Sexual and reproductive health and rights and mHealth in policy and practice in South Africa

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Abstract: Information and Communications Technology (ICT) offers enormous opportunity and innovation to improve public health and health systems. This paper explores the intersections between mHealth and sexual and reproductive health and rights in both policy and practice. It is a qualitative study, informed by policy review and key informant interviews. Three case studies provide evidence of what is happening on the ground in relation to ICTs and reproductive health and rights. We argue that in terms of policy, there is little overlap between health rights and communication technology. In the area of practice, however, significant interventions address aspects of reproductive health. At present, the extent to which mHealth addresses the full range of reproductive justice and sexual and reproductive health and rights is limited, particularly in terms of government initiatives. The paper argues that mHealth projects tend to avoid contentious aspects of sexual health, while addressing favourable topics such as pregnancy and motherhood. The ways in which information is framed in mHealth mirrors current gaps within sexual and reproductive health and rights, where a limited and conservative lens predominates, and which may result in narrow programming and implementation of services. © 2015 Reproductive Health Matters. Published by Elsevier BV. All rights reserved.

Keywords: South Africa, reproductive health policy and programmes, integration of services, maternal health, priority setting, reproductive and sexual health

Introduction

Information and Communications Technology (ICT) is a promising new area which holds great promise for health and development. In 2006, South Africa’s telecommunications market totalled US$25 billion and mobile phone revenue is expected to expand by more than 40% in the next 20 years. It is expected that mobile-related businesses will contribute 8% of the GDP by 2020 and that health will dominate the “mobile for development” market. The term “mHealth” has come to refer to the use of mobile phones and other technological, portable devices in health. Substantial innovation has occurred in mHealth in South Africa, including in the use of mobile communication channels for health messaging and for community health worker support and data collection. The appeal of mHealth is in its ability to reach wide audiences relatively cheaply and to convey tailored, appropriate health information to individuals. mHealth is promoted as offering many benefits, including: a means of more easily providing people with health information and thus enhancing disease prevention; new forms of data accumulation for research and disease surveillance; decision-making aids provided by mHealth can support clinical service delivery; regular reminders can help patients manage their own health conditions and enhance treatment compliance and mHealth can augment access to health care services by connecting patients and providers through mobile phones and through supporting front line health workers. mHealth can thus potentially provide solutions for health challenges and for health systems that struggle with limited point-of-care services, low staff:patient ratios and lack of access for remote patients, as well as for sexual and reproductive health and rights (SRHR). For example, in maternal and child health, mHealth interventions (such as mobile phone-based information messaging) “show great promise for empowering and enabling health workers to collaborate with pregnant and parenting women to improve [the] delivery of maternal and child health care.”9
SRHR are critical dimensions of the international development agenda, and of individuals’ health and wellbeing. South Africa has impressive legal provisions addressing health and rights and has ratified many key international treaties, and it is viewed as an emerging global health leader by the World Health Organization (WHO). These initiatives call attention to reproductive rights – namely couples’ and individuals’ rights to freely decide how many children to have and when, to make informed decisions and to achieve the highest standard of sexual and reproductive health and reproductive justice. The WHO views SRHR as comprising several, interrelated components, including: enhancing antenatal, perinatal, postpartum, and newborn health care; delivering high quality services (for infertility; abortion; sexually transmitted infections and other gynaecological morbidities); and endorsing sexual health. People whose sexual and reproductive health needs are met have healthier lives. However, as Berer highlights, there is an enormous unmet need which “is about the whole system of delivery of contraception, abortion and sterilisation services, the quality of services, and the training of service providers”. Yet, despite the impressive legal provisions, many South Africans have no opportunities to address their reproductive needs because of social and financial barriers as well as the lack of health infrastructure and services in many areas, thus suffering from a wide range of sexual and reproductive ill-health.

This paper explores the intersections between mHealth and SRHR in both policy and practice in South Africa. It examines what policy directives are in place for addressing sexual and reproductive health needs and how, in practice, mHealth is doing this. It argues that there is little overlap between health policies and policies focusing on communication technology. In the area of practice, however, significant interventions are taking place which address some aspects of sexual and reproductive health. The paper argues that mHealth projects tend to avoid the contentious aspects of SRHR, while addressing less contested topics such as pregnancy and motherhood.

The South Africa Context
South Africa experiences very high levels of adolescent pregnancy with almost a third of all girl teenagers reporting pregnancies. In addition, poor South African women have inadequate knowledge about SRHR and thus struggle to make informed decisions. In South Africa, SRHR are marred by ambivalence stemming, in part, from “population control” programmes from the 1970s onwards which focused on reducing black population growth. This also results, in part, from South Africa’s diverse religious and cultural values, many of which oppose sexual rights and abortion. Finally, as Edwards and Hecht and Breckenridge have demonstrated, prior to 1994, computers used by the apartheid government reinforced white superiority as fingerprint databases and race-based identity registration on computers facilitated the apartheid state’s control over black people. This also resulted in a highly unequal distribution of services, technology and skill with urban, white elites having computers and state-of-the-art health technology while poor, black and rural areas were neglected.

South Africa’s SRHR policies are considered “among the most progressive and comprehensive in the world”. The Constitution guarantees all citizens the right to reproductive health yet makes no reference to sexual health. Other policies address maternal health, teenagers’ access to contraceptives, abortion, as well as focusing on sexual health and rights, HIV, other sexually transmitted infections and tuberculosis. Redressing past discriminations and the health needs of poor black women has been a primary aim of policies introduced since the end of apartheid. There has been wide-scale improvement in South Africa’s health system, including free health care for pregnant women and mothers of young children.

As the use of mobile technology as a tool within government is in its infancy, South African policymakers, health authorities and providers are not fully appraised of ICTs for addressing health challenges despite the government’s stated intention to do so. In addition, little attention has been paid to the policy domain which manages health systems and to the integration of mHealth. Mobile phones (known also as cellular phones or cell phones) offer potential ways to address SRHR challenges as 90% of South Africans and 75% of the poor own cell phones. In addition, young people have expressed interest in and used cell phones to search for health-related information and many innovative projects already exist.

Methods
This paper is based on qualitative research which emphasises an interpretive approach and which
uses key informant interviews and policy review. Key informant interviews were held with 20 stakeholders who were centrally involved in sexual and reproductive health or mHealth initiatives. Interviewees included senior government representatives from both the National Department of Health and the Department of Social Development; members of the government-formed South African mHealth Task Team; NGO, both not-for-profit and for-profit, consultants or employees directly involved in the implementation research of mHealth initiatives and university researchers who publish on South African health issues. These interviewees were selected through a stakeholder mapping exercise and then through network sampling, based on recommendations. Semi-structured interviews aimed to solicit their opinions, and to understand what they – as experts in their respective areas – identified as successes or challenges in how mHealth has been used to address reproductive health needs. Interviews also sought to examine the extent to which their work was constrained or enhanced through specific policies. These interviews were undertaken face-to-face in convenient public settings or by telephone or Skype. Semi-structured interview was used because of its appropriateness for interviewing senior government officials, project members, managers and policy makers, and because it enabled the researchers to address specific themes with all stakeholders while remaining open to new areas of discussion. Detailed notes, taken during these interviews, were coded and analysed to identify emerging themes.

Eight national policies (four relating to health and four to ICT) were chosen, from a range of policies, for review. These were identified by a senior researcher in the South African Parliament and confirmed by a member of the South African mHealth Task Team as the most appropriate policies. We did not examine provincial policies and avoided policies with related, but very specific remits. The health policies analysed include: the National Strategic Plan on HIV, Sexually Transmitted Infections (STIs) and Tuberculosis 2012–2016 (hereafter referred to as the National Strategic Plan); the Integrated School Health Policy; the National Contraceptive and Fertility Planning Policy and Service Delivery Guidelines (hereafter referred to as the National Contraceptive Policy); and the National Contraception Clinical Guidelines. The ICT policies reviewed were: The National E-health Strategy 2012–2017 (hereafter the e-Health Strategy); the South African Connect Broadband Strategy (Broadband Strategy); the National Integrated ICTs Policy Green Paper 2014 (Green Paper); and the MHealth Strategy and Implementation Plan (mHealth Strategy), which is still in draft form. The policy review explored the scope to which health policies addressed ICT-related issues and on the inclusion of SRHR in ICT-related policies. Key terms aiding the policy review included: family planning, population control, fertility, contraception, sexual disease, maternal health, postnatal health, gender, youth, adolescents or adolescence, teenagers, women, communication, sexual empowerment, and mHealth.

Ethical approval was attained from the African Gender Institute, Faculty of Humanities, University of Cape Town (UCT) and guaranteed respondents anonymity. One limitation of the study is thus that interviewees are not identified in this paper. This is not unusual in qualitative research where it is necessary to speak to high-level actors engaged in policy formulation or implementation and be able to reflect on their challenges. However, the research findings were circulated among respondents for review and feedback. Study limitations also include not interviewing mobile phone providers, not exploring women’s and girls’ participation or political engagement, or their emic experiences of mHealth initiatives, and not reviewing the full range of mHealth initiatives. Several reviews of South African mHealth initiatives have already been undertaken in South Africa.

Findings

Interviews: During the key informant interviews, interviewees were asked about their roles in relation to mHealth, about their need to relate their work to policy frameworks; how their work addressed reproductive and sexual health and whether it also addressed associated rights. The questions used to guide the key informant interviews did not identify any mHealth initiatives, leaving it up to respondents to decide whether they wished to mention specific mHealth projects in their responses. As a result, about 30 different mHealth initiatives were referred to during the interviews (including MomConnect, m-Assist, Mobile Alliance for Maternal Action (MAMA), Young Africa Live (YAL), the Pan African mHealth Initiative (PAMI), Smart Sex, Mad for Soccer, B-Smart, Talk and Tango, HIV360, I Choose When).
The most striking finding evident in almost all, bar a few government representatives’ interviews, was the absence of awareness or engagement with policy as a means to refine their work. A second striking finding was the sectoral nature of most interviewees’ experiences: those who had health expertise commented on their lack of ICT knowledge and those who had technological or implementation experience tended to have less experience in health and health information dissemination. In mHealth initiatives, these skills have to come together. A third key finding was the conservative nature of much of the work on maternal health. The National Department of Health was not viewed as an advocate for SRHR and its approach to maternal and child health was said to ‘deliberately ignore abortion’. A further summation of the findings of the interviews is presented through the lens of three mHealth initiatives or case studies below. In these case studies, key informants’ information and viewpoints have been supplemented by publications, information on websites and other grey literature. These case studies are not representative of all mHealth initiatives in South Africa. Rather, they exemplify how mHealth is addressing sexual and reproductive health needs in South Africa.

The following section examines three mHealth projects – MomConnect, m-Assist and Young Africa Live (YAL) – that are different in their aims and target audience, partnerships, and nature of health information. These projects were chosen to demonstrate examples of how mHealth initiatives are addressing SRHR in South Africa. The first, MomConnect, is a national, government initiative which deals with maternal health, the most common of all mHealth initiatives. The second, m-Assist, is a small randomised control trial dealing with abortion, which is a stigmatised and underserved area of SRHR. The final case, Young Africa Live, is a mobile platform which offers young people the opportunity to share ideas and learn about sexuality and health and which demonstrates the massive appeal that mHealth can have. In each case study, we explore the aim of the intervention; who is being targeted; the partnerships involved and the nature of health information.

MomConnect

MomConnect is a free mobile phone-based health service which provides stage-based advice and information on pregnancy to all South African pregnant women and mothers of young children. MomConnect was developed based on a voluntary mHealth programme MAMA (Maternal Alliance for Maternal Action) founded by, among others, Johnson and Johnson and USAID, and introduced in South Africa in 2013. MomConnect was launched in August 2014 and is the first national mHealth project, reflecting the priorities of the Minister of Health and his desire that health messaging in South Africa reach at least a million women.

MomConnect was developed by a multi-expert team, including government health experts, leaders in mobile communications and UK-based experts in Maternal and Child Health communication, and implemented through a collaborative partnership between the National Department of Health, non-profit and private sector representatives. It provides data collection tools, supports clinical care, and contributes to the national pregnancy registry.

MomConnect text messages were developed with the aim of achieving a balance between technical, medical jargon and colloquial language. The National Department of Health wanted to send some health information explaining pregnancy and the accompanying bodily processes and some instructional messages directed at behavioural change, directing women when to visit a clinic or have a blood test. As it needed to reduce costs and send only essential messages, one MomConnect implementer explained, “we had to cut some messages, merge some and decide which to have”.

The National Department of Health commissioned the testing of the SMS messages. This research showed that some messages were clear, educational and well-received. Interviewees explained that it had been difficult to develop appropriate and nuanced text messages in 160 characters while also explaining or translating terms such as fortified foodstuff or quantifying amounts such as heavy or light bleeding. The commissioned research and testing also highlighted a lack of clarity in combined messages. For example, one message informed women about the development of their babies and the growth of fingers alongside telling them to visit the clinic if they felt unwell; women wondered if the baby’s fingers induced their ill-health.

MomConnect messages specifically address maternal health issues and do not focus on abortion, HIV prevention, adolescent sexuality or contraception. In so doing, MomConnect augments
women’s knowledge of pregnancy and childbirth and offers Maternal and Child Health (MCH) enhancement.

*m-Assist*

m-Assist was a randomised control trial, undertaken between October 2011 and May 2012, exploring the impact of text-based post-abortion support to women who have undergone a medical abortion (using misoprostol and mifepristone), assessing women’s apprehension and emotional unease as well as their ability to understand and manage their physical symptoms between clinic visits. In this trial 469 women were randomised into the intervention and control group, with those in the intervention arm receiving a series of messages in the period (14 to 21 days) between the medical abortion and the follow-up clinic visit. Results of the study are published elsewhere.7,31

m-Assist was initiated by the Women’s Health Research Unit at the University of Cape Town (UCT). It was based on a partnership between the University of Cape Town and a not-for-profit company called Cell-Life Communicate Services, which uses technology to support HIV and health communications. m-Assist is supported by the WHO with supplementary funding from UCT’s Research Development Grant and the Harry Crossley Senior Clinical Fellowship.

The text messages in the m-Assist trial reminded women to complete their prescriptions as well as providing information on their physical symptoms, offering advice on managing bleeding, pain and cramping and other side effects as well as highlighting possible problems.7 The messages offered a combination of information and reassurance, helping women to assess how long their symptoms should last and when to seek medical advice. Working in collaboration, UCT and Cell-Life developed the text messages and communicated these messages to the women in the intervention group. The results of the trial showed that the combination of information, self-assessment and support provided via mobile phones reduced the need for follow-up visits by clients; enhanced the experience of medical abortion; reduced demands on abortion providers; and increased post-abortion knowledge.7,8

Supported and this effectively reduced their anxiety around abortion. The messages also improved women’s understanding about what was happening to their bodies during medical abortion.8

**Young Africa Live (YAL)**

YAL is a mobile platform that enables young people to talk anonymously about sexuality, relationships, HIV and other sexually transmitted infections, etc. Aware that tens of thousands of young people are active on network operator-based mobile platforms, the implementer, a not-for-profit organisation named Praekelt, resolved to harness this audience. Its aim, as a Praekelt staff member informed us, was to do something positive in relation to HIV information, finding a way that people could talk about the activities which fuel the HIV epidemic in an interesting and engaging manner. YAL is highly popular with young people and has nearly 2 million registered users. Mobile phones are seen by YAL’s implementers as facilitating social change and reaching millions of young people.

YAL is a Praekelt Foundation Initiative including partners such as the Vodacom Foundation, USAID and Childline. In May 2015, a partnership with the National Department of Health was announced for the development of an mHealth app for youth-orientated health.

YAL seeks to provide educational and health content in a positive and engaging way. It provides information on sexual health and tackles politically sensitive topics such as abortion and choice. YAL does not provide professional medical advice. Instead, key terms such as “abortion” or “suicide” trigger automated responses that provide information about national helpline services and users are encouraged to seek professional care. By providing this platform, where young people can freely discuss health and sexual issues, YAL recognises young people’s sexuality and other contentious sexual and reproductive rights issues such as abortion and choice. It seeks to drive discussions that challenge social norms. In addition to allowing content to be driven by the users, YAL organises live conversations with medical doctors with expertise in HIV, other infectious diseases or sexual health, during which users can pose questions. The popularity of these sessions is reflected, as an employee at YAL explained, in the fact that the medical expert will usually receive up to 500 questions during a two-hour session.
Online mobile spaces do not, however, only support healthy SRHR choices. They are also platforms for sexual abuse. Although YAL allows content, in part, to be driven by the users, it has very strict rules on what is acceptable and full-time moderators delete swearing, racial slurs and blasphemy. The technology cannot protect from sexual predation online. The framing of health messaging can either sustain or undermine sexual health.

**Policy review**

SRHR policy development occurs in a challenging context in South Africa with unacceptably high rates of HIV, teenage pregnancy, and unintended pregnancies; high infant mortality rates; high maternal mortality and mother-to-child HIV transmission as well as high rates of tuberculosis.

The content of the reviewed health policies reflects the prioritisation of SRHR programming, with some recognition of the vulnerabilities facing marginalised women. The National Contraceptive and Fertility Planning Policies clearly address SRHR, supporting a method mix of contraception options which draws on the full range available in financially-constrained settings, within a human rights framework. It elaborates upon health workers’ ability to understand and impart knowledge. The Integrated School Health Policy includes “a package of on-site service” provided at schools and offering sexual and reproductive health services, dual protection (thus preventing pregnancy, STIs and HIV infection) and HIV counselling and testing. The National Strategic Plan, a national policy framework, also emphasises access to a package of services including termination of pregnancy, provision of female condoms and addressing gender violence. As in the National Contraceptive and Fertility Planning Policies, the National Strategic Plan does not engage with the details required to deliver sexual rights, suggesting that the commitment to delivering on these rights is lacking. South Africa’s health policies are thus characterised by a conceptualisation of sexual and reproductive health programming through HIV prevention activities, with less focus on rights. Instead, particular aspects, such as maternal health or contraception are emphasised, with little understanding of sex positive work (which emphasises the pleasurable dimensions of sex amongst consenting adults) and with little recognition of adolescents’ vulnerabilities. None of these policies make any mention of mHealth. Furthermore, the National Contraceptive and Fertility Planning Policies have no budget for implementing behavioural change programmes.

South Africa’s ICT policies seek to facilitate the production of a “seamless information infrastructure by 2030” which underpins an information society and knowledge economy and is accessible to all. The four ICT policies reviewed, namely the e-Health Strategy, the Broadband Strategy; the Green Paper and the mHealth Strategy, all make reference to technology as benefiting health. For example, the Green Paper aspires to enable “all sectors of society [to] reap the benefits of the digital age.” All these policies emphasise the importance of health, but provide no budget for this. The e-Health Strategy sees technology as a means to identify at-risk infants; link pregnancy and neonatal records; coordinate patients’ transportation; and enhance treatment and promote information services. There is, however, no discussion of gender as a social determinant of health, of its significance as an axis of inequality; of women’s differential access to health services, or of the promotion of SRHR.

**Discussion**

As indicated above, both health and ICT policies recognise the potential of ICT-bolstered delivery of health care and MCH. These policy issues have wide-ranging stakeholder support and are relatively uncontroversial. They are, as one respondent on the mHealth Task Force explained, “safe” topics, “topics about mothers and feel-good sensations”. However, when it comes to the broader range of SRHR, a wide gap exists with most health policies making little explicit mention of ICTs and most ICT policies neglecting health rights altogether. As the WHO has pointed out, developing appropriate policy which can keep pace with rapid technological change is not easy, especially when multiple different sectors and actors are involved and when, as is the case in mHealth, the technology is constantly evolving.

The issues associated with sexual and reproductive rights – sexuality, abortion, gender-based violence, sex-positive messaging and teenage sexual pleasure – are, in addition, politicised, involve religious and moral values and receive polarised opposition. This polarisation is also reflected in government departmental practice. Representatives from the Department of Social Development emphasised their focus on South Africa’s sexual and reproductive rights commitments, in particular, the ready availability of contraception and preventing violence against women and children. In contrast, the Minister of
Health prioritises health information systems and maternal health. As noted by one government representative, as a consequence there is “very little interface” between sexual and reproductive rights and ICTs and very little interaction between members of the National Department of Health and the Department of Social Development. Similarly, among researchers and implementers, SRHR experts have limited understanding of the current use of ICTs in health and implementers have only partial perspectives on SRHR. Their sectoral knowledge is accompanied by a complete lack of knowledge about policy, as one implementer of a mobile platform for youth and sexuality commented:

“The scary thing is how possible it is to do this without ever coming up against these policies. Anyone can put a sexual health and advice site up with no restrictions, no regulations.”

As several respondents working in the area of implementation pointed out, even in areas where there is good policy, implementation is challenging, and policy is not sufficiently correlated with need. South Africa’s ICT policy focuses on expanding broadband access, and on high-income country standards. It sees cell phones as automatically overcoming gender exclusions, yet some health researchers pointed out that adding more phones may not improve access. Rather, they argued, structural factors (such as poverty, unemployment, literacy, residence, and patriarchal relations) limit women’s use and access to ICTs. As one respondent said: “Access [to ICTs] mirrors inequality offline”. Addressing inequality in women’s health is therefore not just about providing more phones. Rather, a transformative approach with dedicated programmes is needed.

South Africa’s policy framework for mHealth can be seen as comprising two dimensions: on the one hand, there are health policies which recognise sexual and reproductive health but have little conceptualisation of rights and no reference to mHealth and, on the other hand, there are ICT-focused policies which recognise the significance of health, but fail to specifically address rights associated with health. Neither set of policies has a budget for mHealth initiatives. This suggests an uneven approach to the contested and controversial topic of SRHR.

The three case studies offer an indication of the range of mHealth interventions on SRHR. The case studies are all remarkable and all have achieved a significant measure of success, showing that mHealth can offer a wide range of ways of addressing sexual and reproductive health in South Africa. Yet, each case study also reveals a combination of limitations and positive aspects: MomConnect is a government initiative which focuses primarily on MCH and will enhance many South African women’s experiences of pregnancy, yet with limited reference to other reproductive rights. M-Assist is a randomised control trial, undertaken by a partnership between a university and a not-for-profit company which conveys information specifically about medical abortion by mobile phone, but offers services only to a very limited population. YAL, initiated by a not-for-profit organisation, provides a platform for sharing messages and provides for politically-sensitive yet wide-ranging messaging on SRHR and content on abortion, adolescent sexuality, and sexual empowerment, yet does so in a complex and contested environment which may also potentially undermine sexual and reproductive rights.

Moreover, powerful actors are able to influence how, within these mHealth initiatives, information is conveyed which can enhance or undermine sexual and reproductive rights. For example, government officials interviewed were candid in referring to the Ministry of Health as conservative in relation to SRHR, and in advocating specific approaches in its promotion of Contraception methods. The Contraception and Fertility Planning Policies explicitly recommend a mixed methods approach to facilitate contraception within a human rights framework, providing information about the different methods that can be used to prevent pregnancy, HIV and sexual infections. However when launching these policies and in his State of the Nation Address discussing this policy, the Minister of Health has emphasised only the long-lasting implant method, Implanon. In so doing, he omitted from his presentations, the fundamental concept that women have the right to freely choose from a range of contraceptive options. This conservatism, combined with a prioritisation of maternal health in mHealth implementation and the lack of policy specification for a wide range of SRHR, suggests that contentious aspects – such as abortion, sexual rights, and adolescent sexuality – have been, to date, included in policy yet side-lined in implementation.

Conclusion

The field of ICTs and mHealth is developing swiftly and is becoming increasingly significant. mHealth offers new forms of health education and information provision. These new innovations are occurring in a policy context which does not strongly
connect ICT technology with SRHR and which does not specifically link mHealth with sexual and reproductive rights. Debates — about health as part of women’s empowerment, about abortion and about young people’s sexuality — which have long concerned South Africa, are continuing to be played out through this new media. The wide range of possible forms of intervention in mHealth can provide for an assortment of SRHR and needs. Yet no one intervention can address all women’s SRHR and, as shown in the case studies above, there is a need to tailor content and style to specific audiences. In this policy context, many mHealth interventions will struggle to overcome existing biases against difficult and controversial topics. Debates about how to best support women’s comprehensive SRHR will remain. For those interested in promoting the full range of SRHR it will be important to pay attention to mHealth and other new forms of technology and find ways to ensure that a range of options, a wide menu of technological platforms and health provisions, is available addressing MCH as well as sex positive work, adolescent sexuality, abortion and rights issues. It will also be necessary to develop accessible ways of navigating across and between the different mHealth platforms and sites, so that people can find and access the kinds of information they desire and need.

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Résumé
Les technologies de l’information et de la communication (TIC) offrent un potentiel et des innovations formidables pour améliorer la santé publique et les systèmes sanitaires. Cet article étudie les intersections de la m-santé (ou santé mobile) avec la santé et les droits sexuels et génésiques, dans les politiques comme dans la pratique. Il s’agit d’une étude qualitative, étayée par un examen des politiques et des entretiens avec des informateurs clés. Trois études de cas renseignent sur l’évolution des TIC sur le terrain par rapport à la santé et aux droits génésiques. Nous avançons que, du point de vue politique, il y a peu de recoupements entre les droits à la santé et les technologies de communication. Néanmoins, dans le domaine de la pratique, des interventions marquantes abordent certains aspects de la santé génésique. Actuellement, la m-santé contribue de manière limitée à l’éventail complet de la justice génésique et de la santé et des droits sexuels et génésiques, particulièrement en ce qui concerne les initiatives gouvernementales. L’article affirme que les projets de m-santé tendent à éviter les aspects litigieux de la santé sexuelle, tout en traitant des thèmes favorables comme la grossesse et la maternité. Les formulations de l’information dans la m-santé reflètent les lacunes présentes dans la santé et les droits sexuels et génésiques, où domine une perspective limitée et conservatrice, qui risque de restreindre la programmation et la mise en œuvre des services.

Resumen
Las Tecnologías de Información y Comunicación (ICT) ofrecen una enorme oportunidad e innovación para mejorar la salud pública y los sistemas de salud. Este artículo explora las intersecciones entre salud móvil (mHealth) y salud y derechos sexuales y reproductivos tanto en políticas como en la práctica. Es un estudio cualitativo, informado por la revisión de políticas y entrevistas con informantes clave. Tres casos estudiados proporcionan evidencia sobre lo que está sucediendo en el campo con relación a las ICT y la salud y derechos reproductivos. Argumentamos que en términos de políticas, existen pocas similitudes entre los derechos relacionados con la salud y las tecnologías de comunicación. Sin embargo, en la práctica, importantes intervenciones abordan los aspectos de la salud reproductiva. En la actualidad, mHealth está limitada para abordar la gama completa de salud reproductiva y salud y derechos sexuales y reproductivos, particularmente con relación a las iniciativas gubernamentales. Este artículo argumenta que los proyectos de mHealth tienden a evitar los aspectos polémicos de la salud sexual, mientras que abordan temas favorables tales como el embarazo y la maternidad. Las maneras en que la información es proporcionada en mHealth refleja las brechas actuales en salud y derechos sexuales y reproductivos, donde predomina una perspectiva limitada y conservadora, lo cual puede restringir los programas y la prestación de servicios.