facing significant inequities in SRHR. Socio-cultural norms may constrain their agency, their access to appropriate health services may be poor, and they may experience vulnerabilities related to coercion, exploitation and violence.[5] One topic generating much recent interest is that of adolescent pregnancy and parenthood, a situation prevalent in many countries and often portrayed in a negative light. In their commentary on youth centred approaches in Papua New Guinea, Bell et al disassemble the concepts within the triad of sexual, reproductive and maternal health, to inform potential responses to adolescent pregnancy, framing an exploration of adolescent pregnancy in a positive and holistic manner.[6] Perspectives on early fertility and teenage pregnancy are also presented from South Africa by Swartz and colleagues, who give in-depth insights into how adolescents use their fertility and performance of parenthood to navigate the childhood to adulthood transition. This ethnographic work reveals the economic, social and emotional pressures faced by adolescents due to early fertility and parenthood, while also eliciting how pregnancies give a sense of self-worth and are viewed positively by young people.[7]

Although "young people" (defined by the World Health Organization as 10–24 years of age)[8] are described differently in the papers within our themed issue, they emerged as a group of interest in relation to inequity considerations. In Jamaica, Logie and co-authors discuss how criminalisation and constrained protection of human rights can result in health and social inequities that compromise the SRHR of sexually and gender diverse young people. A range of daily survival challenges prevents access not only to healthcare but also to other fundamental needs such as housing,

employment and personal relationships. Importantly, the authors of this paper also show how the risks encountered are navigated through self-acceptance and social support.[9] Small, intimate island communities can affect personal privacy and create reticence in discussing taboo subjects openly. In the Maldives, Hameed investigated the attitudes of unmarried young people on sexual and reproductive health, some living in rural environments, in a country where non-marital sexual activity is illegal.[10] Although the data was generated nearly 10 years ago, we believe that the implications of the findings are still relevant to the country today. RHM prefers to publish work emerging from current or recent research, but we have made a special case in this instance, given the unusual and unique circumstances.

Inequities related to rurality and small, close communities are not confined to low and middle-income countries. In the Appalachian region of the USA, O'Donnell et al analyse rural women's experiences related to pregnancy decision-making and pathways to abortion services. They find that these rural women face numerous barriers which relate to inequitable access to abortion care, including issues of acceptability around abortion, the absence of narratives in the community and physical distances involved in accessing care.[11]

Last year, RHM's themed issue on disability and sexuality drew attention to some troubling questions and silences surrounding the inequities faced by disabled people.[12] Badu and co-authors add to that knowledge base by exploring the "double vulnerability" of gender and disability faced by women who are visually impaired. The study describes the barriers of cost, physical access and health worker attitudes experienced by women in Ghana, which contribute to inequitable access to sexual and reproductive health services.[13]

How politics and legislation can deepen inequities

Looking beyond our usual sphere of expertise can often help us to understand how broader factors influence specific events. As a public health practitioner myself, I found the two articles from Peru and Argentina particularly enlightening, and would recommend them to those not familiar with legal and political analyses. Tracing historical events over the course of nearly two decades, Puig Borràs and Alvarez Alvarez show how legislation and state policies resulted in restricted access to emergency contraception for the poor in Peru. The paper highlights how emergency contraception in Peru became politicised and criminalised, without being based on good scientific evidence, while the needs of the most vulnerable populations were disregarded.[14]

This year, Argentina narrowly missed passing a bill to relax restrictions on abortion. Ruibal's case study from Argentina investigates the play of different mechanisms affecting implementation and enforcement of abortion rights at local authority level in recent years.[15] The importance of analysing when critical moments occur in politics, how opposing incentives work at national and subnational levels, and of understanding ideological preferences and political allegiances is demonstrated in this paper. Knowledge of this nature can help or hinder advocates and activists in moving forward changes that help to protect women's rights and equitable access to healthcare.

The complex interplay of policy, power and health system responses was studied by Pot et al in Malawi, when a temporary reintroduction of user-fees for maternity services occurred. They describe how suspension of donor funding, changes in political leadership, shifting priorities and unstable health service contracts resulted in malfunctioning of the health system, loss of trust in the health services and ultimately, the exclusion of vulnerable rural women from maternity services, at variance with the strong national policies for safe motherhood.[16]

Policy, practice, community and individual level solutions

Exploration of the inequities in the papers contained within this themed issue have brought up recommendations for potential solutions. From a policy perspective, Abdul Karimu points out that compliance with national and international frameworks on just and equitable access to health services for all is insufficient, and that disability inclusion in Ghana needs to start at the policy level supported by sound data representing the needs of adolescents with disabilities.[17] The need for evidence to inform laws and legislation is also a theme echoed by Puig Borràs and Alvarez Alvarez's paper on emergency contraception.[14] In addition, the process of decision-making needs to be clearly documented and adequately explained to allow the building of a comprehensive

knowledge base which can be referred to in future situations. Proceedings of the United Nations Human Rights Committee regarding the violation of women's rights in Ireland comes under examination by Sękowska-Kozłowska, who posits that the Committee's findings may have provided better guidance for future reference had their conclusions been supported by deeper analysis and detailed documentation, particularly in relation to the concepts of "formal" and "substantive" equality.[18] In Jamaica, decriminalisation is recommended as a means to uphold the the sexual health and rights of sexually and gender diverse young people.[9]

India is the home of many innovative health programmes designed to target those hardest to reach, and some of these are described by Patel and colleagues in their paper. Their study focused on so-called "scheduled caste" women, who are a group identified in India as facing discrimination, deprivation and health inequities.[19] The recommendations put forward by Patel et al for programme enhancements reflect solutions which have emerged in many other settings, and include the need to change factors which affect the acceptability of childbirth in health facilities, improve the reach of outreach workers in rural *and* urban areas, promote information, develop transportation modalities and abolish charges for health services – both in the form of sanctioned user fees and unauthorised charges from health workers. Although the study did not tease out the specific inequities faced by scheduled caste women over other communities in India, it is likely that the most vulnerable will be affected disproportionately by programmatic inadequacies. Other papers, for example Khatri and Karkee's review of differential maternity service use in Nepal using a "social determinants of health" framework,[20] put forward non-health sector solutions to redress inequities, which included educational and housing needs, creation of job opportunities, and mainstreaming of marginalised communities in economic activities.

Interventions at individual level were also recommended. With the World Health Organization now recommending self-management for some health-related tasks, with appropriate information and support, Erdman pulls together examples drawn from a range of countries, presenting the self-management of abortion as a harm reduction measure and social change which can result in reprieve from immediate inequities of access and the indignities experienced in formal settings.[21] Logie and colleagues also touch on how interpersonal and individual counselling can have positive downstream effects on education, housing and healthcare access.[9] Above all, reframing our own perceptions, as politicians, activists, programme implementers, researchers and community members, in positive directions, for example by looking at coping mechanisms,[6,7] survival strategies[9,20] and reduction of harms[21] may reap benefits in the form of new perspectives, ideas and approaches.

SRHR for all?

The papers included in this themed issue show that we have far to go in realising the vision of SRHR for all. Most poignantly, one paper stands out in demonstrating that much more needs to be done to reach those most vulnerable. Nandi and co-authors write about the Baiga people, a tribal group in India, who have been demanding the right to contraceptive services.[22] Since 1979, their access to permanent, and sometimes temporary, contraceptive methods has been restricted. Their experiences and perceptions in accessing contraceptive services are analysed in the paper, with the authors concluding that the Baiga people are being treated inequitably, discriminated against and denied their reproductive and human rights.

The existence of inequities challenges ideologies of social justice, and situations such as those presented by Nandi et al and other authors, evoke in us a sense of moral outrage.[4] The ambition of the call for no one to be left behind is revealed in the multidimensionality of inequity illustrated in this collection of papers. The papers give examples of inequities resulting from legal restrictions, poor governance, self-motivated political interests, inadequate resources, lack of agency, an inadequate knowledge base and cultural exclusion; bettering our understanding of the diversity and depth of inequity in SRHR. Generating solutions will not be easy, but taken individually and together, the papers can contribute to inspiring new knowledge and actions needed to achieve social justice. It has not escaped our notice that themes of power, politics, stigma and discrimination echo across the papers; areas which we will continue to explore in RHM in coming issues.

References

1. The sustainable development goals 2016. [cited 2018 Oct 5]. Available from: https://unstats.un.org/sdgs/report/2016/leaving-no-one-behind.
2. What does it mean to leave no one behind? A UNDP discussion paper and framework for implementation. July 2018 [cited 2018 Oct 17]. Available from: http://www.undp.org/content/dam/undp/library/Sustainable%20Development/2030%20Agenda/Discussion_Paper_LNOB_EN_lres.pdf.
3. World Health Organization. Equity. [cited 2018 Oct 18]. Available from: http://www.who.int/gender-equity-rights/understanding/equity-definition/en/.
4. Global Health Europe. Inequity and inequality in health. [cited 2018 Oct 18]. Available from: https://www.google.co.uk/search?q = Global + health + europe + inequity&oq = Global + health + europe + inequity&aqs = chrome..69i57.5538j0j7&sourceid = chrome&ie = UTF-8.
5. Morris JL, Rushwan H. Adolescent reproductive and sexual health: The global challenges. Intern J Gynecol Obstet. 2015;131:S1.
6. Bell S, Kennedy E, Black K, et al. Youth-centred research to help prevent and mitigate the adverse health and social impacts of pregnancy amongst young Papua New Guineans. Reprod Health Matters. 2018;26(54):5–12.
7. Swartz A, Colvin C, Harrison A. The problem or the solution? Early fertility and parenthood in the transition to adulthood in Khayelitsha, South Africa. Reprod Health Matters. 2018;26(54):145–154.
8. World Health Organization. Youth and health risks. [cited 2018 Oct 31]. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_25-en.pdf.
9. Logie CH, Abramovich A, Schott N, et al. Navigating stigma, survival, and sex in contexts of social inequity among young transgender women and sexually diverse men in Kingston, Jamaica. Reprod Health Matters. 2018;26(54):72–83.
10. Hameed S. To be young, unmarried, rural and female: intersections of sexual and reproductive health and rights in the Maldives. Reprod Health Matters. 2018;26(54):61–71.
11. O'Donnell J, Goldberg A, Lieberman E, et al. "I wouldn't even know where to start": unwanted pregnancy and abortion decision making in Central Appalachia. Reprod Health Matters. 2018;26(54):98–113.
12. Addlakha R, Price J, Heidari S. Disability and sexuality: claiming sexual and reproductive rights. Reproductive Health Matters. 2017;25(50):4–9.
13. Badu E, Gyamfi N, Opoku MPOP, et al. Enablers and barriers in accessing sexual and reproductive health services among visually impaired women in the Ashanti and Brong Ahafo regions of Ghana. Reprod Health Matters. 2018;26(54):51–60.
14. Puig Borràs C, Alvarez Alvarez B. The history of universal access to emergency contraception in Peru: a case of politics deepening inequalities. Reprod Health Matters. 2018;26(54):47–50.
15. Ruibal A. Federalism, two-level games and the implementation of abortion rights in subnational Argentina. Reprod Health Matters. 2018;26(54):137–144.
16. Pot H, Finyiza G, de Kok B. When things fall apart: local responses to the reintroduction of user-fees for maternal health services in rural Malawi. Reprod Health Matters. 2018;26(54):126–136.
17. Abdul Karimu ATF. Disabled persons in Ghanaian health strategies: reflections on the 2016 adolescent reproductive health policy. Reprod Health Matters. 2018;26(54):20–24.
18. Sękowska-Kozłowska K. A tough job: recognizing access to abortion as an equality issue. A commentary to the views of the UN Human Rights Committee in cases *Mellet v. Ireland* and *Whelan v. Ireland*. Reprod Health Matters. 2018;26(54):25–31.
19. Patel PC, Das M, Das U. The perceptions, health seeking behaviours and access of Scheduled Caste women to maternal healthcare in Bihar, India. Reprod Health Matters. 2018;26(54):114–125.
20. Khatri R, Karkee R. Social determinants of health affecting utilisation of routine maternity services in Nepal: a narrative review of the evidence. Reprod Health Matters. 2018;26(54):32–46.
21. Erdman JN, Jelinska K, Yanow S. Understandings of self-managed abortion as health inequity, harm reduction and social change. Reprod Health Matters. 2018;26(54):13–19.
22. Nandi S, Joshi D, Gurung P, et al. Denying access of Particularly Vulnerable Tribal Groups to contraceptive services: a case-study among the Baiga community in Chhattisgarh, India. Reprod Health Matters. 2018;26(54):84–97.