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Reproductive Health Update 2002

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Table of contents

TABLE OF CONTENTS	2
LIST OF ACRONYMS	3
INTRODUCTION	4
TURNING BACK THE CLOCK ON WOMEN'S HEALTH AND RIGHTS	5
THE THAI SUCCESS STORY: THE 100% CONDOM PROGRAMME	7
YOUTH FRIENDLY RH SERVICES	10
ADDITIONAL SELECTED LINKS AND REFERENCES	15

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Disclaimer

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List of Acronyms

AIC	Aids Information Centre
DALYs	Disability Adjusted Life Years
EU	European Union
ICPD	1994 International Conference on Population and Development, Cairo
IPPF	International Planned Parenthood Federation
GTZ	German Technical Cooperation
HRP	WHO's cosponsored special programme on Research, Development and Research Training
MSF	Médecins sans Frontières
RH	Reproductive Health
SDC	Swiss Agency for Development and Cooperation
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Disease
UNFPA	United Nations Fund for Population Affairs
US	United States
USAID	US International Development Agency
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Introduction

This Reproductive Health Update is a follow up to two previous papers.

The issue of Reproductive Health is today threatened to be pushed off the agenda of priorities in international health.

Switzerland is one of 179 countries that have signed the Cairo Commitment to promote universal and equal access to reproductive services and rights. The Swiss Agency for Development and Cooperation has contributed for many years to several multilateral and international organisations in the field.

The current update follows two previous documents produced for SDC. A key issue paper on Reproductive Health in 2000 explained the basic concept of RH and touched specific issues such as the evidence base, the burden of disease, health sector reform and integration of RH services. The 2001 update already touched on the shifting focus of the U.S. foreign RH policy and dealt with female controlled HIV prevention and new developments in the field of contraceptives.

The current update is written at a time when the issue of reproductive health is under heavy debate and when achievements of the past decades risk being undermined. The first section deals with current developments and trends influenced by fundamentalist movements threatening to amputate the RH concept.

The paper then shows that success in reproductive health can be achieved with major beneficiary impact for the most vulnerable populations. The Thai success story of the 100% condom programme is portrayed.

Finally, one of the most sensitive and controversial issues of reproductive health beside abortion will be dealt with. Should adolescents and unmarried young people have access to reproductive health services and information on sexual and reproductive health? The last section highlights this question and shows, how a project implemented by Médecins sans Frontières with funding support of the Swiss Agency for Development and Cooperation is considered a best practice in Kyrgystan.

Turning back the clock on women's health and rights

The ICPD Conference led to a paradigm shift from population control to a comprehensive view of reproductive health and rights .

The Cairo conference on Population and Development issues, ICPD, in 1994 marked an international consensus acknowledging the right of all people to decide for themselves on when and how many children to bear and the right to good reproductive health as basic human rights. The Cairo commitment was endorsed by 179 nations. (*see also Key issue paper on Reproductive Health, SDC 2000*)

The conference was seen as a landmark in history leading to a paradigm shift from population control to a more comprehensive concept of reproductive health and rights, including the concern about quality of care. Sexual and Reproductive Health was looked at in a holistic way with its socio-cultural, gender and human rights dimensions. The new "life cycle approach" addressed the needs of both women and men, as well as of people in various age groups (from children and adolescents to the elderly) and a wide range of health issues linked to human reproduction. Ever since, the so-called "Cairo Commitment" was the reference, which guided international development and cooperation in this field.

The U.S. has frozen funding to several multilateral and international organisation involved in RH.

Since Cairo, a debate continues in some countries as well as in international forums about some aspect of sexual and reproductive health, particularly the programmatic content of reproductive health services, the provision of information and services to adolescents, and issues surrounding unsafe abortion and its prevention. As a result, the ICPD goal of universal access to reproductive health by 2015 was not included as one of the Millennium Development Goals. Responding to intense pressure by anti-abortion groups and religious fundamentalists, the Bush administration reinstated in 2001 the so-called Global Gag Rule¹. (*see RH update 2001, SDC, and <http://www.heldtoransom.org/gag.asp> for further details on the Global Gag Rule*). As a result, over the last two years the United States have frozen their funding to UNFPA (34 million \$ for 2002), to IPPF (10 million \$ annually) and many other organisations. Only very recently it was announced that the funding to WHO's programme on Human Reproduction (HRP, 3 million \$) will most likely be reallocated. All these international organisations have been actively involved in promoting access to family planning and information, to give couples around the world better reproductive choices and to prevent unsafe abortions. For UNFPA, it was its collaboration with China, which led to the funding cut. This comes at a time, when China has declared that it has shifted from a concept of population control to providing the "best reproductive health services", respecting

¹ The "Global Gag Rule" denies U.S. Federal funds to any organization engaged directly or indirectly in abortion-related activities (including prevention and counseling) outside the US, even if they used non- US funding for these activities.

The U.S. withdraws from the Cairo commitment.

individual reproductive rights. HRP/WHO has been conducting research on emergency contraception and on methods for safe abortion, such as the RU 486 pill and manual vacuum extraction techniques.

The latest in a long line of politically driven setbacks to reproductive health and rights is the public announcement of the US delegation to the preparatory meeting for the Asia and Pacific Conference on population in October 2002 that the US was “unable to reaffirm its commitment to the ICPD Programme of Action, and that this position was non-negotiable”. Two terms, “RH services” and “reproductive rights” were at the centre of the dispute and were requested to be replaced by “RH care” as the first can be construed as promoting abortion.

The burden of reproductive ill health in developing countries is still dramatic.

This move towards fundamentalism and away from the commitment reached in Cairo almost ten years ago raises the question, whether reproductive health should no longer be considered a priority.

Fact is, that sexual and reproductive ill- health, including HIV/AIDS, is thought to have accounted in 2000 for 15% of disability-adjusted life years (DALYs) lost, most of them in developing countries and in countries with economies in transition. Despite impressive progress in contraceptive coverage achieved (from less than 10% of couples using contraception in 1965 to some 62 % at the turn of the century), more than 122 million women around the world still have an unmet need for contraception². Close to 40% of all pregnancies are unplanned and some 46 million of them are terminated each year through induced abortion. Regarding this most controversial issue, available data numbers 26 million legal abortions and 20 million unsafe abortions taking place in 1995. The World Health Organisation estimates that unsafe abortions result in some 80'000 maternal deaths annually and hundreds of thousands of disabilities, the majority in developing countries. A new WHO report (2002) has demonstrated that illegal abortions were the second leading cause of death among women in Ethiopian hospitals. More women die from complications arising from illegal abortions than from any other cause, except tuberculosis. WHO officials estimate that 70% of women who are admitted to Ethiopian hospitals after undergoing an illegal abortion will die, and most of these deaths occur among women ages 16 to 20. WHO does not recommend legalising abortion in Ethiopia, but instead has called for improved access to family planning services to prevent unwanted pregnancies.

A new WHO study shows that illegal abortion is the second leading cause of death of women in Ethiopian hospitals.

Similarly alarming figures could be given for the other, less controversial components of reproductive health, that are equally being affected by the current funding withdrawal. By far the majority of countries still adhere to the commitments made in Cairo. The WHO report of the Commission on Macroeconomics and Health underlined the urgent need for

The majority of donor countries continues to

² Unmet need of contraception: couples are not using any method of contraception although they want to space pregnancies or limit their fertility.

promote the Cairo commitment and calls to balance the impact of the US move.

doing so: “Investments in reproductive health, including family planning and access to contraceptives, are crucial accompaniments to investments in disease control”. In addition, reducing fertility leads to a reduction in dependency rates which again is essential for poverty reduction.

Ministries of Health in developing countries, EU delegates, UN officials and Reproductive Health experts of many bilateral and international development agencies have expressed extreme concern about the potentially devastating effect of the latest developments that could undermine decades of work and progress in the field. They have launched a “call to action to defend the ICPD Programme of Action”. EU parliamentarians have also called to fill the “decency gap” created by the US funding cut. Several European countries, such as Finland or Germany have increased their contributions to affected organisations, such as the IPPF, as a result.

Sources used : *Various documents of WHO/HRP, IPPF newsletters*

The Thai success story: the 100% condom programme

Thailand recognised as the first Asian country to have an HIV/AIDS problem.

Thailand was the first Asian nation to recognise that it had a major HIV/AIDS problem deserving priority attention on the national agenda. Most new HIV infections in Thailand in the 1980s and 90s were occurring through commercial sex. Nation-wide, HIV prevalence among brothel-based sex workers had risen from 3.1% in 1989 to 15.2% in 1991 and from 0.5% to 3% in military conscripts over the same time period.

A multisectoral collaboration allowed to introduce the idea of 100% condom use in all Thai sex establishments.

In 1989, a new approach to promoting condom use in commercial sex was being pioneered in Ratchaburi province and then scaled up nation wide in 1991. The 100% Condom Programme aimed at gaining the agreement of the owners and managers of all commercial sex establishments to enforce condom use as a condition of commercial sex. Sex workers should be instructed to refuse sex to any customer who refuses to use a condom. If all sex establishments enforced this policy, clients would have no choice - they either use condoms or they don't have sex.

The programme was rapidly scaled up and accompanied by comprehensive prevention efforts.

Local leaders, police and health workers had to work together to develop the programme, and to ensure the agreement and co-operation of the owners of sex establishments. When they did not co-operate, they faced sanctions, including warnings and the temporary or permanent closure of their businesses.

In addition, the Thai government introduced a variety of other prevention effort, ranging from quality assurance measures for condoms, promotion of condom use through mass media, peer education and outreach programmes. Check-ups and STDs treatment for sex workers and clients were reinforced and 60 million condoms a year provided for

free. The Prime Minister's Office and several Ministries organised presentations at national, provincial and district meetings of governors, chiefs of police and medical authorities and instructed them to implement the programme locally. By 1992, all provinces reported that the 100% condom programme was in place.

Findings showed the programme was significantly effective in:

There is evidence for strong impact on increasing condom use, reducing the incidence of STI's and the prevalence of HIV.

1. increasing condom use in sex work throughout the country (over 90%)
2. Reducing the incidence of Sexually Transmitted Infections (10 fold, 1991-1993);
2. Reducing the prevalence of HIV in specific target populations (5 fold, 1991-1993);
3. Changing attitudes and practices regarding condom use and sexual high risk behaviour (e.g. visits to sex workers);
4. Strong relationship between the increase in condom use and the rapid decline in Sexually Transmitted Diseases in sex establishments.

On the other hand, the programme had little impact on condom use in non- commercial relationships of both sex workers and clients, leaving potential routes for HIV transmission.

Lessons learned

The current number of people living with HIV/AIDS in Thailand is a 77% reduction from the projected estimate in 1991 (4 million were projected for 2000). Although Thailand has achieved a significant success in controlling the spread of HIV/AIDS, with new infections falling from 143'000 cases in 1991 to 25'000 in 2001, the country still has as high as 1million people living with HIV/AIDS. Some 300'000 people have already died of AIDS.

Some of the important lessons learned from the experience with the 100% Condom Programme in Thailand are:

1. **Political commitment** at both the national and local level was essential to the success of this programme. Strong and high level national commitment by the Prime Minister, the Minister of Public Health and the Minister of the Interior resulted in the adoption of a national policy and aggressive efforts to enlist the aid of provincial administrators. The political commitment also translated into a **consistent supply of good quality condoms** for distribution free of charge to sex establishments, a crucial feature of this programme
2. **STD care and a 100% condom programme have synergistic interactions.** The programme reduced the incidence of STDs, while existing STD treatment services were helpful in monitor and evaluate the effectiveness and impact of the programme.
3. While some **enforcement may be helpful in launching a 100% condom programme, in the long**

run cooperation is the more effective approach.

This view is strongly defended by interviewed health administrators. Many of them opposed police closings of establishments because it made sex workers less accessible for prevention.

4. **Measurable positive results can be achieved quickly** with such a programme. Provinces saw declining STD rates within 3 to 4 months of implementation. National rates fell noticeably each year.
5. **The most effective prevention efforts are those that involve multisectoral collaboration.** The governors and police helped to open doors, the brothel owners provided access, the sex workers convinced the clients to use condoms, the clients recognised the need for condoms.
6. The programme in its current form is quite **sustainable** because it has been well **integrated into existing health structures**, with a **division of responsibility** to avoid overburdening any one unit.
7. A 100% condom programme **requires complementary efforts** to reach the client. Simultaneous efforts (prevention campaigns, treatment and care campaigns, etc) should be considered par of the overall package. Future prevention efforts must also strongly **promote condom use with non-commercial partners** for both clients and sex workers.

While the success of this programme is clearly established, some limitations are also evident. Not only has it been recognised that condom use with non commercial partners did not increase to the extent needed, but it became also clear, that the 100% condom programme was more effective in registered and state controlled sex establishments, but less so in bars, massage parlours and other establishments, where commercial sex is available. In addition, human rights groups, such as the “network of sex work projects”, an advocacy group that raised the issue at the Barcelona conference, attacked the 100% condom programme to be a “coercive programme and a misogynist public health approach that violates human rights”. They state that sex workers were taken to STD clinics under police “escort” and photos of women had been displayed so that men can identify any woman who they allege infected them or agreed to sex without a condom.

In the mean time, 100% condom programmes have been introduced in a series of other Asian countries, such as Cambodia, China, India, Indonesia, Myanmar, the Philippines and Vietnam.

Sources used for producing this section

<http://www.unaids.org/publications/documents/care/general/JC-Condom-E.pdf>

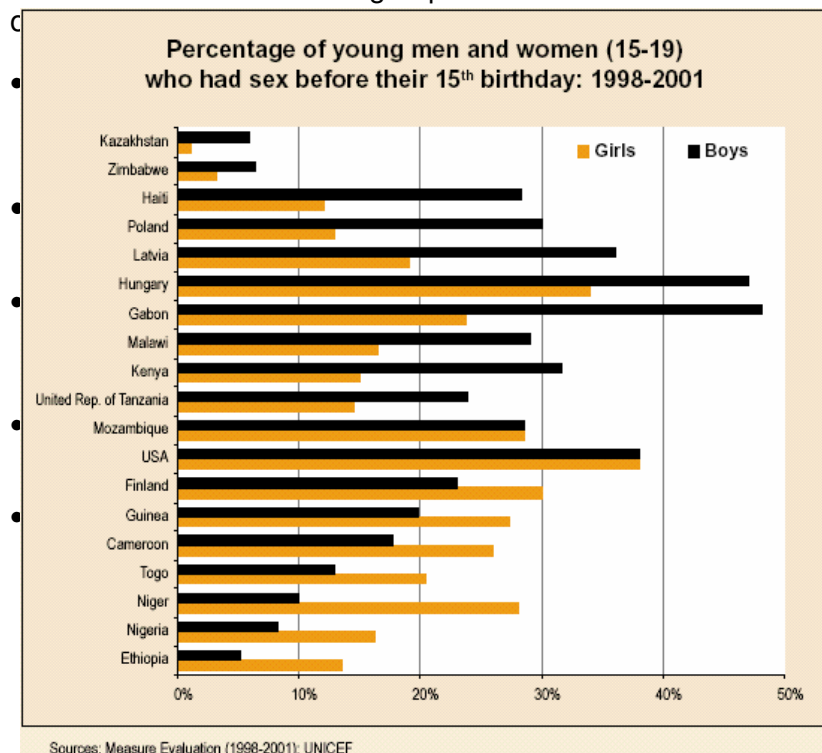
www.wpro.who.int/pdf/sti/100advocacy.ppt

Youth friendly RH services

Should the right to reproductive health extend to adolescents?

Since the International Conference of Population and Development in 1994, much attention has been given to improve reproductive health and rights of men and women. Adolescents, defined as people between the ages of 10 and 19, have received special attention in Cairo (Commitment of Action 7.41). However, efforts to make available information and services to adolescents to help them understand their sexuality and protect themselves from unwanted pregnancies, STDs and subsequent risk of infertility, have been weak so far as they are considered a sensitive issue. Whether young people should get access to such information and services is controversially discussed, not only by fundamentalist religious leaders or the current US government, but also by parents, teachers and health care providers.

More than 1 billion young people are between 15 and 24 years of age. Especially in developing countries, this age group composes a large segment of the total population (some 20%). It is an established fact, that adolescents are increasingly sexually active at very young ages (*see table*). Rising age at marriage and falling age at menarche mean that many more people now become sexually active before marriage, leading to extramarital sex and many unwanted pregnancies. As a result adolescents share a large burden of the reproductive ill health and should be considered as one of the most vulnerable groups and not as the healthiest



reproductive health, they also have specific needs in terms of information and services. They need to understand what is going on in their bodies, and how these changes can affect their futures. Confidentiality and appropriate and empathic counselling are important issues when working with youth. Existing services are often inaccessible to them (too expensive, opening hours during school time, staff being reluctant and at times hostile to provide them with services). Adolescents also need specific counselling in terms of appropriate contraceptive methods and how to exercise greater control over their sexual and reproductive lives. Quality school-based programmes, while proven effective, are scarce. And where they do exist, they are not available to adolescents who are not in school.

Reproductive health services for adolescents

Young people need, want and have a right to reproductive and sexual health services. Ignoring their sexuality will not make their problems go away. There is now established evidence from many studies that teaching young people about sexuality and contraception does not provoke earlier or promiscuitive sexual activity, as often feared, but has rather the opposite effect of reducing sexual activity among young people and increasing the use of condom and other contraceptives among sexually active youth. Denying them the right to take informed decisions, as is the case in the “abstinence only” school sex education programme sponsored by the US government, simply leaves adolescents vulnerable to unwanted pregnancy, unsafe abortion, and sexually transmitted diseases, including HIV/AIDS.

This having said, abstinence is one of the promising - and certainly the most effective, if complied with - methods of contraception and protecting youth from sexually transmitted infections. Uganda is one of many countries who promoted as one of the 3 ABC pillars (Abstinence, Be faithful to one partner, otherwise use Condoms). While it is known that an increasing number of young Ugandans are postponing their first sexual activity, the exact impact of the “abstinence” component on the decreasing HIV/AIDS prevalence is currently being studied in a multi-country study by the U.S. Agency for International Development (USAID).

The abstinence debate should not divert from efforts to better meet in a comprehensive way the RH needs of adolescents, both within and outside of the health clinic setting. Without adolescents having access to appropriate services, information and education can be largely ineffectual, as shows UNFPA’s experience.

Involving young people into planning, designing, implementing and monitoring youth friendly activities is a key prerequisite to success, as demonstrated by the experience of agencies heavily involved in working with

youth, such as the IPPF, UNFPA and GTZ. Adults need not regard adolescents and young people as problems. *"Young people can and should be a part of the solution to the problems in the world. Everywhere, young people and youth organisations show that they are not obstacles, but invaluable resources for development."* (Braga Youth Action Plan, adopted at the 1998 World Youth Forum)

Many experiences of services having been developed specifically for adolescents are today available. In Senegal, UNFPA has set up a network of so-called youth friendly clinics, which offer RH and HIV/AIDS services, social services and leisure activities. The AIDS information Centre (AIC) in Uganda has designated a clinic area to counselling and voluntary testing (VCT) for young people. In Mombasa, Kenya, VCT centres are staffed with trained peer educators who provide youth with HIV information. In Demographic and Health Surveys in Kenya and Zimbabwe, more than 60% of some 6000 adolescents who had not undergone HIV testing reported that they would like to be tested. Again, the cost of the test, confidentiality and parental consent are major issues to be considered specific for this age group. Another challenge facing specific youth services is that of sustainability, as providing services to young people often needs to be given for free or for charges, which do not cover the expenses incurred. Cost-effectiveness, however, should be judged in terms of the return of investing in young people's health, which is an important investment into the future of a population.

SDC's contribution: The Rainbow Centre in Kyrgystan

In the late 90s, The Swiss Agency for Development and Cooperation has been funding MSF France's work in the second largest city of Kyrgystan. Today, the project is managed by a national non-governmental organization. One of the components of that project, which focused on improving the offer in prevention and treatment of sexually transmitted diseases of particular risk groups, also targeted young people. In an "Assessment of the Reproductive Health Needs of Young People in Kyrgyzstan" conducted and reported by the Reproductive Health Alliance Europe, the evaluators highlight the work of MSF in the summary of findings.

There are a number of NGOs providing services to young people in Kyrgyzstan. In general, people said that NGO programmes are usually more effective than government programmes but they are limited in scope and coverage. They often provide services that are not provided by the government, issue special literature and tend to be closer to the people. Their services have better confidentiality, which is an important and attractive aspect for young people. Many people interviewed were aware of the work of Medecins Sans Frontiers (MSF) in Osh. Several young people mentioned the Rainbow Centre.

The Rainbow Centre, Osh

Since it opened in October 1998 until May 1999, some 1500 young people visited the Rainbow Centre in Osh, established by MSF as an HIV/AIDS information centre.

Most visitors have requested other sexual and reproductive health advice and referral for services.

The two staff running the centre provide an essential service but were unprepared for the larger role they are required to fulfil and feel the need for broader training and support.

MSF are planning a programme called "*children to children*", through which they will train young people from grades 8 -10 to do health education work in Osh. According to staff of MSF, there were complaints from one teacher regarding their work with young people, but all others were supportive of their work and raised no opposition.

**Sources used for
producing this
section**

- **UNFPA has an important focus on youth and adolescents, *see***
<http://www.unfpa.org/adolescents/index.htm>
- **Adolescent Reproductive Health, Network 2000, Volume 20, Number 3.** A newsletter by Family Health International
<http://www.fhi.org/en/fp/fppubs/network/v20-3/index.html>
- **RHAE (1999) An Assessment of the Reproductive Health Needs of Young People in Kyrgyzstan.** Reproductive Health Alliance Europe, London.
http://www.rhalliance.org/execsum_kyrgyzstan.htm Also available in Kyrgyz and Russian, from Kyrgyz Family Planning Alliance, Bishkek, Kyrgyzstan.
- **Sexual & Reproductive health:** Briefing cards; Family Care International, 2000
- **IPPF and GTZ short course on "Young people: implementing a sexual and RH and Rights approach"**
(youthcourse@ippf.org, www.ippf.org)

Additional Selected Links and References

- **Reproductive Health Gateway:** is a gateway to RH information of the Population and Health Materials Working Group of the Johns Hopkins University, supported by USAID; <http://www.rhgateway.org/>
- **Development Gateway:** The Development Gateway is an interactive portal for information and knowledge sharing on sustainable development and poverty reduction. <http://www.developmentgateway.org/>; The Gateway offers amongst others: AiDA - the most comprehensive database of development projects and knowledge sharing on key development topics, such as RH; <http://www.developmentgateway.org/node/146526/>
- **IPPF directory of hormonal contraceptives,2002:** the Directory of Hormonal Contraceptives lists contraceptives by brand, composition, country, manufacturer and type. It is extremely useful for experts who work in several countries in the field of RH. <http://contraceptive.ippf.org/>
- **Selected practice recommendations for contraceptive use, WHO 2002.** The document gives detailed guidance on who can safely use contraceptive methods, according to personal characteristics (including age), reproductive health history and medical conditions. It includes guidance on the use of 15 contraceptive methods among women with over 70 different medical conditions. http://www.who.int/reproductive-health/publications/rhr_02_7
- **How Gender- sensitive are your HIV and Family Planning Services, IPPF 2002.** The HIV/Gender Continuum is a tool to investigate how responsive an organization's services and programs are to gender issues related to HIV prevention within an overall rights-based approach to sexual and reproductive health. http://www.ippfwhr.org/resources/gender_continuum.html
- **Where women have no doctors,** by A. Burns et al 1997. Combines self-help medical information with an understanding of the ways poverty, discrimination and cultural beliefs limit women's access to care and health; following the format of the famous "Where there is no doctor". ISBN 0-942364-25-2