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**Inequalities in reproductive health: What is the challenge for social work and how can it respond?**  
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### **Abstract**

*Summary:* The purpose of this article is to identify contemporary reproductive health issues and the role of social work in combating them. It draws on an extensive range of sources to overview key reproductive health concerns currently facing millions of people – primarily girls and women in the world's poorest countries: genital cutting; infertility; HIV/AIDS; antenatal sex selection; complications of pregnancy, childbirth and pregnancy termination; and sexual violence.

*Findings:* The article draws on the International Federation of Social Workers/International Association of Schools of Social Work joint statement Ethics in Social Work, Statement of Principles, as a vehicle for providing both a mandate and the necessary value base for social work engagement with reproductive health issues.

*Application:* Finally, the article considers the role of social work in challenging reproductive health disadvantage and inequality, locally, nationally and internationally, highlighting both constraints and suggestions for developing interventions.

*Keywords* ethics reproductive health social work

### **Introduction**

The reproductive health of many millions of the world's population, the vast majority of whom are girls and women who live in middle- and low-income countries,<sup>1</sup> is compromised in the 21st century: girls who are subjected to genital cutting; men and women who are affected by infertility, by HIV and other sexually transmitted diseases; 'missing girls' who are 'selected out' both before and after birth; women and children who are affected by complications of pregnancy, childbirth, and unsafe pregnancy termination, and women who are subject to enforced pregnancy termination in pursuit of state population policies. Behind these unacceptable statistics lie poverty, inadequate access to basic amenities and services, social injustice, discrimination and the systematic subordination and disempowerment of women whose prime – and sometimes only – function in many countries is successful procreation. In spite of recent debt-relief measures for some of the world's poorest countries, the diversion of scarce resources to service debt repayment in many low-income countries – often more than the amount of new aid – has increased poverty-related mortality and ill health. Even within affluent countries many people live in poverty – a large proportion of whom belong to ethnic and racial minorities – with adverse consequences for both their general and reproductive health.

Hitherto, inequalities in reproductive health have not been afforded particular priority by the social work profession, either at national or global levels. This article summarizes key reproductive health issues, indicating the scale, extent and consequences of these where this information is available. That accurate and contemporary data are not always available underlines the need for greater attention to these scourges on the health of the world's poorest citizens. Drawing on the IFSW/IASSW (2004) Ethics in Social Work, Statement of Principles, this article identifies common values and principles on which a social work response to the challenges presented by reproductive health inequalities can begin to be formulated at local, national and international levels.

### **The Challenges**

#### *Female Genital Cutting*

Female genital cutting (otherwise referred to as genital mutilation or, more euphemistically as 'female circumcision'), is a generic term used to describe the partial or total removal of the external female genitalia, and which is performed on girls and women for social or cultural purposes to protect them from non-consensual sexual intercourse, or to prevent them from engaging in illicit sexual activities. Genital cutting may take one of three forms: removal of the prepuce or clitoris, or both; removal of the clitoris and labia minora – accounting for up to 80 percent of all cases; and infibulation, removal of part or all of the external genitalia and stitching or

narrowing of the vaginal opening – the most severe form of cutting which constitutes about 15 percent of all procedures (World Health Organization, 2000).

Despite a 2002 global commitment to end female genital cutting by 2010 (UNICEF, 2007) each year around three million girls and young women at ages ranging between early infancy and first pregnancy are subjected to cutting, although the procedure is most frequently performed on girls between four and nine years of age. It is usually carried out by a traditional practitioner using a variety of implements, including knives, scissors, razor blades, broken glass and tin lids, although an affluent family may arrange for the procedure to be performed by a health professional using surgical equipment and anaesthesia. Worldwide, more than 130 million girls and women are estimated to have been genitally cut. Cutting is practised primarily in sub-Saharan Africa and some Middle Eastern countries, although girls and women who have undergone genital cutting are also increasingly found in Asia and the Pacific, North and Latin America and Europe, primarily within diaspora communities (World Health Organization, 2000).

The adverse physical consequences of genital cutting include severe pain, haemorrhage, damage to tissue or organs surrounding the clitoris and labia, urinary and reproductive tract infections, fertility difficulties, painful or dangerous sexual intercourse and death. HIV transmission may occur as a result of using the same instrument in multiple operations. Women who have been subjected to the most extensive forms of cutting and who subsequently become pregnant are more likely than women who have not undergone cutting, or who have undergone a less severe form of cutting, to experience caesarean section, postpartum haemorrhage, and extended hospital stay; while their infants are more likely to require resuscitation, and to be at higher risk of low birth-weight, stillbirth or early neonatal death. Psychological and psychosexual effects include anxiety, terror, betrayal, depression, humiliation, sexual dysfunction and impaired sexual fulfilment. Paradoxically, genital cutting may be a social requirement to ensure that a woman is accepted within her community, since women who have not been cut may be ostracized as ‘unclean’ or promiscuous, and considered ineligible for marriage – often the only role available for women in communities within which genital cutting is endorsed (World Health Organization, 2000; WHO Study Group on Female Genital Mutilation and Obstetric Outcome, 2006; UNICEF, 2007).

## **HIV/AIDS**

Worldwide, AIDS has claimed the lives of 25 million people since it was first identified in 1981. By 2006, between 34.1 and 47.1 million people throughout the world were living with HIV, of whom between 1.7 million and 3.5 million were children under the age of 15 years. In 2006 a further 3.6 million to 6.6 million new infections occurred, affecting between 410,000 and 660,000 children; between 2.5 million and 3.5 million people died of AIDS-related illnesses, of whom 290,000–500,000 were children. The number of people affected by HIV continues to increase in every part of the world, with especially large increases in Central and East Asia, and Eastern Europe. Almost 25 million people living with HIV live in sub-Saharan Africa, two-thirds of the global population with HIV. In 2006, two-thirds of all new infections and one third of all AIDS-related deaths – occurred here (Joint United Nations Programme on HIV/AIDS, 2006). Increasingly evidence has been provided linking commercial sex work and trafficking for sex work with increased risk of HIV/AIDS, and its spread across national borders (Silverman et al., 2007).

While access to treatment has improved significantly, World Bank investment in reproductive health and HIV/AIDS programmes declined by over 40 percent between 2003 and 2006, while limited funding is provided for reproductive and sexual health by regional development banks for Africa, Asia and South America (Dennis and Zuckerman, 2007). In addition, the World Health Organization failed to meet its ‘3 by 5 initiative’ target – to make available antiretroviral therapy to three million people with HIV/AIDS in the world’s poorest countries by the end of 2005 (World Health Organization, 2003a). Kevin De Cock, the WHO’s HIV/AIDS Director, estimated that by the end of June 2006, 1.65 million people – around a quarter of those in low and middle-income countries needing antiretroviral therapy – were in receipt of it; the lack of treatment most evident in the world’s poorest regions (De Cock, 2006).

Without adequate prevention, about a third of children born to HIV-positive women will contract HIV. Although mother-to-child transmission has been virtually eliminated in industrialized countries, in high-prevalence countries an increasing proportion of childhood mortality is AIDS-related, accounting for two percent of deaths of African children aged under five in 1990, but rising to 6.5 percent in 2003 (World Health Organization, 2005).

## *Infertility*

Infertility is believed to affect a considerable proportion of the world's population, although estimates vary widely and significant variations in prevalence are recorded between different countries. Global estimates range from 60–80 million people who experience primary<sup>2</sup> infertility (affecting between 1 and 8%) or secondary<sup>3</sup> infertility (up to 35%) – most living in low and middle income countries (Vayena et al., 2002) to at least 186 million couples in the world's poorest countries alone (World Health Organization, 2003b). In any event, estimates need to be treated with some caution since they are largely defined on the basis of people who seek assistance to conceive, thus excluding those who do not request such help.

Most infertility experienced by women in the world's poorest countries is attributable to damage caused by reproductive tract infection, notably gonorrhoea and chlamydial infection and is, therefore, largely preventable (Giwa-Osagie, 2002), although it is probable that some social practices prevalent in some cultures, such as marriage between close blood relatives, may also contribute to the incidence of infertility (Unisa, 1999).

While both men and women are affected by infertility, it is generally accepted that the burden of infertility falls disproportionately on women. Women's personal and social identities are more likely to be defined in terms of their biological capacity to conceive and carry a pregnancy and women are more likely than men to be held responsible for a couple's failure to conceive a child. Women are more likely to be the specific targets of – and more vulnerable to – sanctions, although the corollary is that men are frequently sidelined. Women affected by infertility are subjected to a range of psychological, social and communal pressures; the more severe sanctions, including social exclusion, severe economic deprivation, abuse, violence, violence-induced suicide, murder and 'lost dignities in death' (i.e. a lack of respect afforded to a childless woman after her death) are experienced predominantly by women in low and middle income countries. These are accentuated by limited access to information about infertility and assisted conception services, limited availability of assisted conception services, and the high cost of assisted conception services relative to incomes (Daar and Merali, 2002).

## *Sex Selection – Antenatal Elimination of Girls*

In many societies, it is not usually sufficient for a woman to conceive a child – there are strong historical, cultural and religious expectations and pressures on her to produce a son. This is often the only means by which women can achieve respect, status and security; while men who fail to produce a male heir may be regarded as failing to discharge their kinship obligations (see, for example, Qiu, 2002). In 'son preference' cultures, 'unwanted' infant girls have traditionally been abandoned, placed for adoption, neglected – thus reducing their chances of survival – or killed (Chan et al., 2006).

Developments in ultrasound technology have enabled similar objectives to be achieved ante-natally to determine the sex of a foetus, and subsequent abortion of an unwanted female. It is claimed that the impact of sex selection in reducing the number of baby girls born has resulted in millions of 'missing' girls in China (Xinhua, 2006) and India (Jha et al., 2006) and serious sex ratio imbalances in these and other countries such as Korea and Taiwan. Hudson and den Boer (2004) estimate that by 2020, there will be approximately 30 million 'surplus' males aged 15–35 in both China and India. Although prenatal testing solely to determine the sex of a foetus has been banned in these countries, it is questionable whether government action has occurred in time to forestall an unprecedented demographic crisis:

a stage may soon come when it would become extremely difficult, if not impossible, to make up for the missing girls. (United Nations Population Fund, 2003: 1)

Inevitably, there are consequent human costs, with increased reports of abductions/'bride trafficking' and forced marriage affecting many young women (Banister, 2004; Hughes et al., 1999), although the nature of these practices necessarily means that it is impossible accurately to document their prevalence and impact.

## *Children Born with Congenital Health Problems*

Each year nearly eight million babies – accounting for six percent of all births – are born with birth abnormalities of genetic or partially genetic origin. More than three million are stillborn and approximately four million die within a month of birth (Save the Children, 2006). At least 3.3 million children aged under five years die from birth abnormalities annually and an estimated 3.2 million survivors may be disabled for life (March of Dimes Birth Defects Foundation, 2006). Ninety-four percent of birth abnormalities and 95 percent of infant deaths occur in the world's poorest countries – resulting from significant differences in maternal health and other risk factors, including poverty, inadequate access to maternal health care services, differences in the

frequency of younger mothers, consanguineous marriage rates and an increased frequency of some disease-causing genes. Evidence from affluent countries shows that up to 70 percent of potential birth defects are preventable through measures such as improved access to maternal health care, genetic testing; nutrition programmes; folic acid supplements in mothers' diets; prenatal diagnosis; infant screening; and surgical repair of heart defects – whose availability is much reduced in the world's poorest countries (March of Dimes Birth Defects Foundation, 2006).

### *Pregnancy Termination*

Each year, around 80 million girls and women have unintended pregnancies, 45 million of which are terminated (Glasier et al., 2006). An estimated 68,000 of the 19–20 million girls and women who undergo an abortion performed by an insufficiently skilled individual, or in an environment lacking in adequate medical standards – or both – will die (Grimes et al., 2006; International Planned Parenthood Federation, 2006) – accounting for at least 15 percent of maternal deaths worldwide and up to 50 percent in some countries, and making unsafe pregnancy termination one of the most significant contributors to global maternal mortality. Ninety-seven percent of unsafe abortions occur in the world's poorest countries (World Health Organization, 2004). Enforced pregnancy terminations are imposed on women in some parts of China in compliance with the state one-child policy (Marquand, 2006).

Many thousands of survivors of pregnancy termination face resultant debilitating, and frequently lifelong, injuries, more than 96 percent of whom live in the world's poorest countries (International Planned Parenthood Federation, 2006).

Efforts to ensure safer pregnancy termination and to meet internationally agreed targets to reduce the number of maternal deaths in the world's poorest countries, where the provision of services is dependent on financial assistance from donor countries, have been hampered by the 'Mexico City Policy' of the United States (otherwise known as the 'global gag' rule), introduced by the Reagan government in 1984, lifted by the Clinton administration but reimposed by the Bush administration in 2001 (Bush, 2001).<sup>4</sup> The 'global gag' prevents foreign NGOs in receipt of US family planning funds from providing pregnancy termination (except where pregnancy endangers the woman's life or is the result of rape or incest) or offering advice on pregnancy termination, even when that work is funded from non-US sources. In practice, fear of breaching the 'global gag' rule has frequently curtailed the provision of permitted pregnancy termination and dispensation of emergency contraception (Center for Reproductive Rights, 2003). However, the perverse effect of the 'global gag' has not been to stop pregnancy termination; rather, it has reduced significantly the provision of safe pregnancy termination, and facilitated the proliferation of clandestine and less safe pregnancy termination for women desperate, at whatever risk to their own health and lives, to terminate an unwanted pregnancy.

### *Unsafe Pregnancy and Childbirth*

More than half a million women die from complications associated with pregnancy, childbirth, and the postpartum period, greatly increasing the risks to their young children (Glasier et al., 2006). At least another 15 million women suffer serious illness or debilitating injuries (Murray and Lopez, 1998). Ninety-eight percent of all maternal deaths occur in the world's poorest countries (Save the Children, 2006). In these countries, pregnant girls aged under 15 are at increased risk of premature labour and are four times more likely than women aged over 20 to die from pregnancy-related causes (Guttmacher Institute, 1998). Maternal complications connected with pregnancy and childbirth are more likely to occur in the absence of adequate health care before, during, or after childbirth. Since around half of all births in low and middle income countries are not attended by a qualified health professional, the incidence of adverse outcomes is not well documented. The most severe complications of pregnancy and childbirth in the world's poorest countries are:

- Severe postpartum haemorrhage – the leading cause of maternal death.
- Infection during or after labour – women who survive the initial infection may develop pelvic inflammatory disease which, if untreated, can cause chronic pelvic pain and permanent reproductive damage.
- Obstructed or prolonged labour when the foetus will not fit through the mother's pelvis – particularly affecting very young, not fully adult, mothers.
- Pregnancy-induced hypertension (pre-eclampsia and eclampsia).
- Unsafe pregnancy terminations that are self-induced or performed by unskilled abortionists (Ashford, 2002).

## *Sexual Health, Sexual Violence and Reproductive Health*

While I have expressly avoided incursion into the areas of sexual health and sexual oppression of women that do not also have a clear association with reproductive health, I will refer to three practices, forced marriage, so-called 'honour' killings and rape as a weapon of war, within the context of reproductive health.

### *Forced Marriage*

The true incidence of forced marriage, to which at least one the parties has not given her or his valid consent and has been subject to overt or implicit physical and/or psychological coercion, is unknown. In the UK, several hundred cases are brought to official attention each year. While most victims are women, some are men and children as young as 12. Forced marriage may also involve kidnapping or trafficking. Most known instances in the UK involve South Asian families, although it is also known among families from Africa, Europe, the Middle East, and South-East Asia (Forced Marriage Unit, 2006). The major reasons for forced marriages include:

- Controlling 'undesirable' behaviour and sexuality, especially among young women.
- Controlling 'unsuitable' relationships.
- Protecting 'family honour'.
- Meeting family obligations.
- Acquiescing to family or peer group pressure.
- Promoting family connections.
- Retaining land and possessions within the family.
- Acquiescing to perceived cultural and/or religious ideals.
- Facilitating residence and citizenship applications (Foreign and Commonwealth Office, 2004).

### *'Honour' Killing*

'Honour' killing, predominantly inflicted on women, may be committed for a variety of reasons which involve perceptions that the offender has brought dishonour on her family. Offending behaviours include disapproved sexual behaviour, participating in a disapproved sexual or emotional relationship, refusing to agree to an arranged marriage, and seeking divorce. A woman who has been raped may become a victim of 'honour' killing because of the shame experienced by her family. In most known instances of 'honour' killing, the victim is executed by a close family member, who is likely to receive community endorsement. More rarely, a man may be the victim of 'honour' killing, especially where he has been party to the proscribed behaviour, although a male offender can often evade death by agreeing to compensate the family of the female victim. Perversely (but indicative of the low status afforded women), women from the offender's family are not-infrequently traded as part of a compensation agreement. The prevalence of 'honour' killings is difficult to estimate since families and sympathetic officials may conspire to ensure that the murder is formally recorded as suicide or accidental death. Reported 'honour' killings are most prevalent in the Middle East and South Asia, and in migrant communities in other parts of the world (Amnesty International, 1999, 2004; BBC News Online, 2004; Gendercide Watch, n.d.).

The state may also sentence to death women who engage in illicit sexual relationships. Several northern Nigerian states apply Sharia law, under which capital punishment may be imposed following conviction for extra-, or premarital, sex – often evidenced by the woman's pregnancy. A rape survivor can receive a similar punishment, unless the woman is able to convince the court of her involuntary participation. This can be difficult to establish because of courts' inclinations to accept as proof of innocence a man's denial under oath of having had sexual intercourse with the woman, unless refuted by four independent and reputable eye-witnesses. The nature of the offence means that an accused woman can rarely summon such confounding evidence (BAOBAB for Women's Human Rights and Amnesty International, 2002).

### *Rape as a Weapon of War*

Rape has tended to be perceived as a more-or-less inevitable by-product of armed conflict, providing sexual gratification for male combatants. However, rape has also been tactically and systematically used, to extract information, to enforce population dispersal and to demoralize, humiliate, intimidate and subjugate target populations. Rape has also been employed deliberately as an instrument of 'ethnic cleansing' – to compromise the ability of the subject population to regenerate. Unmarried rape survivors may be deemed 'unfit' for marriage, while the marriage of married survivors may be jeopardized. As a result of these feared consequences, it is widely accepted that many rapes remain unreported and that official data significantly underestimate the prevalence of abuse. Rape in war – especially where the conflict has an ethnic focus – may also be used with the intention of impregnating subjugated women, further to compromise the ethnic integrity of the rival group

(Amnesty International, n.d.; Physicians for Human Rights, 2002, 2006; Thomas and Regan, 1994). Refugee women are also exposed to rape, sometimes routinely, in refugee camps ostensibly established to ensure their safety and survival (Pittaway and Bartolomei, 2001).

### **So What Can – and Should – Social Workers Do?**

I do not take it as self-evident that the issues raised in this article will necessarily be accepted as a responsibility for social workers per se – over and above the legitimate concern that any of us might be expected to have, as concerned individuals, for our fellow human beings.<sup>5</sup> After all, it might well be argued that social work is more than fully occupied with its ‘core business’ – and outside specialized positions, very few social workers in industrialized countries, at least, will confront reproductive health disadvantages in their daily work.

A review of the social work literature reveals that most reported social work activity in reproductive health has focused on HIV/AIDS (see, for example, Chernesky and Grube, 2000; Health and Social Work, 2004; Joseph and Bhatti, 2004; Ka’Opua and Mueller, 2004; Mugambi, 2006; Sachdev, 2005; Social Work in Health Care, 2006; Voisin et al., 2006) and infertility and assisted conception (Bergart, 2000; Blyth, 1993, 1999; Blyth et al., 2001; Daniels, 1993; Gagin et al., 2004; Landau, 2004; Robinson and Miller, 2004; Schneider and Forthofer, 2005; Sewpaul, 1999; Wincott and Crawshaw, 2006). Social work engagement in other areas of reproductive health appears limited: adolescent and teen pregnancy (de Anda, 2006; Marx and Hopper, 2005; Rothenberg and Weissman, 2002; Sangalang et al., 2006); ‘high risk’ pregnancy (Leichtentritt et al., 2005), and sex selection (Hollingsworth, 2005).

Furthermore, the sheer scale of the problems internationally and the numbers of people affected may easily render us incapable of contemplating a positive response; encouraging restriction of our attentions to issues that are closer at hand, more obviously social work ones, and apparently more amenable to alleviation. Webb (2003: 191, cited in Lyons, 2006) has also suggested that social work is primarily concerned with local practice:

At best [social work has] a minimal role to play with(in) any new global order, should such an order exist . . . [and] . . . any notion of global or trans-national social work is little more than a vanity.

However, Lyons (2006: 366) counters this view, arguing that social work everywhere is confronted by social problems that are influenced by local and global processes. For Lyons, social work needs to act trans-nationally and trans-culturally in order to develop collaborative regional and international responses – to ‘think globally; act locally’.

The case I make for social work to be concerned about reproductive health draws primarily on the general notion that social workers frequently act as ‘the conscience of the community’ (IFSW, 1996) and, more specifically, to core ethical principles to which social workers subscribe as elucidated in the IFSW/IASSW (2004) Ethics in Social Work, Statement of Principles. National professional bodies’ codes of ethics are also relevant and some years ago I made what I hoped was a reasonably persuasive case to advocate for social work interest in infertility and assisted conception through reference to the British Association of Social Workers’ Code of Ethics for Social Work (Blyth, 1999). Below, I outline the justification for social work globally to give consideration to the broader issues of reproductive health and the actions that can be promoted in accordance with the IFSW/IASSW Statement of Principles<sup>6</sup> (see Table 1).

Social work is not the principal professional interest group in matters of reproductive health. Even where social work is more centrally involved in reproductive health, unless its goals and concerns are also shared by more powerful interests, it risks being marginalized and is unlikely to be in a strong position to promote change without the support and endorsement of the international social work community. Solidarity and joint action have been successfully employed by women to promote their empowerment to make decisions about their own reproductive health. These can be adapted to similar effect by the social work community at both national and international levels through collaboration with other groups and organizations who share similar concerns and agendas to achieve improved sex equality and life opportunities for women, better access to quality health care, more equitable laws and policies and their application, and to make freedom of reproductive choice a reality rather than a rhetorical illusion.

In promoting such international endeavours, those of us from affluent countries must avoid the ‘colonial imperative’ of giving the impression that we know best what other countries should do to promote the empowerment of their girls and women, especially when there is still much to be achieved in our own countries. My own country, the United Kingdom, records the highest rate of teenage conceptions in Western Europe (Department for Education and Skills, 2006). The world’s richest and most powerful country, the United States,

provides an even starker caution. It remains one of only two member states of the United Nations yet to ratify the UN Convention on the Rights of the Child, and one of a handful that have failed to ratify the UN Convention on the Elimination of All Forms of Discrimination Against Women.<sup>7</sup> Infant mortality rates in the United States are among the lowest for industrialized countries (Save the Children, 2006), affecting particularly black, Hispanic, Asian and American Indian babies (Healy et al., 2006). Federal and state policies provide ‘a grim reminder of the continuing assault on women’s reproductive health’ (Sable and Galambos, 2006: 163).

The reproductive health of many American women (mostly black and poor) is compromised by domestic legislation and policy that severely curtail access to pregnancy termination or emergency contraception (NARAL Pro-Choice America, 2007). Misinformation motivated by religious fundamentalism that accompanies some federally funded ‘abstinence-until-marriage’ sex education programmes effectively encourages unsafe sex among sexually active adolescents. Through the President’s Emergency Plan for AIDS Relief, ‘abstinence-until-marriage’ programmes – whose domestic success in delaying or preventing teen sex has come under scrutiny (Trenholm et al., 2007) – are being exported to other countries, including to countries with high HIV rates (Human Rights Watch, 2005).

**Table 1 IFSW/IASSW Ethics in Social Work: Statement of Principles and social work action to promote reproductive health**

IFSW/IASSW Statement of Principles	Examples of social work action to promote reproductive health
‘The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being’ (2)	Promotion of gender equality, to ensure that women and girls are treated equally with men and boys in all areas of life.
‘Principles of human rights and social justice are fundamental to social work . . . International human rights declarations and conventions form common standards of achievement, and recognise rights that are accepted by the global not done so. community’ (2–3)	Pressurizing own governments to meet their obligations to international commitments (especially UN Conventions) and to ratify and implement such Conventions where they have not done so.  Social work advocacy at the United Nations (Cronin et al., 2006).
‘Social workers should be concerned with the whole person, within the family, community, societal and natural environments, and should seek to recognise all aspects of a person’s life.’ (4.1.3)	Promotion of a holistic definition of ‘well-being’ – which necessarily includes all aspects of reproductive health.
‘Social work is based on respect for the inherent worth and dignity of all people, and the rights that follow from this. Social workers should uphold and defend each person’s physical, psychological, and spiritual integrity and well-being.’ (4.1)	Challenge all forms of reproductive violence (rape, forced marriage, female genital cutting, enforced pregnancy termination that targets female foetuses).  Promotion of relevant educational programmes (e.g. to counter assumptions and beliefs that forms of reproductive violence are sanctioned or mandated by particular faith communities) – and challenge cultural practices that provide a basis for such discrimination against girls and women.
‘Social workers should respect and promote people’s right to make their own choices and decisions.’ (4.1.1)	Promotion of individual reproductive choice and decision-making (that is consistent with avoiding harm to vulnerable third parties) and challenge reproductive health policies and practices that facilitate forms of reproductive violence, and restricted access to services.  Promotion of adequate access to services irrespective of status and geographical residence – in particular ‘race’, ethnicity and gender.
‘Social workers have a responsibility to challenge negative discrimination on the basis of characteristics such as ability, age, culture, gender or sex, marital status, socio-economic status, political opinions, skin	Support for full implementation of international human rights declarations and conventions (e.g. Universal Declaration of Human Rights; Convention on the Elimination of All Forms of Discrimination

colour, racial or other physical characteristics, sexual orientation, or spiritual beliefs.’ (4.2.1)	against Women; Convention on the Rights of the Child; the ‘Cairo Consensus’; Millennium Development Goals’) <sup>a</sup>
‘Social workers have a duty to bring to the attention of their employers, policy makers, politicians and the general public situations where resources are inadequate or where distribution of resources, policies and practices the are oppressive, unfair or harmful.’ (4.2.4)	Promotion of foreign aid, debt-relief provisions and fair global trade, to ensure that the socio-economic advantages, including access to quality healthcare services, currently enjoyed by the world’s most affluent countries, become available to all.
‘Social workers have an obligation to challenge social conditions that contribute to social exclusion, and to work towards an inclusive society.’ (4.2.5)	Challenge practices that exploit materially disadvantaged women for reproductive purposes. <sup>b</sup>

**Notes:**

a The 1994 International Conference on Population and Development (ICPD) formulated a 20-year Programme of Action (the ‘Cairo Consensus’) to promote gender equality and women’s empowerment, infant, child and maternal mortality reduction; and universal access to family planning and sexual and reproductive health services. The conference also considered three previously-neglected areas: unsafe pregnancy termination; violence towards women – in particular female genital cutting; and adolescent sexual and reproductive health (United Nations Population Fund, 1994). Progress on implementing the plan of action was reviewed in 1999 at the ‘ICPD+5’ review (United Nations Population Fund, 1999) and in 2004, ‘ICPD at 10’ (United Nations Population Fund, 2004). In the meantime, the UN 2000 Millennium Summit, which produced the ‘Millennium Declaration’, identified eight ‘Millennium Development Goals’, also for implementation by 2015, reaffirming the international community’s aspirations to promote gender equality and empower women, reduce child mortality, improve maternal health, combat HIV/AIDS, and to tackle the ‘special needs’ of Africa (United Nations, 2000). Immediately after the 1994 ICPD, reproductive health funding by wealthy donor countries increased substantially, but then fell back. And it is clear that, while the targets for 2015 have always been described as achievable, little progress has been made in achieving either the 1994 commitments or the reproductive health priorities specified in the ‘Millennium Development Goals’. The lack of progress has been especially evident in the least advantaged countries of sub-Saharan Africa (United Nations, 2004, 2005).

b See, for example, the resolution adopted by the International Federation of Social Workers at its 2006 General Meeting: *An increasing number of people, primarily from wealthy countries, are obtaining fertility treatment in countries other than their own, because such treatment is illegal or otherwise unobtainable in their own country or because it can be obtained more cheaply in the destination country. This General Meeting requires IFSW to consult with members about the impact of these activities on the well being of all concerned and bring forward policy proposals to the 2008 General Meeting.*

**Conclusion**

The challenges to reproductive health faced predominantly by millions of the world’s girls and women are enormous. I have offered a summary overview of these in this article and have begun to outline what I consider to be social work’s mandate to respond to these challenges. There is evidence that the international social work community has begun to do so. An international Social Work and Health Inequalities Forum was established at the joint International Federation of Social Workers and International Association of Schools of Social Work congress held in Adelaide in October 2004, with objectives to ‘promote discussion and action by social work practitioners, managers and educators to combat the causes and consequences of unjust and damaging socially created inequalities in health’, and which is currently engaged in reviewing and updating IFSW’s Policy Statement on Health (Social Work and Health Inequalities Forum, 2004).

As regards reproductive health specifically, it is evident from the resources drawn on in preparation of this article that while there will be different concerns and priorities in individual countries, common cause can be found with a range of national and supranational organizations whose mandate is to safeguard and promote human rights generally and to improve reproductive health more specifically.<sup>8</sup> While the challenge is daunting, it is not therefore one that social work is forced to face alone. Forging effective collaborative networks should be a priority for the international social work community.

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## Notes

1. Based on 2006 per capita gross national income (GNI), the World Bank has categorized countries as 'high income' (GNI >US\$11,116), 'upper middle income' (GNIs US\$3596–US\$11,115), 'lower middle income' (GNIs US\$906–US\$3595) and 'low-income' (GNI <US\$906) (World Bank, 2006).
2. Primary infertility is defined as a failure to conceive a pregnancy after at least 12 months of unprotected intercourse, although some definitions use a 24-month time period.
3. Secondary infertility is defined as a difficulty conceiving after already having conceived and carried a pregnancy to term.
4. In September 2007, the Democrat-dominated Senate and House of Representatives each supported measures reversing 'global gag' policies, although at the time of writing these remained subject to the threat of Presidential veto (Preston, 2007).
5. As individuals, social workers can also, of course, support various national and international groups, for example, Amnesty International, Gendercide Watch, Human Rights Watch, whose campaigns are designed to improve individual's human rights, including reproductive health.
6. I am mindful of the argument that ostensibly universally accepted conventions themselves may represent an imposition of 'Western' values on other cultures – see for example, Aziz (1999) and Skegg (2005). It is essential that cultural diversity is given adequate recognition while not permitting this to provide a 'cloak of respectability' for the perpetuation of human rights abuses.
7. The UN Convention on the Elimination of All Forms of Discrimination Against Women is 'the only human rights treaty which affirms the reproductive rights of women and targets culture and tradition as influential forces shaping gender roles and family relations. It affirms women's rights to acquire, change or retain their nationality and the nationality of their children. States parties also agree to take appropriate measures against all forms of traffic in women and exploitation of women' [<http://www.un.org/womenwatch/daw/cedaw/>].
8. See, for example, Ipas [<http://www.ipas.org/>] and the International Federation of Gynecology and Obstetrics Women's Sexual & Reproductive Rights Committee [<http://www.ifo.org>].

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