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RESEARCH ARTICLE

Global Reproductive Health: Perspectives, Challenges, and Future Directions

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Abstract: The paper conducts a synthesis integrative review of the existing literatures about the various local perspectives on contemporary issues, challenges, lessons and opportunities that several countries around the world confront with regards to reproductive health program and services. Using the public policy approach, the paper seeks to create a global perspective synthesis on reproductive health experiences in the context of policy issues, policy opportunities, and policy-making dimension. In the end, the paper found out that global reproductive health programs and services issues included an interplay of culture and ethnicity, socio-economic status, tradition, religion, language research, education, and equity and quality challenges while policy-direction challenges and opportunities encompasses a more devolved primary health clinics and hospitals, funding for research on sexual and reproductive health, developing a framework for indicators on health care, civil society engagement, reproductive health education , reproductive health as a matter of human right as well training and professionalization of reproductive health service providers.

Keywords: global, health care, program, public policy, reproductive health,

A lot of countries have already passed a reproductive health law which intends to safeguard women from unsafe abortion, promote maternal care, and protect them from the unnecessary detrimental effects of early and premature pregnancy, provisions for maternity clinics and medicines, and the like. Women around the world rejoice and applaud the advent of a law that would specifically advance and take care of their reproductive rights and maternal health through access to contraception and the freedom to decide childbearing.

While there are reproductive health programs in place, there are still several issues, challenges, and questions in its policy-making and policy-implementing dimensions. In viewing reproductive health as human right for instance, there are nagging questions whether it is a matter of provisions or a matter of access; and which foundational and decisional model which it would adhere upon in its theoretical and practical understanding. Much in question also includes the effectiveness of the delivery of reproductive health programs and services to the clients by its

health care providers and professionals (Davies, 2010; Gable, 2010).

Reproductive health rights include the right to make free and informed decisions on child-bearing; respect for the protection and fulfillment of reproductive health and rights; right of access to effective and quality health care services and medicines; respect for individual's preferences and choice of family planning methods in accordance with one's religious beliefs and cultural background; provision of reproductive health care, information, and supplies especially for the poor; and other set of human rights stated in international human rights treaties.

The International Conference on Population and Development (1994, par. 7.2) defined reproductive health (RH) as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfactory and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so".

This definition is universally accepted. It stresses a positive approach by not limiting RH to absence of disease or infirmity. The term refers to a multi-disciplinary focus, and it incorporates a rights-based approach. Furthermore it includes, in the second part of the definition, three main areas: sexual health (satisfying and safe sex life), family planning (knowledge of and access to contraceptives, as well as treatment of infertility), and mother and infant health; nowadays often referred to as safe motherhood (Ketting & Esin, 2010, p. 272).

Sexual health was originally defined as one of the components of reproductive health but over time the concept of reproductive health has come to be known as sexual and reproductive health. Sexual and reproductive health (SRH) covers issues such as education, gender, poverty, and mobility in addition to the original components of reproductive health (Shaw, 2009).

The World Heart Organization (2009) on its part gives a much recent definition of reproductive health which implies that people are able to have a responsible, satisfying, and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. This definition enunciate the element of freedom and responsibility in the decision-making and capacity of individuals and couples which RH methods and programs they find rational, ethical, and appropriate as a matter of choice.

The much recent and applicable definitions of reproductive rights is the one made by the National Black Women's Health Project (as cited in Fried, 2013, p. 11) which places the right to have a child, the right not to, and the right to parent one's existing children on an equal footing and stressed that legal rights alone are not adequate. Women must have the resources necessary to turn their rights into realities. Thus, access to health, education, and employment all become part of the reproductive rights agenda, and an individual woman's rights and health were linked to that of her community.

With these ideas in mind, the article would adhere to the following content and structure: Firstly, it would review, analyze, and synthesize current program and service issues and perspectives of reproductive health care as culled from various academic literature; secondly it would attempt to identify and criticize the results and outcomes of these issues and perspectives hurled towards reproductive health care; and thirdly, the article would posit and argue some possible recommendations and suggestions as opportunities for improvement of reproductive health programs aided by various literature and studies written bearing the subject and topic of sexual and reproductive health as future directional opportunities. The article will conclude with some afterthoughts on the future directions and challenges which still lies ahead that needs to be realized and researched upon in the pursuit of a better reproductive health program formulation and implementation.

The article presents and analyzes the reproductive health programs and services issues, perspectives, and challenges which are existing in several countries that embrace the concept of reproductive health in its policy-formulation and implementation, particularly in implementation of reproductive health rights by providing the adequate and sufficient resources

necessary to its realization. These challenges are crucial and critical, which affects all the stakeholders involved in reproductive health whether in the capacity of a lawmaker, health officials, health providers and professionals, young adolescents, men, and more importantly women and their babies who are the main beneficiaries and the foremost persons in mind in the formulation of the law and in the implementation of its programs and services.

The article also highlights the criticality of reproductive health issues and challenges and how awareness of these RH issues and challenges will aid policy makers and program service providers seek answers, solutions, recommendations, and suggestions as a basis of understanding on how the effectiveness of reproductive health care programs and services may be enhanced and improved upon through an accumulation and conglomeration of interlocking and intertwined sets of appropriate theories and practices which countries around the world may heed from each other as best practices and examples of reproductive health care fitted for its culture and purpose.

Methods

Literature on reproductive health was sought via electronic database EBSCO searches and journal hand searching in the identification of the papers to be utilized and reviewed for the period of January 1973 to January 2013. The search was limited to articles on reproductive health published in English using key words such as "reproductive health", "reproductive health law", "reproductive rights and justice", "reproductive politics" and sexual reproductive health as a basis for literature search. The criteria of the literature search include policy-based approach, synthesis review-oriented as well as the significance and relevance of its perspectives and findings supportive to the paper's thrust and objectives. There were more or less 53 articles employed and utilized in the analysis and discussion of the paper's significant points and ideas. Integrative review was utilized based on the methodology of Whittenmore and Knafl (2005). An integrative literature review sought to provide a comprehensive understanding of a topic and produce new knowledge through the synthesis of existing information.

Articles retrieved included diverse methodologies, including both experimental and non-experimental studies. The review targeted articles using a policy-based approach, and then employed a discourse analysis through assignment of meanings and interpretations to the perspectives, issues, challenges, and opportunities presented by such reviewed articles. The paper opts for a qualitative approach employing an integrative review manner to provide synthesis knowledge and understanding in order to develop future program capacity-literature in developing reproductive health program and services.

Results

Global Reproductive Health Programs: Issues and Perspectives

The reproductive health policies, systems, program, and services remain a daunting challenge and enviable task for social science researchers and practitioners. The design of reproductive health programs fell within the category and purview of capacity-development challenges while the delivery of such reproductive health programs and services coincided within the program-implementation challenges (Smit, Church, Milford, Harrison, & Beksinska, 2012; Whittenmore & Knafl, 2005).

There have been numerous sexual and reproductive rights and legislation already passed but these SRH laws remain inadequate and insufficient to meet and satisfy the needs of the clients and other stakeholders in the reproductive health sectors. But the RH policy-making challenges were not left unnoticed and unabated by some RH researchers.

Table 1 reveals the matrix of specific RH issues and challenges in which some countries confront and experience RH delivery of programs and services. The main specific and detailed points of the matrix table are discussed and analyzed in the subsequent topics.

Table 1 *Matrix of RH Issues and Perspectives in Some Countries*

Country	Issues and Perspectives
United States	Disparities in priorities and establishment of RH hospitals, clinics and center; access inequalities among the minority, young, and disadvantaged; linguistic and socio-economic difference (Hall, Moreau, & Trusell, 2012; Natavio, 2013; Moore et.al., 2012)
Mexico	Restrictive legislation, conservatism, religion (Becker & Olavarrieta, 2013; Westoff & Bumpass, 1973; Instone & Mueller, 2011; Gaydos, Smith, Hogue, & Blevins, 2010)
Guatemala	Ethnic and linguistic differences; Spanish-Mayan language dichotomy (Ishida, Stupp, Turcios-Ruiz, William, & Espinoza, 2012)
Ecuador	Weak interaction between right holders and duty bearers (Goicolea, 2010)
Germany	Adequacy, timeliness, and appropriateness of information dissemination (Stoebel-Richter, Geue, Borkenhagen, Braehler, & Weidner, 2012; Berger, Wieringa, Lacroux, & Dijkhuizen, 2011)
Russia	Limited resources; moral decisional challenges (Larivaara, 2010)
Turkey	Uplifting the professionalization of nursing in RH care (Yazici, Zengin, & Karanisoğlu, 2011)
Netherlands	Lack or limited access of illegal female immigrant to RH care and service (Schoevers, van den Muijsenbergh, & Lagro-Janssen, 2010)
Nigeria	Harmful cultural practices and traditions (Igberase, 2012)
South Africa	Verbal, emotional, and physical abuse (d'Oliveira, Diniz, & Schraiber, 2002)
Ghana	Verbal and emotional abuse (Yakong, Rush, Bassett-Smith, Bottorff, & Robinson, 2010)
Jordan	Basic information on sexuality, gender, and reproductive health education (Khalaf, Abu Moggli, & Froelicher, 2010)
Egypt	Inadequate reproductive health facilities and physicians (Zaky, Khattab, & Nahal, 2010)
Australia	Teen-age sexual promiscuities (Siebold, 2011)
New Zealand	Inequities of reproductive health programs and services in some school clinics (Denny et al., 2012)
Taiwan	Reproductive health awareness of care givers to women with intellectual disability (ID) (Lin et al., 2011)
Vietnam	Commune hospital system as income-generation facility to rural poor (Ngo & Hill, 2011)
India	Community hospitals accessible to rural men (Char, Saavala, & Kulmala, 2011)

RH issues and challenges in North America (US and Mexico). The observation made on the RH issues and challenges in the United States points to the disparity of priorities and establishment of reproductive health hospitals, centers, and clinics, which varies depending on the availability of funds and resources which are needed for its establishment and to lure prospective competent health care providers and professionals through sufficient government funds and subsidies. Such disparities and inequalities in terms of accessibility to reproductive medicines and facilities may be affected by socio and cultural factors like budget allocation, competency and availability of health care professionals, and government healthcare policies and programs.

These views on the disparities and inequities in RH services among women particularly of the marginalized and underprivileged segment of society are reinforced by Hall et al. (2012, p. 366) when they noted that:

> Inequalities in reproductive health care for women in the United States exist, and they disproportionately affect young, minority, and socioeconomically disadvantaged women. Disparities in service use may reflect changing

> social and political factors that undermine confidential reproductive health care for all women but particularly for women of certain socio demographic groups.

Hall et al. (2012) focused in the socio-economic demographic profile challenge that reproductive health care posed on the marginalized women such as the young, minority, and the poor women which may have been deprived of right and access to reproductive health care programs and services. These findings was later concurred and shared by Natavio (2013, p. e1) when she posited that women who reside in the highly populated and diverse county of Los Angeles may face barriers to obtaining comprehensive reproductive health services. In particular, women may face linguistic, cultural, and socio-economic barriers, among others, that contribute to disparities in reproductive health and access to safe abortion.

This time, Natavio (2013) specifically singled out these socio-economic challenges cited by Hall et al. (2012): overpopulation and language problem. Overpopulation stood as an RH challenge because, normally, women competing for limited supply and resources of reproductive medicines, clinics, and hospitals would find themselves empty handed if there are more counterparts and beneficiaries availing such programs and services. Language differences on one hand served as a stumbling block in communication and interacting the wants and needs of the clients to their health care providers more specifically their doctors, nurses, midwives, and caregivers. Such disconnect with language preferences more often than not resulted into communication breakdown with either both the client and health providers getting confused and frustrated which inevitably result to clients being unattended and uncared for.

Moore et al. (2012, p.1833) further depicted the existing condition of growing inequalities and disparities of RH, which affected exotic women dancers in the United States as marginalized women when they emphasized that the numbers of women served exceeded expectations, but few women were connected to a clinic for full reproductive exams despite referrals, next-day appointments, telephone reminders, and incentive.

In this study, Moore et al. (2012) dug deeper on the plight of exotic women dancers as they addressed the issue of lack of access and the absence of programs and mechanism by which these women may avail and have access to reproductive health programs and services owing to the nature and schedule of their work. Among key findings were that mobile reproductive health services were feasible and affordable because they were integrated into needle exchange services and volunteers were used. Joint provision of needle exchange services and reproductive health services to exotic dancers has the potential to reduce unintended pregnancies and link pregnant women to care, and such programs should be implemented more widely (Moore et al., 2012, p. 1833)

While the RH challenge in the United States revolved around policy change and program directions with regards to socio-economic and cultural barriers, in Mexico the RH challenge laid on structural reforms particularly in the enactment and promulgation of a national statute which legalized safe abortion applicable to all parts of the country not just to its capital, Mexico City. Becker and Olavarrieta, (2013, p. e4) explained that:

> Although Mexico City's abortion legislation is an important first step to improve women's reproductive health and rights in Mexico, the continued restrictive abortion legislation in the states of Mexico and the conservative backlash will likely result in the persistence of unsafe abortions in Mexico's states and the criminalization of women who seek abortions. To end unsafe abortions and ensure equal access to reproductive rights and health for all Mexican women, similar abortion legislation is needed across the entire country.

Since Mexico's population were predominantly Catholics, such move to legalize abortion would likely face stiff opposition from the Roman Catholic religious leaders of the country, which preached respect for life that begins during conception and were very much against the free distribution and use of contraception as a tool for population control. In Mexico, religion played an important role in figuring out the RH challenge and must be

put into the equation in the same mold of socio-economic, demographic, and language dimensions which factored in prominently on the RH issues and challenges in North America.

RH issues and challenges in Latin America (Guatemala and Ecuador). Westoff and Bumpass (1973) underscored and examined the link between religious identity and fertility among women of child-bearing age in Lain America, particularly the differences between Catholics and Protestants, with higher fertility rates reported among Catholic women. Given the array of National Family Planning options and the large number of Latinas who identified themselves as Catholic, the Church's teachings supplied an important religious context for the reproductive health decisions of Latina women. By the 1970s, however, the gap in fertility rates between US Protestants and Catholics began to disappear as Catholic women had fewer children.

This observation supported the enormous influence of religion in opposing RH laws and programs which employed the use of pills and any form of contraception during pregnancy as a means of abortion. Pro-life groups and activists enjoyed the full support of the Catholic Church in its collective and discursive struggle against any reproductive health and population development control mechanism espoused on the other side of the debate by the pro-choice proponents. The great RH debate inevitably pitted the state on left political spectrum endorsing the promulgation and implementation of an RH law as against the Catholic Church to be precise on the right political spectrum, which stopped the passage of an RH law that embraces the use of contraception as a means of depopulation.

Instone and Mueller (2011, p. 944) instead elucidated that in response, several NFP methods were developed, each based on the normal physiological changes within a woman's reproductive cycle, including counting the days of the month (the calendar or rhythm method), measuring basal body temperature, or observing changes in cervical mucus (the Billings ovulation method).

These methods were the ones the Catholic Church endorsed to its faithful and followers as opposed to the methods which were prescribed by RH proponents, civil society groups, and lawmakers. The intense policy differences and programs disagreements with the state, civil society groups, and legislators have led the Catholic Church to call RH laws and programs as a policy which denies life and promotes death.

Instone and Mueller (2011) likewise underscored even more that, although other measures of birth control were available, including barrier methods like the condom and diaphragm, and the ''pill'' in 1960, the Church reaffirmed its position in 1968, when Pope Paul VI issued the encyclical letter, Humanae Vitae, announcing that direct interruption of the generative process already begun and, above all, all direct abortion, even for therapeutic reasons, are to be absolutely excluded as lawful means of regulating the number of children (Pope Paul VI, 1968).

The papal decree made the RH debate much more intense when it already touches on the choice on the number of children a couple should have in which some RH laws incentivized couple having fewer children than those who have more children and using the government funding and resources in the execution of such programs and services like the distribution of condoms, contraceptives, and abortive medicines.

But such increased tension and separation between religion and the state may be tempered and moderated by allowing them to be partners in understanding the diversities and complexities in the RH debate. Gaydos et al. (2010) on their part opined that:

> Reproductive health focuses on communities which are necessarily complex, consisting of multiple individuals, leaders, social structures, mores, and other intricacies, many of which are tied into religious and faith structures. The value in establishing a field in religion and reproductive health is recognizing these complexities and working with them rather than fighting the tensions that often result between religion and health policy advocates around issues of sex and reproduction. However, these partnerships are not without challenges. (p. 480)

The recognition and realization that religion, culture, and experience do matter in settling the issues

and controversies surrounding the RH debate in Latin America. It is very vital to find a common framework and middle ground solutions in formulating and enforcing the provisions of RH law. The church, the state, and other major stakeholders in the RH issues should continue their discursive and deliberative struggle to search for a common solutions without necessarily compromising the common values, principles, and aspirations which they share, but rather concentrate on the similar faiths and beliefs, policies, and programs which bind them together as friends and partners for the promotion of the common good of their common subject—the citizens and their faithful.

While Latin America is confronted by the challenge of religion in the RH context, other Latin American countries are beset with the language challenge. In Guatemala, Ishida et al. (2012, p. 106) for instance, found out that a large portion of ethnic differences in the use of institutional delivery services and modern contraceptives was attributable to indigenous women not speaking Spanish. This suggests that increasing the number of health care personnel who speak the local Mayan language may raise the use of institutional health care services among indigenous people.

These lead us back to the observations made by Natavio (2013) which also cited language problems as a barrier for women residing in Los Angeles between the RH clients and users and RH providers. RH clients and users encountered difficulty using the English language as a medium of communication as against RH providers fluency and spontaneity in the use of the English language. But in the case of Ishida et al. (2012), the disparities lie between the health personnel speaking fluently in Spanish and the RH clients being fluent in the use of the native Mayan language.

The approach and program between the findings of Natavio (2013) and Ishida et al. (2012) may take two different directions with the former prescribing the teaching of the use of the English language to its RH clients and users and with the latter requiring the staffing and recruitment of health personnel, which speaks fluently of the Mayan language as a means of improving accessibility, usability, and delivery of RH programs and services. In other words, in Los Angeles, California, the RH client and user should be the RH personnel and caregiver and in Guatemala, the RH personnel and caregiver should be the RH client and user in terms of the use of language as medium of communication.

Such reversal and complementation of roles as a way of interaction and communication between the RH clients and users and the RH personnel and providers are vital keys in the knowledge dissemination and information generation of the relationships involve in the RH programs and services. In Ecuador, Goicolea (2010, p. 9) captured this when she uttered that:

> From a global perspective, the combination of methodologies and approaches could be useful to explore sexual and reproductive health issues. The interaction between rights-holders and duty-bearers on the realization of sexual and reproductive rights, and the acknowledgment of the importance of gender power relations on sexual and reproductive decision making could contribute to a better understanding of Adolescent Pregnancies.

While interaction and communication in the local setting matters, Goicolea (2010) initially put emphasis on the integration of global RH theory, praxis, and perspective into the local or national setting. This is to fully maximize the interaction and relationships between the RH right holders and the RH duty bearers concerning the sexual reproductive health and gender relations as progenitors for the better understanding of teen pregnancies. But the maximization and optimizations of knowledge and use of reproductive health programs and services may be useless if there is a strong disconnect and dichotomy between the RH right holders and RH duty bearers in terms of language use in the local setting.

It would be clear that there will be no mutual and reciprocal interaction, consensual recognition, and acknowledgement as to the sexual and reproductive health issues and gender power relations without developing a common language and common vision applicable to a particular local context in which the RH rights-holders and RH duty-bearers could agree and meet together for an increased and improved access, utilization, and delivery of RH services and

programs to take place. Consequently, it would empower the RH client and users of its tangible and concrete benefits which they may derive from such RH programs and services. Even embracing the common parlance and terminologies in the field of RH remains a daunting challenge as in the case of figuring out what an RH right holders and RH duty bearers actually mean. The RH challenge therefore also entails an issue of semantics and hermeneutics.

RH issues and challenges in Europe (Germany, Russia, Turkey, and Netherlands). With regards to Europe, the importance of interaction and communication challenge in the dissemination of knowledge and information of RH providers to their RH clients was found out in Germany, when Stoebel-Richter et al. (2012) observed that adequate information transfer is needed concerning female fertility as well as success rates and risks of reproductive medicine. Normally, couples get their information about decreasing female fertility if their desire to have a child is renewed or they are already in fertility treatment.

This time, the key challenges are not just about the transfer of information but the timeliness, appropriateness, and accurateness of the information with regards to fertility and childbearing issues. Timeliness because the period of high fertility and low fertility are significant basis that would constitute their ability to make decisions on whether they want another child or not and on whether they would avail of the RH services and programs for preventive or corrective measures.

Appropriateness also is a challenge because the assurance that reproductive medicine and other prescriptions would likely meet their expectations would provide the couple other options and alternatives on their decisions and actions with regards to their reproductive health. Finally, accurateness is a challenge because wrong prescriptions or remedies with regard to reproductive medicines would result to premature pregnancies, unwanted abortion, and health problems, particularly to the mother and infant.

Hence, interventions should start before or early in the pregnancy. In the absence of available iron-fortified foods, weekly supplementation of women of reproductive age could be a cost-effective, safe, and long-term strategy to improve maternal and infant health and pregnancy outcomes. Along the same lines, provision of low-dose multi-micronutrients (e.g. weekly supplementation or fortification) to WRA should be investigated (Berger et al., 2011, p. s84).

While proper and accurate dissemination of information is the dominant challenge in Germany, in St. Petersburg, Russia, the moral decisional challenge persists when Larivaara (2010, p. 369) enunciated that:

> In the Russian context, reliable contraception has become accessible considerably later than in Western countries, but it has clearly grown into a powerful source of new moral demands for individual women to foster their reproductive function. In a country where the public health services and many patients are under pressure from limited resources, the demands for managing health risks may differ from those in wealthier countries in terms of content. Nonetheless, the expectations of individual moral responsibility may be equally insistent.

Although we could see morality and religion factoring and influencing in the decision-making abilities of women in St. Petersburg, in which the populace are predominantly Russian Orthodox Catholics, on whether they would avail of RH programs and services, there will be moral repercussions and implications for their actions. But we could see in Russia a new paradigm of morality where women are demanding adequate and sufficient RH resources in terms of infrastructures, facilities, clinics, and medicines. More Russian women are becoming increasingly aware of their reproductive rights and reproductive health through a popular demand for a better delivery of RH programs and services and are seeking ways to emancipate and liberate them from reproductive malfunction and dysfunctional sickness and disease.

In Turkey meanwhile, the RH challenge relates to the uplifting of professionalization and nursing education standards in RH care when Yazici et al. (2011, p. 50-53) retorted that:

> These results suggest that these students, at the start of their professional lives, will now be more equipped with the knowledge and positive attitude needed to be beneficial to the community in the context of matters of SH/RH. SH/RH topics are the substance of the basic training of midwifery students and in this respect, midwife students are more knowledgeable than their nursing counterparts.

The finding that midwifery students are more knowledgeable than their nursing counterparts may be attributable to their curriculum focus and content in which RH topics were given a substantial priority component in the curriculum design and development of the midwifery course. This allows them to have a considerable advantage as compared to the nursing students because they have strong basic and foundational grounds on which RH themes and topics are anchored and built upon.

Netherlands seems to wrestle with the immigrant challenge when Schoevers et al. (2010, p. 261) revealed that:

> The reproductive health status of illegal female immigrants in The Netherlands is worrisome. Our results show a lack of or delayed prenatal care, low use of contraception, high abortion rates, low rates of Pap smears and STD screening and untreated sexual and gynecologic problems. Illegal female immigrants are not able to exercise control over their own reproductive and sexual health for the following reasons: lack of information about reproductive health services and contraception; problems with financing of services; sexual and physical violence; and fear of deportation.

This is a huge RH challenge particularly to female illegal immigrants owing to the fact that immigrants lacks the legal personality to avail of the RH programs and services which a permanent resident or national enjoys the full protection and enjoyment. Naturally, if one is an illegal immigrant, she would not seek and avail of the RH programs and services because there are certain requirements and conditions which would lead to the discovery of her illegal residency. Hence, the RH programs and services would subject her to self-incrimination, which would then lead to her arrest, detention, and deportation.

RH challenges and issues in Africa (Nigeria, South Africa, and Ghana). In Nigeria, it could be noted that the cultural challenge seems to be the prevailing RH challenge when Igberase (2012, p. 31) stressed the harmful cultural practices affecting pregnant women. Reproductive life is often deeply rooted in the culture and tradition of the people such as the use of toxic herbs, the patronage of traditional birth attendants, female circumcision, female genital mutilation, early forced marriage, fire and heat treatment, widowhood rites, and male child preference.

The challenge lies at the very core of the way of life in which the society still adheres upon, which deserves a serious, careful, and sensitive look on the part RH policy-makers and implementers. When cultural practices and outlooks infringe on women's rights and freedom and inflict harm or injury to her personhood, culture, and tradition, this gives way to the ascendancy of a law which protects women from insidious injury and violence perpetrated against her. A structural reform, such as the enactment of RH law which ensures that the women are given full protection to assert their reproductive rights and access to RH programs and services, needs an urgent consideration to protect the Nigerian women against harmful practices brought about by culture.

In South Africa, similar RH abuse challenge on women occur when d'Oliveira et al. (2002) discovered that South African women suffer from severe neglect, verbal and emotional abuse, treatment refusal, and physical assault such as slaps on their faces and thighs in a study based on maternity care experiences. This may be attributable to South Africa's socio-political history which still carries the vestiges and remnants of apartheid discriminatory policies which inflict wounds and brokenness to the nation and its people.

The marginalized and disadvantaged women require serious attention in their quest for a better and quality RH services. They have long been deprived of gender sensitive seminars and programs connected

with the utilization and delivery of RH programs and services especially on the part of the RH duty-holders who are supposed to provide care and compassion instead of hate and prejudice to its RH clients.

In Ghana, the RH challenge has something to do with professional diligence and care particularly with regards to being highly sensitive to the RH environment which run parallels with d' Oliviera et al.'s (2002) findings on a lesser degree. Yakong et al. (2010, p. 2439) conveyed that healthcare providers' relational practice influenced women's healthcare-seeking behaviors. Major themes from women's stories were: (a) experiences of intimidation and being scolded, (b) experiences of limited choices, (c) receiving silent treatment, and experiences of lack of privacy. Women emphasized the importance of their relationships with nurses and the impact of these relationships on their healthcare- seeking. As compared to the experiences of South African women in maternity care, the women in Ghana do not experience physical harm but nevertheless suffers from verbal and emotional neglect and abuse in the hands of the healthcare providers.

RH issues and challenges in the Middle East (Jordan and Egypt). In the Arab region such as in Jordan, Khalaf et al. (2010, p. 329) have seen that young people require not only basic information about their bodies, preventing HIV/STIs and pregnancy, but also programmes that address gender equality, empowerment, rights and responsibilities, sexual and reproductive negotiation, and decision-making. The capacity-building poses a hurling question when it comes to RH challenge in terms of education, research, training, and seminars on gender equality and sexual and reproductive health rights not only in terms of the foundational concepts and notions but a more sophisticated decisional and problem-solving thinking skills, abilities, and actions on the delivery and acquisition of RH programs, policies, and services.

Such RH capacity-building efforts and initiatives are also found to be wanting and lacking in Egypt when Zaky et al. (2010, pp. 350-351) shared that:

> The different rates of client turnout in the two governorates, together with complaints of long waiting times, difficulty in appointment booking, the lack of seating facilities in waiting areas, lack of choice of provider and/or forced registration with physicians according to lists assigned at district level, are all problems that should be further investigated if the needs of reproductive health service users are to be addressed.

It is in Egypt that the 1994 International Conference on Population Development was held and it is where the basic definitions and assumption on sexual and reproductive health were conceived. That is why Egypt is very serious and keen on implementing the RH in their own country. But even Egypt is not spared by the RH challenge, most notably of quality challenge attributes mentioned by Zaky et al. (2010). But among these challenges, forced registration is an alarming issue because it misleads the public that the RH programs and services are successfully given to the number and volume of RH clients seeking to avail the RH programs and services.

It likewise poses a challenge to the transparency, honesty, openness, and accountability of the entire RH mechanisms by compelling women to register even though women do not receive the quality and fair treatment which they deserve. In other words, figures and statistics would just remain numbers if the delivery of RH programs and services do not have downstream or trickle down quality to the major clients and stakeholders.

RH issues and challenges in Asia-Pacific (Australia, New Zealand, Taiwan, Vietnam, and India). In Asia-Pacific, Siebold (2011, p. 135) argued that sexual promiscuities among teenagers and reckless sexual behavior among young adolescents is a primordial RH challenge in Australia:

> At the same time pressure to engage in sex at younger and younger ages and continuing pressure to engage in unprotected and risky sex remains a concern. The young women in this study were cynical about a double standard still operating and were forceful in identifying a need for a much better approach to education at younger ages that is honest, relevant and directed at both sexes. The

> importance of family values, particularly mothers as role models, emerged as important determinants of behavior.

While sexual promiscuity challenge among the young remains a serious concern in Australia, the RH challenge implores the family members, more importantly the mother, as an important predictor and determinant in the education of the young women's sexual behavior thorough effective role modeling and setting good examples which their daughters and sons would consider as values worthy of emulation to prevent and correct the occurrence of their sexual promiscuities.

Denny et al. (2012, p. 14) on their part observed the inequities of RH program and services in some school clinics in New Zealand when they stated that:

> For example, some clinics may provide comprehensive and intensive services staffed on-site by a multidisciplinary team of highly trained personnel, whereas other school clinics may provide only limited on-site services with visiting health personnel. Furthermore, provision of contraceptives, condoms, and screening for sexually transmitted infections in many schools remains controversial, thus limiting their availability.

In Taiwan, Lin et al. (2011, pp. 64–66) perceived that such programs need to consider factors such as the caregiver's gender, educational level, and experience assisting with reproductive health care issues since these items are significantly associated with adequate reproductive health awareness of caregivers with respect to women with ID. Women with ID belong to the radar of RH challenge given the criticality and sensitivity of the moods and temperaments of women afflicted with it. Just like any other RH clients and user, women with intellectual disability requires the much needed attention of RH caregivers which possesses the characteristics of being gender sensitive, experienced, competent and qualified, patient, and compassionate in dealing with the delivery of RH programs and services to the women with intellectual disability.

In Vietnam, Ngo and Hill (2011, p. 244) exclaimed that:

> In areas with accessible alternative health services reducing the need for CHS services, rationalizing of services is needed. Those CHSs that attempt to function in the shadow of hospital facilities need to be protected by referral practices and clear differentiation of services to avoid unnecessary provision of routine RH care by more costly staff, in higher cost level facilities. At the same time, efforts should be made to improve service quality at the local CHS as the economy improves and clients demonstrate growing demand for higher quality services.

The Commune Hospital System rationalization serves as a challenge in the RH context in Vietnam. Commune Hospital System may stop pretending that it is capable of providing the same quality services which bigger public and private hospitals are affording to the RH clients and users given the limited government funds an subsidies that it receives from the government. Instead, Commune Hospital Systems may design a pro-poor income generating payment scheme to augment and offset the lack of government funding to continuously concentrate their services on the marginalized and disadvantaged sectors of the Vietnamese society, especially those in the rural areas where RH programs and services are inaccessible and unavailable.

Same thing can be said with that of India when Char et al. (2011, p. 484) demonstrated that:

> The findings clearly indicate the need for focused interventions in the rural areas of India, where young men seem ready and willing to absorb reproductive health messages and access services. It is important that program planners identify this underserved group of young unmarried men with effective communication strategies that will enable them to act responsibly not only in the present, but also in the future, when they are married, and take crucial family-planning decisions together with their wives.

While the rural poor challenge exists in Vietnam, the rural men challenge abounds in India where a strong demand for rural unmarried Indian men to seek the benefits of RH programs and services but such services and programs remains distant and unavailable. Bringing closer to the rural masses the beneficial possibilities and potentialities of RH programs and services serves as a constant challenge among Vietnamese, Indians, and probably for the rest of Asia where poverty incidence is high.

Global Reproductive Health Programs: Challenges and Future Directions

Table 2 depicts the matrix of RH authors and their corresponding policy-capacity opportunities and solutions in the enhancement and development of the delivery of RH programs and services. While every nation and region are confronted with an entirely unique different blend and spectrum of RH issues and challenges, the opportunities, lessons, and future trajectory path of RH may be found in their own realization that there must be a better and effective way in the delivery and implementation of the RH programs and services as indicated in the matrix.

Table 2 *Matrix of Reproductive Health Authors and Policy-Opportunities*

Reproductive Health Authors/Policy-makers	Policy-Recommendations and Directions on Reproductive Health Delivery Service and Program
Patel, Roberts, Guy, Lee-Jones, & Conteh (2009)	A more devolved and decentralized hospitals, clinics, and health care systems on the community based level
Ishida et al. (2012)	Effective allocation of limited health care resources, increasing institutional capacity for delivery assistance, and reducing unnecessary caesarean sections
Davies (2010)	Developing a framework of indicators on states performance in reforming their health care systems to better reflect the reproductive health care needs of women and attaching an incentive structure to this framework
Hindin, Christiansen, and Ferguson (2013)	Prioritize funding for research on adolescent sexual and reproductive health
Seims (2011)	Increase the voice of civil society in the design and implementation of programs to strengthen the health sector, enhance the visibility and impact of UNFPA, identify ways to better assess the impact of aid, and use these to guide health investments, allocate more resources for special innovative approaches, improve understanding of the economic benefits of achieving better health for women, and strengthen SRHR capabilities
Hoover et al. (2012)	Continued research involving collaborative partnerships among researchers, health care provider, and community members
Stoebel-Richter, Geue, Borkenhagen, Braehler, and Weidner (2012)	Explore the use of digital and interactive media to reach young people effectively. Other possibilities for the clarification of young women about female fertility and the success rates and risks of reproductive medicine are conversations and the offer of relevant information material during the gynecological practice.

Rathfisch, Aydin, Pehlivan, Bozkurt, and Kaplica (2012)	Provision of efficient and reliable reproductive health services is required for adolescents and implementation of special educational programs and peer educations supported by their own environment.
Teitler (2002)	Improve the availability of reliable contraceptives, reproductive health services, and better sexual health education in schools
D'Souza, Somayaji, and Subrahmanya (2011)	Nurses have to move away from the disease treatment model and move towards mutual goal setting leading to "goal attainment."
Pillai and Gupta (2011)	Broad-based policies strengthening democratic institutions as well as agencies and organizations at the governmental and non-governmental levels for promoting social development
Gable (2010)	Uphold decisional aspects of human rights as applied to reproduction
Cottingham et al. (2010)	Raise awareness on states obligations, protecting vulnerable groups, involving other sectors, increasing civil society participation
Wilcher and Cates (2009)	Assertion of RH as human right among HIV patients
Ketting and Esin (2010)	Essentiality of primary health clinics as the first point of healthcare system
"The Reproductive Health Report" (2011)	Research is needed to look at other important aspects of SRH, e.g., sexual education, risk of sexually transmitted infections, gender-based violence, and effect of migration.
World Health Organization Report (2008)	1) Universal coverage reforms, to improve health equity, 2) Service delivery reforms, to make health systems people-centered, 3) Leadership reforms, to make health authorities more reliable; and 4) Public policy reforms, to promote and protect the health of communities

One lesson and direction for RH program development is that there is a need for increased budget allocation, subsidy, and funding on the part of the government to satisfy and meet the growing demands of RH clients to avail such programs and services, particularly in establishing primary care and community hospital systems, adequate supply of reproductive medicines, and in getting the right kind of health personnel, namely, doctors, nurses, midwives and caregivers capable and sensitive to the needs of RH users. Such increase in government budget, subsidy, and fund for RH programs and services would lessen the inequalities and disparities which the RH challenge in terms of access and provisions of RH services and programs brought about by geographical differences, language barriers, cultural and ethnic diversities, and ethical and professional challenges in the context of RH.

A more devolved and decentralized hospitals, clinics, and health care systems on the community-based level are vital in the attainment of successful RH programs readily accessible and available to its clients and users especially to developing and conflict-ridden countries. Studies have observed that progress towards the Millennium Development Goals in conflict-affected countries is generally slower than in non-conflict-affected countries and that substantially more resources need to be mobilised and better spent in conflict-affected countries (Patel et al., 2009, p. 11).

Thus, by effectively allocating limited health

care resources, increasing institutional capacity for delivery assistance, and reducing unnecessary caesarean sections (and their potentially adverse effects), Guatemala may help reduce the barrier between indigenous women and the reproductive health services they need. Future studies should continue monitoring the association between ethnic disparities and Guatemalan women's receipt of these services (Ishida et al., 2012, pp.106-107).

Aside from increased budgeting and spending for RH structural needs, giving priority and emphasis on capacity-building of research and education about RH by forging networks and linkages to generous and philanthropic international donors may be carried out to supplement and augment the limited government funds and resources considering the growing number of unwanted teenage pregnancies and illegal abortion happening around the world.

On her part, Davies (2010, p, 404) suggested a two-way process, namely, (1) developing a framework of indicators on states performance in reforming their health care systems to better reflect the reproductive health care needs of women and (2) attaching an incentive structure to this framework that measures the performance of states, donors, and international organizations in meeting their collective obligation to improve women's reproductive health.

Hindin et al. (2013, p. 18) also examined the link between global donors in the research capacity-building initiatives of the RH programs when they surmise that:

> Because adolescents are all different and live in dissimilar contexts, regional and national exercises will undoubtedly be needed to identify and prioritize the research most pressingly needed in a given society. Nonetheless, the results of the work we have performed can help global donors and programme managers in their efforts to prioritize funding for research on adolescent sexual and reproductive health.

Seven countries giving health funds to international organizations namely, Denmark, Finland, Germany, Netherlands, Norway, Sweden, and United Kingdom were given seven recommendations as donor countries on SRH, namely, increase the voice of civil society in the design and implementation of programs to strengthen the health sector; enhance the visibility and impact of UNFPA; identify ways to better assess the impact of aid, and use these to guide health investments; allocate more resources for special innovative approaches; improve understanding of the economic benefits of achieving better health for women; and strengthen SRHR capabilities at the embassy level (Seims, 2011, pp. 152-153).

Hoover et al. (2012, p. 1648) on their part focused on the intertwined relationship of environmental health and reproductive health when they pointed out that, "thus there is a great need for the concept of environmental reproductive justice in environmental health research. Continued research, involving collaborative partnerships among researchers, health care provider and community members, is needed to determine the impact of environmental contamination on community members' health and to develop necessary remediation, preventative measures, and protective policy interventions."

While Hoover et al. (2012) have seen the link of environmental health and reproductive health, the EU "Reproductive Health Report" (2011, p. 62) highlighted the necessity of research advocating RH topical affairs when it posits that research is needed to look at other important aspects of SRH, for example, sexual education, risk of sexually transmitted infections, gender-based violence, and effect of migration.

Another capacity-building dimension in which the RH programs and services may take its lead is in the area of education. Family planning and reproductive medicine aspects should be an integral part of sex education at school—just like education about contraception and prevention of sexually transmitted diseases. It may be advisable to explore the use of digital and interactive media to reach young people effectively. Other possibilities for the clarification of young women about female fertility and the success rates and risks of reproductive medicine are conversations and the offer of relevant information material during the gynecological practice. Furthermore, population-wide education campaigns should be considered, which can certainly

allow an effective information transfer (Stoebel-Richter et al., 2012 p. 8).

Rathfisch et al. (2012, p. 54) seemed to concur when they observed the primacy and importance of RH on young adolescents education in shaping and forging their sexual behavior when they assert that while students exhibit generous and liberal attitudes toward sexual issues, their knowledge on RH and sexually transmitted diseases/AIDS is still limited. Therefore, provision of efficient and reliable reproductive health services is required for adolescents. For these students, implementation of special educational programs and peer educations supported by their own environment may be beneficial.

Teitler (2002) also acknowledged the role of sex education in the effective delivery of RH programs and services as improved availability of reliable contraceptives, reproductive health services, and better sexual health education in schools may explain this trend. Also the social norms on contraception and child-bearing seem to converge in Europe.

Another direction that the RH programs and services has to take is the continuous upgrading and uplifting of the professional and ethical standards of the health care personnel, more importantly the nursing profession because they are at the forefront and the first-line of bearing the duty in attending to the needs of the RH clients and users.

As the significance of the domains of reproductive health and QOL has taken a prominent place among women, nurses have to move away from the disease treatment model and move towards mutual goal setting leading to "goal attainment." Since women place high value on satisfaction and importance of domains, they need to be proactive and empowered in seeking nurse-directed interventions, which increase their probability for a healthy reproductive life (D'Souza et al., 2011, p. 1973).

It should be noted that one of the glaring RH challenges concerns itself with the hostile and antagonistic relationship between the RH right holders and RH duty bearers brought about by cultural traditions and practices, language barrier, and ethical issues. These challenges may be obliterated if a high degree of professional and ethical standards are exhibited by the RH duty bearers, providers, and caregivers in the treatment of their patients. Preparing and training doctors, nurses, midwives, and other health professional through value formation in a multicultural environment setting would allow them to acquire the much needed increased level of awareness and understanding, compassion and sensitivity, and more importantly, diligence and care in dealing with RH clients and users.

Another opportunity which RH programs and services has to look into deals with the growing assertion of RH as a matter of human rights. First, reproductive health policies should include safeguards against the violation of reproductive rights. Second, gender equality programs should be seen as essential for building sustainable reproductive rights and reproductive health policies. Finally, broad-based policies strengthening democratic institutions as well as agencies and organizations at the governmental and non-governmental levels for promoting social development are essential for achieving reproductive health through improvements in gender equality (Pillai & Gupta, 2011, p. 9).

With the emergence and resurgence of movements and organizations advocating RH as human right, RH advocacy programs introduces and innovates Reproductive Health Assessment After Disaster (RHAD) toolkit as way of life, a part of disaster preparedness program or post-disaster occurrence. RHAD Toolkit may be helpful in promoting and enhancing evidence-based local programs and services to improve the reproductive health of women and the health of their infants after disasters.

In addition to having created the RHAD Toolkit, Division of Reproductive Health is continuing preparedness activities to identify and meet the post-disaster health needs of women of reproductive age, such as creating a preparedness program to address post disaster scientific communications, and internal staffing issues; exploring avenues to conduct surveillance of pregnant women after a catastrophic event; collaborating with other centers in Centers for Disease Control and Prevention (CDC) to develop vaccine and treatment recommendations for bioterrorism agents and diseases; and creating two general CDC websites that address pregnancy

issues in emergency and disaster situations (Zotti & Williams, 2011, p. 1126).

Gable (2010) gave credence to women's autonomy in invoking RH as a matter of human rights in the context of decision-making. According to Gable (2010, p. 969):

> Reproductive rights model, particularly as they have framed in developing countries have typically revolved around the protection of rights of an individual to make autonomous reproductive decisions, grounded in civil and political rights to privacy, liberty, equality, autonomy and dignity. Consequently the reproductive rights model favors efforts to uphold decisional aspects of human rights as applied to reproduction, i.e. rights, conditions and determinants that support the ability of the individual to make autonomous reproductive decisions without coercion.

Cottingham et al. (2010, pp. 521-522) on their part recognized the cogent role of human rights tool in the context of RH in the democratization process when they conclude that human rights tool on reproductive health specifically improve reproductive health services in five critical areas relevant to sexual and reproductive health policies and services namely in raising awareness and understanding states obligations, protecting vulnerable groups, involving other sectors, increasing civil society participation (Cottingham et al., 2010, pp. 521-522).

Wilcher and Cates (2009) took a similar position enunciating the importance of asserting RH as a human right among HIV patients. They consequently stressed the RH and HIV connection at policy, program, and service delivery are both a human right and a public health perspective. Thus, the call for stronger linkages between sexual and reproductive health and HIV fields is well-founded. All women, regardless of HIV status, have a right to make informed reproductive choices. However, because infected women may be more vulnerable to rights abuses than uninfected individuals, sexual and reproductive health, and HIV linkages at policy, programme, and service delivery levels are especially important to ensure that their sexual and reproductive needs are met.

Finally, the last opportunity of RH programs and services deals with the establishment and prioritization of primary health clinic as contingent plan to bring the policies, programs, and delivery services of RH closer and nearer to the people especially the poor, marginalized, and disadvantaged individuals and families. General policy recommendations include that it is essential that primary health clinic (PHC), as the first point of entry to the healthcare system, takes a greater responsibility for this field of healthcare. Attempts should be made to improve PHC quality by making it meet the essential criteria and characteristics of PHC and SRH. Human and financial resources should gradually be transferred from medical specialists in hospital settings to PHC settings. Special attention should be given to the question of acceptability and accessibility of basic SRH through PHC for all hard to reach and vulnerable groups in the community, such as the youths, migrants, sexual minorities, and people without health insurance (Ketting & Esin, 2010, pp. 278–279).

Even the World Health Organization underscores the vital and critical importance that PHC plays in the delivery of RH programs and services as it identifies the core values in which PHC is built and anchored upon. The PHC movement is driven by the core values of equity, solidarity, and social justice. Starting from these values, four major reforms are needed according to the World Health Organization (2008) report: 1) Universal coverage reforms, to improve health equity, 2) Service delivery reforms, to make health systems people-centered, 3) Leadership reforms, to make health authorities more reliable; and 4) Public policy reforms, to promote and protect the health of communities.

Based on the above-mentioned discussion, it appears that there are opportunities, activities, and directions the RH programs and services could assume which would require structural reforms both in policy and system level and these includes government and international support, research capacity building, intensive RH awareness and education, assertion of RH as way of life and as a matter of human rights and the establishment and creation of more primary care health clinic system to areas as RH entry points for marginalized and underprivileged individuals, families, and communities.

Conclusion

Every country and region faces distinct and unique RH issues and challenges entirely applicable to their own predisposition. Each regional map is characterized by RH issues and challenges in its peculiar characteristics which would require a specific and contextual approach and understanding of their socio-economic, cultural, and political underpinnings.

In this regards, the article reviewed, analyzed, and synthesized the prevailing concepts and perspectives the enduring issues and challenges in the various part of the continent and of the world. This paper attempts to seek and achieve a global perspective of reproductive health and point out the glaring challenges, which are contextualized and situated in various local and regional settings, with the help of various literatures on sexual and reproductive health as an aid and tool for discussion.

In synthesis, some of the global RH perspectives and challenges appear to be inequality and disparity in access and in provisions of RH program and service delivery due to ethnic and cultural difference; language and communication breakdown; socio-economic barriers, configuration and tension between the Catholic Church and RH proponents and advocacy groups; linguistic differences between RH right users and RH duty bearers; the knowledge sharing, knowledge dissemination, and RH quality education; detrimental cultural and traditional practices; discrimination and prejudice inflicted by RH providers and caregivers to their RH clients and user by reason of ethnicity and socio-cultural background; and low quality of RH delivery programs and services in terms of infrastructure and facilities like community based hospitals, particularly to rural and far flung areas, and the lack of adequate RH information and sexuality education, poor systems, and procedures.

With regards to the lessons, opportunities, and future directions of global RH programs and services, it appears that there are opportunities, activities, and directions that RH programs and services could assume which would require structural reforms both in policy and system level. These include government and international support, research capacity building, intensive RH awareness and education, assertion of RH as way of life and as a matter of human rights, and the establishment and creation of more primary care health clinic system to areas as RH entry points for marginalized and underprivileged individuals, families, and communities.

This paper does not claim conclusiveness to the findings and observations made in this paper given the limitation of representativeness of samples in a qualitative manner. Nevertheless, I hope that these examples and case from various countries around the globe could in a simple way provide a clear image and picture of the state of RH delivery of programs and services not through a medical standpoint but from a program development vantage points and perspectives as an attempt to depict RH narratives and experiences both on a local and global perspectives.

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