

Reproductive health

Reproductive health is the term used to cover all areas relating to reproduction, from sexual health to couples' choice in the timing and size of their family. Through the provision of information and services the aim is to prevent and solve reproductive health problems, ranging from sexually transmitted infections to maternal mortality. Reproductive health also covers the eradication of female genital mutilation (FGM) and increasingly, and very importantly, awareness and action to prevent the spread of HIV/AIDS.



The international position

At the International Conference on Population and Development (ICPD) held in Cairo in 1994, more than 170 countries endorsed a far-reaching Programme of Action. It concluded that reproductive health care services of the highest possible quality should be offered without coercion and made available to everybody who needs them, regardless of their age, sex or marital status.

At ICPD+5 in 1999, governments recognised that much more needed to be done to find the resources to implement the Programme of Action.

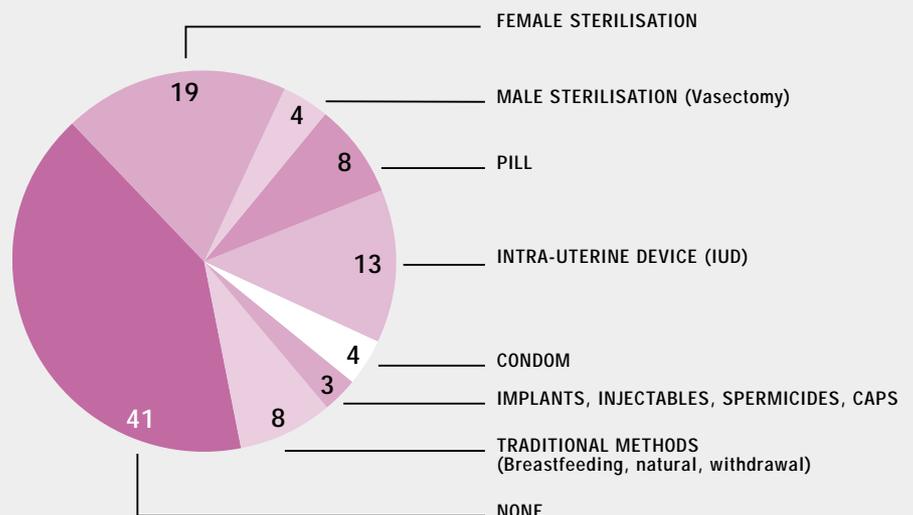
ICPD defined comprehensive reproductive health care as being made up of three closely interrelated components:

- voluntary contraceptive and family planning services
- antenatal, safe abortion, delivery, post-partum and post-abortion services (or safe motherhood services)
- services for the prevention, detection and treatment of sexually transmitted diseases, including HIV/AIDS.

The current situation

Many countries already have high-quality and accessible reproductive health education and services. These have had a positive and direct effect on health indicators, including life expectancy, and maternal and infant mortality. Many countries take these

Contraceptive methods used worldwide (%)



services for granted and they lie at the core of their health infrastructure.

However, in the developing world, reproductive health services are not always fully available and this has a direct impact on infant and maternal mortality rates.

The role of family planning

Family planning provision lies at the heart of reproductive health services. It became established as a basic human right in 1984 at the United Nations Population Conference in Mexico City.

It enables couples to control their fertility, and exercise their human right to choose the timing, spacing and size of their family. It enables

women to space their pregnancies for optimal health for themselves and their children, and encourages barrier methods of contraception to provide protection against infection.

In wider social and economic terms, family planning can free women from the repeated cycle of childbearing, alleviating poverty and enabling them to be economically active.

However, family planning has to be a long-term investment. A sexually active woman wanting just three children will need to spend 16 years of her life using contraception – especially if she wishes to avoid induced abortion.

The United Nations estimates that 51% of the world's married women use modern contraception. A further eight per cent practise natural or traditional methods, including withdrawal, abstinence at fertile times or breastfeeding, bringing the total to 59%. In 2000, there were an estimated 1.066 billion couples in the reproductive age bracket, with around 630 million practising family planning of some sort.

The unmet need for family planning

Over 300 million women worldwide say they do not want any more children, or they want to delay another pregnancy, but do not, or cannot, use an effective family planning method.

About one third of pregnancies, about 80 million a year, are unwanted or unplanned.

In many parts of the developing world, between 20 and 30% of married women between the ages of 15 and 49 do not want a child soon, or ever, but are not using any kind of contraceptive method, or are using traditional methods, for example rhythm or withdrawal methods, that often fail.

There is already a huge unmet need for modern family planning, but that figure is expected to grow. By 2015, there will be an estimated 742 million users. As the world's population increases, so does the proportion of couples wanting to use the latest contraceptive technology.

As women continue to want smaller families, this also means that they use contraception for longer, which in turn means more services are required.

There are already concerns about global 'contraceptive security' – ensuring the future supply of contraceptive methods to those who need them. In Africa, communication projects have heightened awareness of the need for safer sex and the use of barrier methods. However, condoms are not always available and are often re-used until new supplies arrive.

Addressing the problems

- increased international funding is required to meet existing reproductive health needs and growing demands of the future
- wide contraceptive choice and full information must be available. Women need to be offered a full range of methods and given information about all of them, so they can make a fully informed decision and choose the most appropriate method for that stage of their reproductive life
- clinics should be friendly, welcoming and clean, and offer privacy and confidentiality. Staff should be friendly, professional, trained and highly skilled
- good quality voluntary services should be widely available, in convenient locations, with convenient opening hours
- services should be taken out into the community through outreach programmes, mobile clinics and social marketing initiatives, in order to make contraception widely available through a large number of outlets
- men must be involved to ensure joint commitment and continuation, and to share in the responsibility of planned parenthood.

Contraceptive technology

A wide range of contraceptive methods is available worldwide,

Social marketing

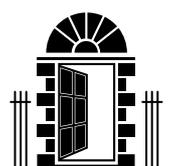
Contraceptive social marketing (CSM) is an excellent way of getting condoms or contraceptive pills into the community. There are many innovative CSM programmes all over the world, using shops, work-based schemes and non-traditional outlets to increase contraceptive availability. Own-brand, high-quality products are supplied, with profits ploughed back into the business.

offering choices for women and men at different stages of their reproductive lives.

Good family planning programmes offer a full range of contraceptives. These include:

- hormonal methods, in the form of pills, sub-dermal implants and injections
- barrier methods, including male and female condoms; caps and diaphragms are also available in some countries, for use with spermicides
- intra-uterine contraceptive devices (IUDs), ranging from normal copper and plastic IUDs to new methods which also release hormones or attach to the roof of the uterus
- voluntary sterilisation, which is offered to men (vasectomy) and women (female sterilisation) who have completed their family
- natural methods, including breastfeeding or avoidance of sex at fertile times in the woman's cycle
- emergency contraception, in the form of hormonal pills or an IUD, to prevent pregnancy after unprotected sex.

For sources, please see insert 13.



International policy

For more than 30 years, the international community has affirmed and broadened its commitment to the right to family planning and reproductive health, to women's equality and to sustainable development. Progress towards these goals can be charted through a series of key United Nations (UN) conferences.

Points of progress

1968 International Conference on Human Rights in Tehran declared that parents have a basic human right to determine freely and responsibly the number and spacing of their children.

1974 Bucharest World Population Conference made a significant change in the language, substituting "parents" with "couples and individuals".

"All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children, and to have the information, education and means to do so."

1975 First World Conference on Women in Mexico City went further by stating that the right to family planning is essential for gender equality.

1984 International Conference on Population, also held in Mexico City, suggested ways in which the right of couples and individuals to family planning could be assured, through community-based distribution and innovative non-government organisations, including women's groups.

1994 International Conference on Population and Development (ICPD) in Cairo shaped the reproductive health strategies many countries have in place today. It represented a radically new approach and way of thinking, shifting the emphasis away from demographic targets designed to achieve sustainable development.

The focus moved instead to meeting the reproductive health needs and preferences of individual women and men.

ICPD established a broad-based definition of reproductive health, including family planning, safe motherhood, protection against sexually transmitted infections, and sexual health, which has since been accepted worldwide.

The empowerment of women within their families and communities is key to this new approach, along with the protection of their reproductive rights.

In addition, for the first time, the conference report estimated the costs of implementing the reproductive health components of the ICPD Programme of Action.

It was recommended that developed countries should contribute one third of these costs, and developing countries should find the remaining two thirds.

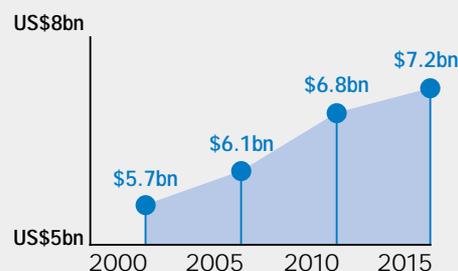
1995 United Nations Fourth World Conference on Women, held in Beijing, produced a Platform for Action highlighting areas of special concern for women. These included:

- poverty
- education
- health
- violence against women
- human rights.

Delegates reaffirmed the goals of the 1994 ICPD Programme of Action, and further strengthened the language on abortion. They



ICPD estimated cost of future reproductive health needs



recognised that unsafe abortions threatened the lives of a large number of women, especially the poorest and youngest members of society, but that deaths and injuries could be prevented through safe and effective reproductive health measures.

At the **1995 World Summit on Social Development** in Copenhagen, delegates called for:

- governments to allocate, on average, 20% of overseas development assistance (ODA) and 20% of the national budget, respectively, to basic social programmes
- governments to work towards an agreed target of 0.7% of gross national product for overall official ODA as soon as possible, and an increase in the share of funding for social development programmes.

At **ICPD+5** in 1999 there was a review of progress since the Cairo ICPD, and a call for action was issued.

Governments were urged to:

- intensify efforts to raise funds for the ICPD Programme of Action because funding promised at ICPD has not been met
- take strong measures to promote the human rights of women and girls
- strengthen access to reproductive and sexual health services
- ensure that the prevention of, and services for, sexually transmitted infections and HIV/AIDS become integral components of health programmes
- increase information, education and HIV prevention services for young people so that 90% of 15 to 25 year-olds can reduce their vulnerability to HIV by 2005.

For sources, please see insert 13.

Policy development in Malawi

International policy does have an impact at national level. Malawi is one country which has demonstrated a new, recent commitment to reproductive health programming, partly as a result of the United Nations, declarations.

Family planning services were first available in Malawi in the early 1960s, but discontinued in 1968 because of misunderstandings about the intent of the programme and its implementation. There was no provision until 1982, when the concept of child spacing was adopted. Services then became available through governmental and non-governmental sectors, starting with just two clinics in 1983 and building to more than 300 within a decade.

The Malawi Demographic and Health Survey of 1992 highlighted the fact that 65% of women of reproductive age did not want another pregnancy in the next two years, or wanted no more children. Only seven per cent of women were using a modern method of contraception. The survey also showed a population growth rate of 3.2%, and a fertility rate of 6.7%.

The Government then implemented a family planning policy and prepared a new curriculum for training family planning service providers. Guidelines on

community-based distribution were also developed and distributed.

In 1994, the Malawi Government adopted the ICPD Programme of Action and implemented a series of changes:

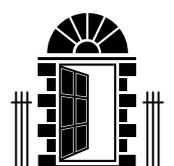
- in the spirit of ICPD, the Government adopted a comprehensive 'umbrella' approach to reproductive health services
- the Government strengthened its adolescent services and the diagnosis and treatment of sexually transmitted infections
- the 'pillars' of safe motherhood were strengthened, including family planning, antenatal care, and obstetrics.

The Malawi Government now fully believes:

"Individuals and couples have the right to have access to voluntary, high-quality family planning services, and that the practice of family planning is a critical factor in the socio-economic development and well-being of every Malawian, especially women."

Since ICPD+5, the Government has responded to the HIV/AIDS pandemic, and put extra resources and commitment towards protecting the health of the nation.

Source: *Family Planning Policy and Contraceptive Guidelines*, Ministry of Health and Population and National Family Welfare Council of Malawi, 1996.



Safe motherhood

Pregnancy and childbirth are the leading causes of death and disability for women in developing countries. Every year, 600,000 women die as a direct result of getting pregnant, with 99% of these deaths occurring in developing countries.

Childbearing can be so dangerous that in Tanzania, mothers who are about to give birth say to their older children: "I am going to the sea to fetch a new baby, but the journey is long and dangerous and I may not return."

However, at least 75% of all maternal deaths happen needlessly. They could be prevented through reproductive health programmes.

The huge disparity in maternal mortality rates between developed and developing countries is one of the most significant indicators of the gap between rich and poor nations.

According to the United Nations Population Fund, women in the Central African Republic have the world's highest maternal mortality rate of 1,100 deaths per 100,000 live births, followed by Eritrea at 1,000. To put this in context, the rate in Northern European countries, such as Sweden, is just five deaths per 100,000 live births.

Worldwide, only 53% of births take place with a skilled attendant present, meaning more than 50 million women are neglected during birth. In western Africa, the figure is the lowest, at 35%.

The figures are shocking, but the human stories behind them are worse. Every year, one million children are left without a mother, reducing their own chance of survival. Research has shown that children are more likely to die if they lose a parent – especially if it is the mother.

Maternal death invariably also represents an economic loss to the family and creates an additional burden for the extended family and the community as a whole.

In addition, for every one woman who dies, an estimated 30 to 40 more (around 50 million women) are left with serious complications, including rupture and prolapse of the uterus, pelvic inflammatory disease and lower genital tract injuries.

An estimated 80,000 women develop a fistula every year following birth. It is caused by prolonged labour, in which the pressure from the baby's skull kills the tissue of the birth canal. After birth, the dead tissue falls away, leaving the mother permanently incontinent unless she has an operation. Some women are then rejected by their husbands and face social exclusion.

Yet despite the appalling statistics, at least 75% of all deaths and injuries could, and should, be prevented through basic reproductive health care measures.

The causes

Severe bleeding causes 25% of maternal deaths, infection accounts for 15%, eclampsia 12%, and obstructed labour eight per cent.

Bleeding and infection cannot always be predicted, but they can be treated if a woman can be transported in time to an appropriate health centre. Eclampsia and pre-eclampsia can be picked up by basic health checks and obstructed labour would require a caesarean-section delivery in a hospital.

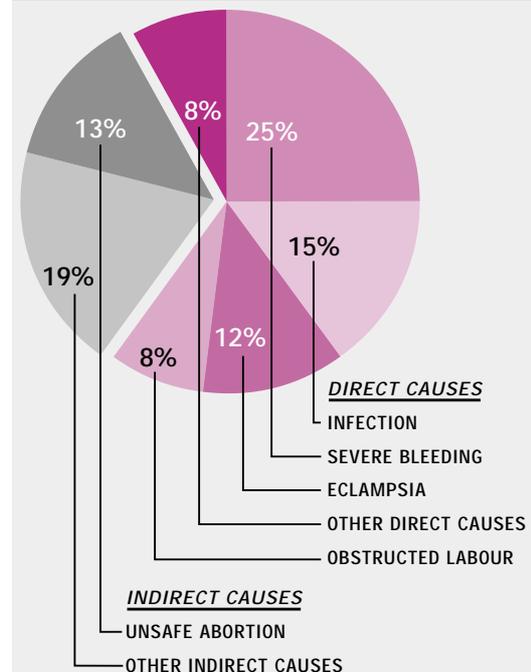


Every minute of every day:



One woman dies

Causes of maternal death



In addition, 13% of deaths (78,000 each year) result from unsafe abortions. These are either self-induced by desperate women, or performed by unskilled practitioners using dangerous techniques in unhygienic conditions. Good-quality family planning, as a vital component of reproductive health care, would prevent unwanted pregnancies.

Indirect causes, such as anaemia, malaria or heart disease are responsible for approximately 19% of maternal deaths. An estimated 60% of pregnant women in developing countries are anaemic, which lowers the chance of survival for themselves and their babies. This could be dealt with through improved nutrition or iron supplements.

Adolescents are particularly at risk. Those aged 15 to 19 are twice as likely to die as women in their 20s. In Africa, half of all women give birth before they reach the age of 20.

In addition, at least five million abortions are carried out every year in the 15 to 19 age group. Appropriate reproductive health services for adolescents, coupled with information, education and communication initiatives, could ensure they survive their teenage years.

The solutions

Safe motherhood initiatives work to ensure all women have access to information and care to enable them to go safely through pregnancy and birth.

Providing that assistance would be the most cost-effective investment of all possible health interventions. It would cost just US\$3 per woman, per year, to provide assistance in pregnancy, delivery and post-natal care.

In 1994, the International Conference on Population and Development called for a global expansion of maternal health services, including:

- education
- effective pre-natal care
- improved maternal nutrition
- adequate delivery services
- a reduction in caesarean deliveries
- facilities for emergency obstetrics and referrals
- post-partum care and family planning.

These would go a long way to helping women in the short-term. However, in the longer term, women need more than medical interventions. Literacy and empowerment would help them to make fully informed decisions about their care.

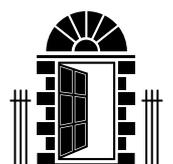
For sources, please see insert 13.

Safe motherhood in action

One of the big obstacles to safe motherhood is gaining the trust of women and getting them to use health services. Charlene Razanamiary, a 36 year-old factory worker from Madagascar, describes the birth of her second baby. Her first child was stillborn.

"For eight or nine years I tried for another baby but it was always impossible. I heard on the television and from my friends that Marie Stopes International (MSI) is very well regarded in safe motherhood. I went to MSI and they explained to me why I couldn't have children.

"I am a small woman with a small, narrow pelvis and I had a cyst inside. After the cyst was removed I became pregnant again and MSI monitored my pregnancy and prepared me psychologically for a caesarean under local anaesthetic. I am very happy and glad to have had my baby in such a caring and supportive atmosphere. I would like to have another baby but only under the supervision of the MSI medical team who have my absolute confidence."



HIV / AIDS

At the end of 2000, around 36.1 million people in the world were living with AIDS or HIV (the human immunodeficiency virus which causes AIDS). This constitutes 1.1% of the adult population.

During 2000 alone, a total of 5.3 million adults and children were found to be newly infected with HIV, and in the same year three million people died from HIV/AIDS – 80% of whom were Africans.

Regional variations

There are large regional variations in:

- the rates and methods of transmission
- the numbers affected
- the outlook for people infected with HIV.

In Sub-Saharan Africa, HIV transmission is almost totally through heterosexual sex. In other developing countries intravenous drug use is also a factor, as it is in Eastern Europe and Central Asia where high HIV rates emerged during the 1990s from drug injecting. In the developed regions, however, transmission has primarily been through men having sex with men.

Sub-Saharan Africa is the worst affected region in the world; 70% of adults and 80% of children in the world who have HIV live there. Africa has also seen the greatest number of deaths, burying more than three quarters of the 20 million people who have died worldwide since the epidemic began.

Those countries which acted quickly by distributing condoms and running health education programmes when HIV/AIDS first emerged are experiencing the best results in combating the spread of the disease. Uganda is among the successful.

However, other countries, such as South Africa, now have areas where one in five of the population has HIV/AIDS. There, and in Botswana, one third of today's 15 year-olds are expected to die from AIDS.

Reducing sexually transmitted HIV/AIDS in Sub-Saharan Africa by increasing current campaigns, including the promotion and supply of condoms, media awareness and voluntary AIDS testing, would cost around US\$1.5 billion a year.

Half of all new HIV infections in the world are in young people, aged between 15 and 24, highlighting the need for sex education and services specifically aimed at adolescents.

Three million children have died since the AIDS epidemic began. Mother-to-child transmission is now a serious source of infection in the under-15s. However, many more non-infected children, up to 14 million of them, have had their lives devastated by their parents' deaths from AIDS. By 2010, there are expected to be 40 million AIDS orphans, 95% of them in Africa.

The role of reproductive health

Reproductive health providers have a major role to play in terms of sexually transmitted HIV. Services increasingly include:

- information, education and communication to raise awareness about the spread of HIV and the need for 'safer sex' (involving the use of male or female condoms to prevent the exchange of body fluids)
- social marketing of condoms to make them more widely available throughout communities, through both traditional outlets such as clinics, and non-traditional ones, such as shops or offices
- diagnosis and treatment of other sexually transmitted infections, which can act as a 'gateway' for HIV



Microbicides

Research is underway to develop an AIDS vaccine, but this is still a long-term prospect. An earlier option is likely to be microbicides which are currently undergoing clinical trials. These would be used vaginally in the same way as spermicides, giving women a chance to protect themselves against HIV. Initially, the drugs would be delivered through vaginal creams or gels, but, in the longer term, could be combined with new contraceptive methods, such as a hormone-releasing vaginal ring.

transmission (please see insert 8 for further information)

- the provision of voluntary confidential counselling and testing (VCCT) for those who think they may be infected with HIV.

AIDS testing is still not available, or is too expensive, in many developing countries. Even if HIV is diagnosed there is often not much that can be done. The antiretroviral drug combinations which are proving successful at stabilising, but not curing, the disease in the developed world, are too costly for developing countries. Pharmaceutical companies are under increasing pressure to drop their prices for non-governmental organisations (NGOs) and others working in the poorest countries.

The international position

The 1994 International Conference on Population and Development (ICPD) called for the integration of HIV/AIDS prevention and family planning. By the time the original Programme of Action was reviewed at ICPD+5, the wider impact of the AIDS pandemic was becoming clear. Governments called for:

- more access to male condoms
- wide provision of female condoms
- legislation to prevent discrimination against those with HIV/AIDS
- antiretroviral drugs for women during and after pregnancy
- information for women on HIV and breastfeeding.

For sources, please see insert 13.

Ugandan women protect themselves

Uganda has an estimated 1.5 million HIV/AIDS cases out of a total population of 21 million and more than one million AIDS orphans. The Ugandan Government, however, has had international praise for its responsible handling of the AIDS crisis and the population is increasingly following the safer sex advice.

In 2000, Marie Stopes International Uganda (MSI-Uganda) introduced a polyurethane female condom and did trials with village women who responded to it very positively.

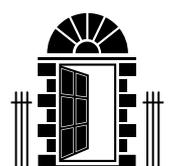
MSI-Uganda then started selling around 2,000 packs (three condoms per pack) a month, but after a major media campaign, which involved journalists trying the female condom for themselves, demand soared as women sought to protect themselves against HIV. Three months later sales had increased by 1,500% reaching 33,000 in one month alone.

The female condom is offered through traditional outlets, such as clinics and pharmacies, but is also taken into the workplace and shown to women. A pack of three costs less than a daily newspaper.

"Ugandans have lived with the threat of AIDS for two decades now, and women are seizing the chance to protect themselves – against HIV and pregnancy. Now we're getting men involved and they are buying it, too,"

said an MSI-Uganda spokeswoman.

MSI-Uganda has pioneered innovative social marketing schemes for selling contraceptives in which the profits are ploughed back into the business, and it is through such schemes that it sells the female condom and its own-brand 'Life Guard' male condoms. Each year, the organisation sells 12 million 'Life Guard' condoms and demand exceeds supply at the 12,000 retail outlets across Uganda, which include grocery stalls and bars.



Young people

The world's largest ever cohort of young people is about to enter its childbearing years, posing huge challenges in terms of reproductive health provision. There are now more than one billion 15 to 24 year-olds. Following behind them are nearly two billion children aged under 15. Together, the two groups constitute nearly 50% of the world's population.

Yet despite their considerable numbers, young people are likely to have the poorest levels of reproductive rights and health unless action is taken now. Traditionally, young people have been underserved, and have suffered the consequences.

The under-24s are most likely to die from unsafe abortions, contract sexually transmitted infections, including HIV/AIDS, and suffer sexual violence. This is the result of a lack of information and targeted services to empower them in their early reproductive years, and before they become sexually active. Empowering young people with the basic human right of reproductive choice is now of critical importance.

The International position

At the 1994 International Conference on Population and Development (ICPD), the Programme of Action called for the following:

- the protection and promotion of the rights of adolescents to reproductive health education, information and care
- a reduction in sexually transmitted infections and pregnancy amongst adolescents
- governments and non-governmental organisations to meet the special needs of adolescents and establish appropriate programmes to respond to those needs.

A global overview

There is wide global variation in the position and status of young people in developing countries. Under the age of 20 many will already be

married and pregnancy is both accepted and expected. In Africa, half of all births occur amongst the under-20s. However, there are universal known health risks to this age group – irrespective of the society in which they live:

- sexually transmitted infections (STIs) are most common amongst 15 to 24 year-olds
- half of all new HIV infections (totalling around three million a year) occur in this age group
- more than five million girls aged 15 to 19 seek abortions each year, the majority in unsafe, illegal conditions
- maternal mortality rates are twice as high for those in the 15 to 19 age bracket as for women in their 20s.

ADDRESSING THE PROBLEMS

Information

Many young people are denied the information they need to make fully informed decisions about their relationships. This means they are not able to protect themselves against infection and pregnancy when sexually active. The lack of information is quite deliberate, often due to a belief at government, school and family level, that it will encourage promiscuity. Sex education or 'family life instruction' is not widely available in most countries and happens in an informal way.

Communications and advocacy initiatives

These are needed at government level to create a positive environment for young people's

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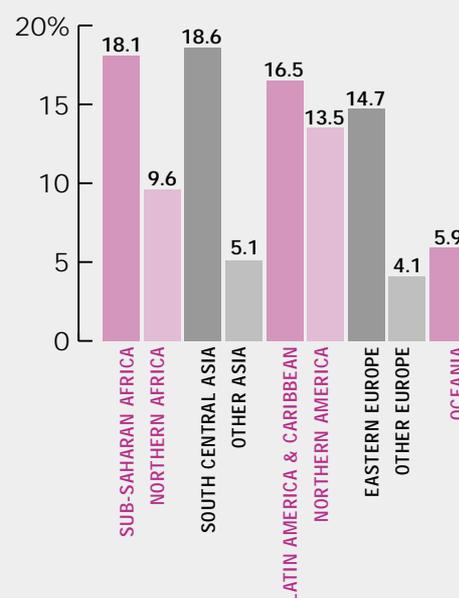


HIV among young girls in Africa

In Rwanda, over four per cent of girls aged 12 to 14 in one study tested positive for HIV. Whilst in one area of Kenya, a recent community-based study showed that 22% of 15 to 19 year-old girls in the general population were already infected with HIV, compared with just four per cent of boys of the same age. Similarly, in Zambia, a study of young city-dwellers in the same age group found that 12.3% of girls and 4.5% of boys were HIV positive.

Source: *AIDS 1998 12:197-203, Taha et al.*

Percentage of all births to woman under 20



reproductive health information. The AIDS pandemic is forcing some governments to address the issue in order to safeguard the health of the younger generation.

Services

Even if young people do manage to get information about reproductive health, they often still have difficulties accessing the actual services.

Some clinics will not see young or single people, and adolescents themselves are often put off by formal provision.

The situation is particularly difficult for girls. Worldwide, there are still double standards about adolescent sexual activity. Boys are often expected (and even encouraged) to be sexually experienced before marriage, with their sexual activity linked to notions of masculinity. However, girls are expected to be inexperienced and this makes it very difficult for them to access services. Even within a relationship, girls often feel they will be judged negatively if they raise the issue of safer sex or contraception.

Reproductive health services for young people have to be appropriate, fully confidential, non-judgemental, free, and designed by adolescents.

Examples of innovative projects that have worked include:

- condom 'cafes' – where young people can meet and get information and contraceptives
- information and services at youth clubs/sports events
- confidential telephone help-lines
- services which offer counselling and discussion.

Providing the services within general primary health care for young people has also been shown to work effectively.

Gender sensitivity

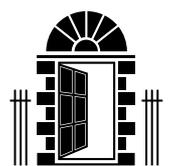
School education that addresses gender issues would go a long way to eradicating the 'double standards' surrounding girls and sex, which currently leaves them disempowered and at risk in relationships. Improving the sexual health of young women, in particular, involves getting rid of stereotypes and prejudice so they feel confident in accessing services and information.

For sources, please see insert 13.

Filipino students design their own sex education

The students of Southeastern College, Pasay City, on the outskirts of Manila, have taken sexual health education into their own hands. The 14 to 17 year-olds developed their own instruction manual for fellow students, including practical discussion sessions and information. They cover general issues such as sexuality and relationships, as well as specific instruction on contraception and the prevention of sexually transmitted infections, including HIV/AIDS.

The project, developed with outreach workers from the Marie Stopes International Partner organisation in the Philippines, Population Services Philippines, includes peer education. Students are trained to lead discussion groups with other students, creating an open atmosphere for reproductive health information. The scheme has been so successful that the students hope to make it more widely available through other schools and colleges.



Refugees

There are currently more than 35 million refugees or internally displaced persons worldwide. Up to 80% of these are women and children.

Until very recently, reproductive health care has been a neglected area of relief work, despite the fact that poor reproductive health is a significant cause of death and disease in refugee camps once emergency health needs have been met.

Lack of quality reproductive health services can lead to high mortality rates among women and children, an increase in the spread of sexually transmitted infections (STIs) including HIV/AIDS, an increase in unsafe abortions, and increased morbidity related to high fertility rates and poor birth spacing.

International policy

The United Nation's International Conference on Population and Development (ICPD) in Cairo in 1994 was the first point at which the reproductive health needs of refugees were recognised. The Programme of Action stated:

"In planning and implementing refugee assistance activities, special attention should be given to the specific needs of refugee women and refugee children. Refugees should be provided with access to adequate accommodation, education, and health services, including family planning."

The problem

Refugee and emergency settings compound many of the problems faced by women, who find themselves in a highly vulnerable situation.

Reproductive health for refugees covers the following areas:

- safe motherhood (including antenatal, delivery and post-partum care)

- prevention and management of the consequences of sexual and gender violence
- family planning
- prevention and treatment of STIs and HIV/AIDS
- emergency obstetric care, including the treatment of abortion-related complications.

Food, water, shelter and primary health care are provided as a matter of course in emergency settings, but reproductive health care provision is far from universal. Lessons from refugee settings worldwide reveal that ignoring the reproductive health needs of refugees can threaten lives. Certain reproductive health services are required from the moment displacement occurs. Other services can be established as the situation develops.

Most refugees are from countries where health indicators are already poor. Flight from war, civil or ethnic conflict or natural disaster exacerbates existing health problems. In these situations, women, in particular, are vulnerable to sexual violence and abuse. Even once women reach relative safety, conditions still prevail that further contribute to their ill health:

- malnutrition and epidemics
- an absence of law and order
- increased responsibility for households in the absence of male family members
- breakdown of pre-existing family structures.

Women are most affected by reproductive health problems. If they become lone heads of households this burden is further compounded by the precariousness of their situation.



Increased vulnerability in refugee camps

In Sierra Leone, experience indicated that fertility was high in the camp environment. Boredom was identified as leading to unsafe sexual activity and prostitution in the camp. An informal assessment was carried out to discover the reasons why women wanted to have many children and the results were given as:

- willingness to replace those lost during the war
- children represented the only stability for women in new relationships
- increased food rations.

It has been shown that women in refugee settings experience:

- higher maternal mortality and morbidity as a result of:
 - poor nutrition
 - repeated, frequent pregnancies
 - lack of clean, safe delivery care
- increased (often unsafe) sexual activity, which results in an increase of HIV/AIDS and STIs because of:
 - the use of sexual favours in exchange for food, money or protection
 - rape as a tool of coercion or humiliation
 - the breakdown of family and social structures, and accompanying behavioural change

- increased fertility rates due to:
 - improvements in child survival rates
 - pressure on women to rebuild the population
 - lack of birth spacing/family planning information and supplies.

Meeting the need

It is important that reproductive health interventions are timely and appropriate. In an emergency it may be easy to overlook particular refugee needs in the urgency of providing other services. Refugee participation is vital in ensuring that services are appropriate.

Recognising the need to introduce reproductive health care as early as possible, the concept of the Minimal Initial Service Package (MISP) has been developed by the international community. The MISP is specifically designed to facilitate the rapid and appropriate delivery of reproductive health services in the initial acute phase of an emergency situation and to plan for services as the situation develops. The MISP concept includes:

- human resources, guidelines and training for the implementation of selected interventions
- material resources, including essential drugs
- basic equipment.

Post-abortion complications account for some 25-50% of maternal deaths in refugee situations. Of the women of reproductive age in a refugee population, an estimated 20% will be pregnant at any one time.

For sources, please see insert 13.

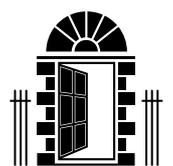
Working with displaced people in Sri Lanka

When civil war erupted in North-East Sri Lanka in the early 1980s, thousands of people were uprooted from their homes. An estimated 750,000 people are still currently displaced and scattered around 530 camps throughout the country. The Government of Sri Lanka aims to provide primary health care for all citizens at their nearest health institution. However, the static approach excluded a vast number of internally displaced people (IDPs), who were settled in informal camps and communities, or in remote areas. Most IDPs have no means of transportation, which also affects their ability to access health services.

Since 1995, Marie Stopes International's local Partner in Sri Lanka, Population Services Lanka, has been implementing a reproductive health project for the internally displaced communities

in three districts. Its key feature has been community involvement from the outset, using displaced people to train as community health promoters. They have played a major role in raising awareness of reproductive health and acting as coordinators for the outreach clinical teams.

The project has provided accessible, high-quality reproductive health care, through three static clinics, mobile outreach services and community outreach workers. The project has been able to offer mother and child health services, as well as a full range of temporary and permanent methods of contraception, information on HIV/AIDS and diagnosis and treatment of other sexually transmitted infections. This successful programme now operates in six areas of the island.



Gender

Gender inequality affects many areas of women's lives, but particularly their health, education, social and economic circumstances. Women's choices and opportunities are restricted and they are forced to live very different lives from men. However, the problem is so widespread, so long-established and so ingrained in many cultures, that it has become either accepted or ignored. Progress towards gender equality has been slow and late in coming.

The international position

In 1976 the United Nations launched its 'Decade for Women', and three years later the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) was ratified by 165 countries. More recently, the 1994 International Conference on Population and Development (ICPD), the 1995 World Conference on Women in Beijing and the 1999 ICPD+5, all called for strong programmatic and policy actions to counter the widespread practice and grave consequences of discrimination against women.

These included calls for:

- vigorous efforts to be made to enroll more girls in school and to reduce drop-out rates
- starting at a very early age, children of both sexes, but particularly boys, should be taught about the need for gender awareness, sensitivity and respect
- influential social, cultural and political leaders in developing countries should publicly refute traditional attitudes and practices that subjugate women and reinforce gender inequalities
- influential members of society should denounce sexual violence against women.

THE RESULTS OF GENDER INEQUALITY

Education

In many parts of Asia and Africa, more boys than girls attend

secondary school. Girls are often kept at home to help their mothers with domestic chores and to take care of younger brothers and sisters. Globally, nearly 600 million women are illiterate today, compared with about 320 million men. In some parts of the world, as many as three out of four women are illiterate.

Girls with little education are:

- more likely to marry at a young age
- less likely to know of their right to practise contraception
- more likely to have unwanted pregnancies and induced abortions
- more likely to give birth at an early age
- more likely to have more children than they want.

In some countries, girls who become pregnant are made to leave school while the father continues his education unaffected.

Health

Cultural traditions that value girls less highly than boys tend to tolerate such harmful traditional practices as female genital mutilation (FGM), a preference for sons, and the use of sex-selection technologies that permit the abortion of female foetuses, which can seriously endanger the sexual and reproductive health of girls and women.

Poor women often suffer from an inadequate diet, and from early and frequent pregnancy. From infancy,



An abuse of childhood

A study in Zaria, Nigeria, found that 16% of hospital patients with sexually transmitted infections were female and under the age of five. At the Genito-Urinary Centre in Harare, Zimbabwe, doctors discovered that more than 900 children under the age of 12 had been treated for a sexually transmitted infection in 1990 alone.

women in many parts of the world receive less and lower quality food, and, when sick, are treated later and less well than men.

Social aspects

Double standards of sexual behaviour often infer that women should be ignorant about sexuality, so that they will not be promiscuous, while male sexual activity is approved and encouraged. A lack of sexual empowerment often means that women feel pressured into having unwanted sex, which exposes them to a high risk of sexually transmitted infections and unwanted pregnancies.

Even where they have been enacted, laws to enforce a minimum age of marriage for girls have often failed. Instead, cultural and social imperatives and, increasingly, economic factors, still favour very early marriage and childbearing for girls.

Violence

Women's low socio-economic status also exposes them disproportionately to physical and sexual abuse. In addition, the law in some countries results in women suffering capital punishment or imprisonment for having sex outside marriage – even if it was against their will.

Millions of women face intolerable levels of violence, often within the family, and at all stages of their life. Many countries have not recognised the concept of rape within marriage, which makes it very difficult for married women to negotiate the practice of safe sex with their partners. In some countries, HIV transmission rates are highest among married women.

Male responsibility

Gender inequality should be addressed both within society and within the family. Men should become involved in defining positive role models, playing a supportive role in safeguarding women's reproductive health and rights, and helping boys to become gender-sensitive adults.

The support of men is crucial for women's empowerment. Women cannot achieve it alone. Men must come to recognise that women's empowerment is not a threat, but a proven way to improve their families and societies. Equality for women is also a basic human right.

For sources, please see insert 13.

Gender violence throughout a woman's life

Pregnancy – women are exposed to sex-selective abortions and battering during pregnancy, and coerced pregnancy

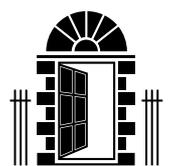
Infancy – female infanticide, emotional and physical abuse, less food and medical care than boys

Childhood – genital mutilation, incest and sexual abuse, less food, medical care and education, child prostitution

Adolescence – dating and courtship violence, abuse in the workplace, rape, sexual harassment, forced prostitution

Reproductive – sexual abuse, marital rape, dowry abuse and murder.

Source: *Violence Against Women: The Hidden Health Burden*, World Bank Discussion Paper, Washington DC, The World Bank, Heise, L, 1994.



Sexually transmitted infections

Sexually transmitted infections (STIs), including HIV/AIDS, constitute a large public health threat around the world. HIV/AIDS is the most serious (please see insert number 4 for more information), but many other STIs can have a devastating impact on reproductive health.

STIs can cause far-reaching health, social and economic consequences for individuals and communities. Sometimes STIs can cause no visible symptoms yet can lead to cervical cancer, ectopic pregnancy, spontaneous abortion, pelvic inflammatory disease or infertility in women. Babies of women who have an STI can be stillborn, risk blindness or pneumonia, or be of low birth weight.

STIs can cause acute discomfort for sufferers and they have risen up the reproductive health agenda due to their role in the transmission of HIV. They have been recognised as acting as a 'gateway' for HIV infection, making STI carriers more vulnerable if they come into contact with an HIV-positive sexual partner. The latest report from the World Health Organisation (WHO) suggests that improved management of STIs could reduce the incidence of HIV-1 in the general population by about 40%.

The international position

The 1994 International Conference on Population and Development (ICPD) recognised the scale of the problems caused by STIs, and called for integrated reproductive health programmes which could span the area of family planning, as well as the awareness, prevention and diagnosis of STIs and HIV/AIDS.

An integrated approach was thought to be the most effective and cost-efficient way of reaching sexually active women and their partners. However, staff at family planning clinics have not always been adequately trained and laboratory services have not always been available for diagnoses.

The integrated approach still has some way to go, but the spread and scale of HIV/AIDS has brought a new impetus.

At ICPD+5, governments were urged to ensure wide provision of, and access to, female and male condoms, and to support advocacy, information and education campaigns that promote "informed, responsible and safer sexual behaviour and practices, [and] mutual respect and gender equity in sexual relationships".

STIs

STIs fall into different categories – viral (including HIV/AIDS), for which there is currently no cure, and bacterial or parasitic infections which can be treated with antibiotics. The most recent figures released by the WHO reveal there were 340 million new cases of curable STI infection in 1999. Transmission of all types of STIs could be lowered considerably through safer sex, involving barrier methods of contraception.

The main treatable STIs

■ **Chlamydia** (92 million new cases a year)
Chlamydia is a bacterial STI and can cause pelvic inflammatory disease in women and genital tract infection in men. In both sexes it can lead to infertility. It is asymptomatic in 70-75% of women and can cause eye infections and pneumonia in newborn babies. There are an estimated three million cases of chlamydia in the USA, making it the most common notifiable infectious disease there. Unfortunately, sophisticated diagnostic equipment is expensive



WHO estimated prevalence of curable STIs

Region	Prevalence per 1,000	Annual incidence (millions)
North America	19	14
Western Europe	20	17
North Africa & Middle East	21	1
Eastern Europe & Central Asia	29	38
Sub-Saharan Africa	119	69
South & South East Asia	50	10
East Asia & Pacific	7	22
Australia & New Zealand	27	18
Latin America & Caribbean	71	151

and scarce in developing countries making monitoring and in turn the diagnosis and treatment of chlamydia difficult.

■ **Gonorrhoea** (62 million new cases a year)
Gonorrhoea is a bacterial STI and can cause pelvic inflammatory

disease, with a risk of infertility in women, chronic pelvic pain, and inflammation of the urogenital tract. In both men and women it can result in septicaemia, arthritis and meningitis, and can cause blindness in newborn babies. Diagnostic equipment is expensive.

■ **Syphilis** (12 million new cases a year)

Syphilis is the most deadly of the bacterial STIs. It causes ulceration of the urogenital tract and if left untreated leads to a generalised infection and can be fatal. Treatment is cheap and effective. The screening test is simple – but not always affordable in developing country laboratories.

■ **Trichomoniasis** (174 million new cases a year)

Trichomoniasis is caused by a parasite; this is the most common STI worldwide. It produces symptoms in 50% of infected women, who get vaginitis. As a result of this parasite men can get urethritis. Trichomoniasis facilitates the spread of HIV. Diagnostic tests are not always available in developing countries.

In total, approximately 49 million cases of curable STIs occur each year in developed countries (not including Eastern Europe) and the remaining 291 million occur in developing and emerging industrial regions.

South and South-East Asia are estimated to have the largest

number of new curable infections each year, while Sub-Saharan Africa has the highest rate of new cases per 1,000 population, followed by Latin America and the Caribbean.

Eastern Europe is experiencing high rates of STI transmission, along with the former countries of the Soviet Union. In 1990, the region had syphilis rates of 5 to 15 per 100,000 people. By 1996 the rate had risen to 120 to 170 per 100,000 people.

The prevention of STIs

The WHO has developed a strategy for STI prevention, which aims to reduce transmission, reduce the duration of the infection and prevent complications in those infected.

Primary prevention:

- health education and promotion of safer sex
- information campaigns on the association between HIV and other STIs
- promotion of condoms.

Secondary prevention:

- encourage people to seek health care quickly
- provide accessible, effective and acceptable care
- offer education and counselling
- provide screening (eg syphilis in pregnant women) to detect asymptomatic infections.

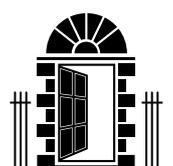
For sources, please see insert 13.

STIs and women

- women, and especially young girls, are much more vulnerable biologically, culturally and socio-economically to STIs
- chlamydia is particularly prevalent among young girls, whose future fertility may be affected
- women and young girls tend not to seek treatment, partly because they may not experience any symptoms, and partly because there is more stigma attached to STIs in women. In addition, they often do not have the time or money for health care.

Male involvement

In Bolivia, reproductive health workers in Santa Cruz set out to address the high rates of STIs amongst men. Health promoters received specialised training and targeted men in the community. They set up a series of talks and meetings with taxi drivers and went to building sites, factories and trade associations to educate and inform men about STIs. They also distributed condoms and assured men they could see a male health worker if they came to a clinic for treatment. The initiative was so successful that more than 120 men a month now visit the La Ramada Marie Stopes Bolivia centre in Santa Cruz for STI diagnosis and treatment.



Poverty and development

Around 1.3 billion people, nearly a quarter of the world's population, live in extreme poverty, surviving on less than US\$1 per day. Of these, 70% are women, who lack, among other things, education and health provision. Men are free to migrate to urban areas to seek employment and escape poverty, but women are frequently left behind to look after the children, and remain in the poverty cycle. The 'feminisation' of poverty has further aggravated social, gender and economic imbalances in the developing world. Women also bear the brunt of ill health.

The international response

The international community aims to halve the proportion of people living in extreme poverty by 2015, and is learning from the experiences of the last 50 years. Since 1960, child mortality rates in developing countries have been halved. Life expectancy rates have been steadily rising, although the impact of HIV/AIDS is now reversing that trend in some countries in Sub-Saharan Africa (please see insert 4 for more information). The percentage of the population with access to safe, clean water has doubled to 70%, and people have more food to eat.

Sustainable development

Development is the recognised way to help people escape poverty, but it must be sustainable. Current standards of living have to be raised without destroying the environment or using up natural resources that will be needed for future generations. Sustainable development requires slower population growth because more natural resources will continue to be used as the world population grows.

ICPD

In 1994, the International Conference on Population and Development (ICPD) established reproductive health as key to poverty alleviation and sustainable development. The role of individual reproductive rights and choice became the new focus at the United Nations conference, shifting the

emphasis away from development through demographic goals. This was a radically new approach which encouraged community participation and human rights, rather than governments enforcing, or encouraging, population policies. However, the 179 countries that attended ICPD recognised that rapid population growth continued to pose a threat to sustainable development, the world's natural resources and the environment.

Population will triple in the world's 48 least developed countries, rising from 658 million to 1.8 billion by 2050 (please see insert number 10 for further information). There is already a shortfall in international funding to meet the reproductive health needs of the world's poorest people. With high rates of population growth, escaping the poverty cycle becomes harder, and the need for reproductive health choices becomes greater. However, without higher living standards, one fifth of the world's population will be faced with continuing malnutrition, disease and illiteracy.

The role of reproductive health

The links between poverty alleviation and reproductive rights are now well established. If women have access to reproductive health information and services they can:

- take control of their fertility and break the cycle of repeated pregnancy, enabling them to seek



Population pressure

- By 2025 three billion people in 48 countries will face chronic water shortages.
- Population has grown faster than food supplies in 64 out of 105 developing countries.
- During the last 50 years 600,000 plant and animal species have disappeared, 40,000 more are under threat.
- High population densities and development have put half of all coastline ecosystems under pressure.

Source: *Time Running Out for the Environment*, Johns Hopkins University, USA, 2001.

Although population size has an impact on natural resources, it is the developed countries that cause the greatest environmental damage. The world's richest 20% of people account for 86% of the world's private consumption, compared to just 1.3% of consumption from the poorest 20% of people.

One child born in a developed country will cause between 30 and 50 times more pollution in a lifetime than one child in a developing country.

employment or training and increase family income

- improve their own health and the survival rates of their children
- protect themselves against sexually transmitted infections, including HIV/AIDS
- work towards empowerment and gender equality.

The development targets

The developed world must now work towards:

- primary education for all by 2015
- progressing gender equality and the empowerment of women by eliminating gender disparity in primary and secondary education by 2005
- reducing by two thirds the mortality rates for infants and children under age five, and a 75% reduction in maternal mortality, all by 2015
- providing access through the primary health care system to reproductive health services for all individuals as soon as possible, and no later than 2015

■ the implementation of national strategies for sustainable development in all countries by 2005, so as to ensure that current trends in the loss of environmental resources are effectively reversed. This should be done at both global and national levels by 2015.

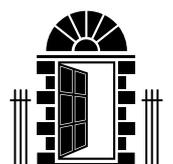
Summary

The rights of the individual to primary health facilities and reproductive health care, education, gender equality and human dignity will remain on the development agenda. However, the experience from ICPD is causing great concern. With a donor shortfall in funding of half of the total US\$5.7 billion annual budget needed to enact the Programme of Action, current needs are not being met. As the world's population continues to grow, future needs will be even harder to meet.

For sources, please see insert 13.

Discrimination and poverty

In countries where discrimination against women is greatest, poverty is more widespread, economic growth is slower and health indicators are poorer. Women must have the same opportunities as men, and they should start in childhood with equal access to primary education. Educating girls is one of the most effective means of promoting development. Economic development also helps women, reducing, for example, the amount of time they need to spend gathering fuel for cooking and fetching water. The challenge is to lift women out of the poverty trap through initiatives such as the provision of reproductive health services and literacy campaigns, so that they can take advantage of economic development and employment opportunities.



Population

The world's population has now passed six billion for the first time in its history and it continues to increase. At a current growth rate of 1.3%, totalling 77 million extra people a year, the world's population will grow by a further billion by 2012.

There are large regional variations in birth rates, death rates, and attitudes to fertility levels. However, there is one universal factor. Couples, with or without the approval of their religious leaders or governments, are choosing to have smaller families than any generation before them. They are exercising their human right to reproductive choice.

The issue of population is closely inter-linked with reproductive health. The provision of reproductive health services enables couples to control their fertility and have a direct impact on the demographics of their country.

In turn, the demographics have an impact on reproductive health provision, indicating the number of future users and the issues and policies which may affect fertility choice, such as ageing.

Regional variations

Population growth is occurring most rapidly in the world's less developed countries – the ones least able to cope with the pressures on their infrastructure, health and education systems and supplies of food and water. Many of those countries are already struggling in their efforts to alleviate poverty.

More than 80% of the world's population currently live in less developed regions, a figure which will increase to 85% by 2025.

The world's two largest countries are China, at 1.3 billion people, and India, at 1.01 billion. However, with highly different growth rates of 0.9% and 1.6% respectively, India will overtake China and become

the most populous nation within the next 50 years.

In 2001, 61% of the world's population lived in Asia (3.683 billion), 13% lived in Africa (784 million) and nine per cent lived in Latin America and the Caribbean (519 million). The remainder, just over one billion (18%), lived in North America, Oceania and Europe combined.

The future

By 2025, the world's population will have risen to nearly eight billion, with the United Nations predicting the biggest growth in Asia, of more than 1.1 billion.

Population projections beyond the next 25 years are highly uncertain because they are subject to quite small variations in anticipated future family size. However, the decisions that people make within this decade will directly affect the future of humankind.

The United Nations projections

High projection – world population reaches 11.2 billion by 2050 (based on women having 2.5 children)

Medium projection – world population reaches 9.3 billion by 2050 (based on women having 2 children)

Low projection – world population is under 8 billion by 2050 (based on women having 1.6 children).

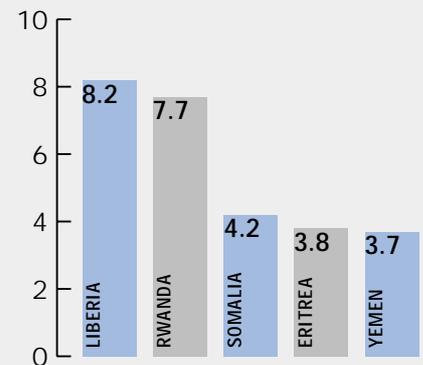
RELATED ISSUES

Reproductive choice

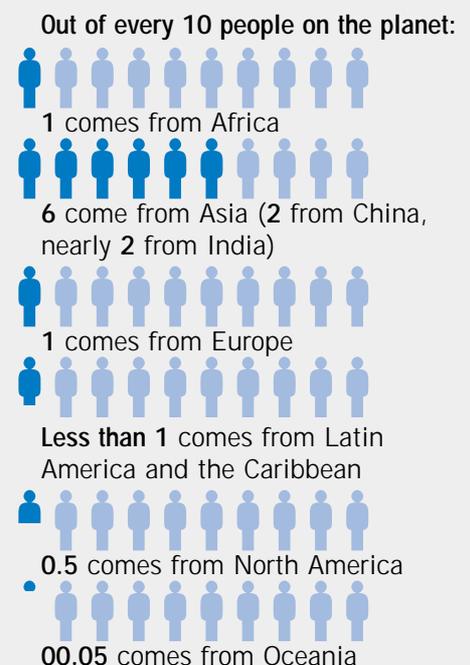
In the first half of the 1950s, the world's average family size was



Top five countries by population growth rate (%)



Current world population make-up



high at five children. By 2000, it had dropped dramatically – to 2.7 children. With increased urbanisation, rising educational levels, declines in infant mortality and improvements in women’s status, more and more couples are deciding that smaller families are preferable to larger ones. Reproductive health programmes and modern methods of contraception have made that desire achievable.

The impact of AIDS

In some regions, especially Sub-Saharan Africa, the AIDS pandemic has started to reverse the steady improvement in public health and life expectancy rates which most countries were experiencing. AIDS is also having a serious impact on economic growth rates. However, population growth will continue even in the most seriously affected countries. Botswana’s figures show 36% of the population is infected with HIV, but a continuing high fertility rate will result in a projected 37% population increase by 2050 (please see insert 4 for more information).

Young people

Even while birth rates are falling, the world’s population continues to grow, due to the huge number of teenagers currently entering the reproductive age bracket. There are an estimated 800 million young men and women aged 13 to 19, whose decisions about fertility will decide the future size of the world’s population (please see insert 5 for more information).

Refugees

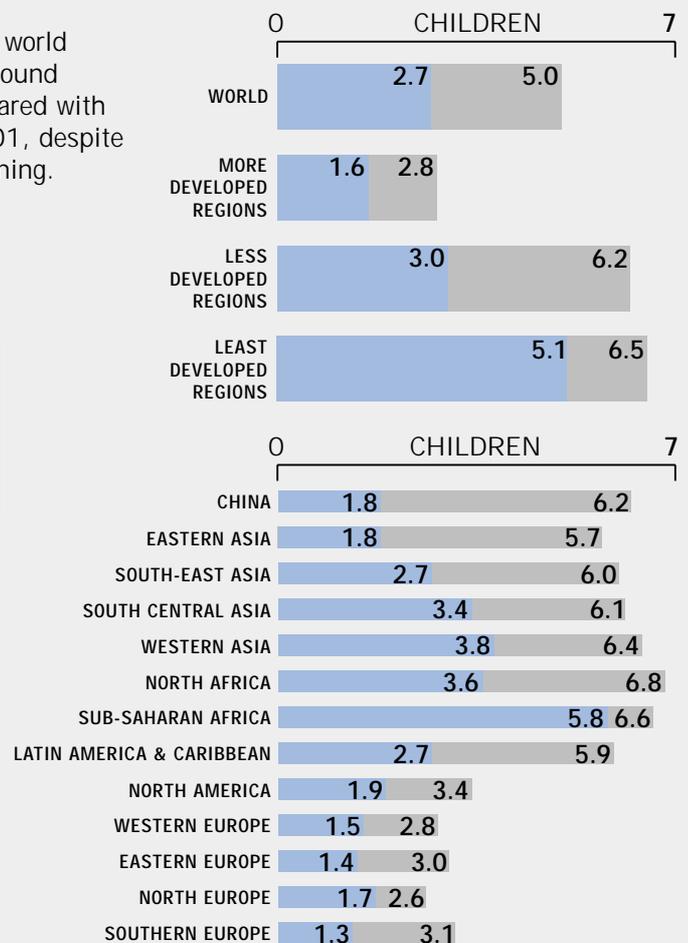
Worldwide, millions of people are on the move, within their own countries and across continents, causing fluctuations in population size (please see insert 6 for more information).

Ageing

By 2050, the number of people over 60 will nearly triple, increasing from the current figure of 606 million to nearly two billion. The United Nations claims many countries

Declining family size 1950-2000

In the 1950s the world population was around 2.6 billion, compared with 6.1 billion in 2001, despite family sizes declining.



will have to “reconfigure their policies on pension, social security, health care and other services for the elderly”. In countries with low fertility and low mortality, the effects are already being felt, leaving many nations with stagnating or negative population growth rates.

Governments are becoming increasingly concerned about the financial and health needs of older populations. Women live longer than men and outnumber them in the over-60 age group.

The international position

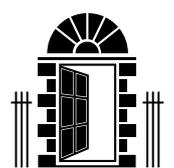
In 1994, at the International Conference on Population and Development (ICPD), the world community adopted a Programme of Action aimed at stabilising population growth. The success of the plan hinges on the pursuit of many human development

goals, but particularly:

- improvements in child health, so that couples can be confident that the children they do have will survive
- ready access to high-quality reproductive health services, including family planning, to improve women’s health and allow them to have only wanted children
- better educational opportunities for girls, to discourage early childbearing and promote women’s overall status.

Europe is now expected to decrease in size by 27 million people by 2025, and some European nations are considering pro-natalist approaches, including tax relief and other financial inducements. The Japanese also have serious concerns over their ‘greying nation’ and the topic is likely to be on the agenda of ICPD+10.

For sources, please see insert 13.



Working with civil society organisations

11

The notion of civil society, or civil society organisations (CSOs) originated from the 1994 International Conference on Population and Development (ICPD). CSOs cover non-governmental organisations (NGOs) and the private sector as well as autonomous organisations at national or local level.

CSOs in the field of reproductive health might include:

- NGOs
- medical and other professional associations
- village councils
- women's associations
- education or research institutions
- community-based development groups
- human rights groups
- religious groups
- the private sector
- advocacy organisations
- service organisations
- youth groups
- media professionals.

It was recognised that the goals of ICPD would be more rapidly and more effectively achieved if governments and CSOs shared in their implementation.

The ICPD Programme of Action called for the promotion of an effective partnership between all levels of government and the full range of CSOs. It urged them to work together in the design and implementation of policies and programmes and in their coordination, monitoring and evaluation.

CSOs can:

- help win support for reproductive health programmes
- campaign for better programmes and monitor the quality of service delivery
- raise funds and train reproductive health workers
- advocate for changes to laws and policies hampering access to programmes such as safe abortion and services for adolescents
- raise awareness of the issues.

CSOs also have a key role to play in reaching the world's poorest people, who cannot easily be directly reached by donors or governments.

The effectiveness of civil society

CSOs often have the vision, independence and flexibility to create programmes in areas where, for political or logistical reasons, governments have not taken action.

NGOs are usually very organised and often have a key role in initiating national family planning programmes and reaching under-served groups, including adolescents and unmarried women. NGOs may be best equipped to help address specialist issues such as the prevention and control of HIV/AIDS infection, the promotion of gender equality and women's empowerment.

However, CSO activities must not replace government functions, and the participation of CSOs must not allow governments to abdicate their basic social responsibilities.

Constraints to partnership and collaboration

The traditional gap between governments and CSOs needs to be bridged. Some NGOs work well with governments, but many of the other CSOs are new to collaboration and do not have lines of communication in place.

Governments are sometimes suspicious of the potential of activist groups to be confrontational or disruptive. Officials often claim that CSOs providing reproductive health services lack accountability, run costly operations, fail to serve the poorest of the poor, and rely too



The private sector as a CSO

The private sector has two important roles to play as a CSO in the field of reproductive health. Businesses can contribute in the actual development, marketing and distribution of new contraceptives or medical supplies. However, they can also work with their employees at all levels to improve their reproductive health through work-based information and service provision. Many employers have realised that investing in the health and welfare of their workforce results in social as well as economic returns.

much on donor funding. CSOs, on the other hand, often consider governments to be rigid, insensitive to local conditions and values, bureaucratic and over-regulatory.

Governments and CSOs must:

- resolve differing, divergent or parallel agendas and priorities
- create a clear legal framework and guidelines for partnership
- develop trust among partner agencies
- overcome cultural, language, class, race and religious prejudices and barriers
- set up effective and regular two-way communication
- overcome geographical, regional and urban-centric biases

- find financial resources and coordination mechanisms
- ensure there are appropriately trained staff in both government and CSOs.

Summary

Involving CSOs in reproductive health initiatives enables programmes to have a wide breadth of support and effectiveness. The use of appropriate partnerships can ensure services are delivered directly to communities and accessed by the people in greatest need. NGOs in particular have a large role to play in CSO partnerships with government. However, they too must work together, and seek new partners, to speed up the provision of reproductive health services.

For sources, please see insert 13.

The UK Government and civil society

Partnerships with civil society are central to the UK Government's response to the HIV/AIDS crisis, primarily in Africa. The Secretary of State for International Development, Clare Short, said:

"Partnership is a lovely word, much used and not often exercised but it's what we need here. We've got a crisis of enormous proportions. We haven't risen to it yet and everyone really needs to come together and pull all our knowledge and all our resources to respond to the challenge that we face – to scale up the good practice and replicate it and get it right across society so that the prevention and care works for all."

Source: *Forging Partnerships with Civil Society*, The International HIV/AIDS Alliance, UK, 2000

The UK Government is committed to supporting initiatives such as The International Partnership Against AIDS in Africa, which brings together CSOs including NGOs and the private sector, donors and African governments.

In a speech in London in 2000, Ms Short said CSOs had a major role to

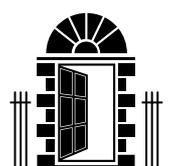
play in education, condom distribution and counselling programmes.

She also highlighted the role of the private sector, suggesting they could collaborate with public health facilities to provide work-based AIDS programmes. One success had been through the Electricity Supply Commission of South Africa, which had pioneered peer education work, destigmatised the disease and provided a supportive environment in the workplace.

Clare Short said workplace programmes and appropriate HIV/AIDS policies could be established at a cost of US\$15-\$25 per employee per year, and could reduce HIV/AIDS infection rates amongst staff by at least one third.

She stressed that the household was the starting point for action against HIV/AIDS, and praised CSOs who could work at a community level to change sexual behaviour or care for AIDS orphans.

These different initiatives demonstrate the range of possibilities for interaction with CSOs to address the specific problems posed by HIV/AIDS.



ICPD+10

12

The 1994 International Conference on Population and Development (ICPD) marked a major achievement in terms of establishing global commitment to reproductive and sexual health.

The conference, held in Cairo, set out clear aims and objectives in its Programme of Action, along with a budget and timescale for the work.

Progress since ICPD

In 1999, ICPD+5 was held in the Hague, in the Netherlands. Progress in the five years since ICPD was evaluated, with recommendations made (please see insert 2 for more information), obstacles identified and new benchmarks set.

The original ICPD had involved 179 countries. ICPD+5 attracted 185 countries, potentially indicating a growing interest in, and commitment to, the issues.

Aims for 2005

The tenth anniversary of ICPD is fast approaching. By 2004, the international community will be close to the 2005 deadline set for some benchmarks to be reached.

By 2005, the countries which signed the ICPD Programme of Action aimed to have:

- raised global funding for reproductive health to US\$6.1 billion per year
- halved the 1990 female illiteracy rate
- ensured 60% of primary health and family planning centres were offering full reproductive health services
- ensured 40% of births in areas of high maternal mortality were attended by a skilled health worker
- reduced the unmet need for modern contraception
- ensured 90% of 15 to 24 year-olds had access to condoms to prevent HIV transmission
- reduced HIV rates by 25% amongst 15 to 24 year-olds in the worst affected countries.

These aims have not, as yet, been met. In some cases, such as reducing HIV rates in young people, the scenario since ICPD in 1994 has worsened. Lack of progress is due to a shortage of global resources and the scale and extent of the challenges.

ICPD+10?

At the time of producing this briefing pack, it was not clear how the United Nations would choose to proceed with ICPD+10.

However, irrespective of whether or not a major conference takes place, policy-makers, governments and all members of civil society should be ready to review the progress to date and the challenges still to be faced.

ISSUES FOR ICPD+10

1. Funding

Funding continues to fall short of the figures laid out in the original ICPD Programme of Action. An annual figure of just US\$2.1 billion is currently available – less than one third of the US\$7 billion pledged by the international community back in 1994.

To date, out of the 20 donor countries, only four have managed to devote 0.7% of their gross domestic product to official development assistance – as encouraged at ICPD. Most of the others do not even come close to this figure, and some donors have actually reduced support.

Resources remain central to the challenge of improving reproductive health status. Limited resources will hold back efforts to meet the aims and do nothing to meet the increasing reproductive health needs



of a growing population, a growing number of adolescents, and a growing AIDS pandemic (please see insert 4 for more information).

In 1999, the United Nations Population Fund (UNFPA) had to cut country programmes, and postpone and cancel activities due to a reduction in contributions. This was a set-back for some of the millions served by UNFPA-funded projects, and for the ICPD Programme of Action.

2. HIV/AIDS

HIV/AIDS is proving to be a much bigger problem than the international community had anticipated (please see insert 4 for more information). Lack of access to reproductive health care and education on HIV/AIDS is contributing to the increased incidence of HIV infection. Programmes to prevent the spread of HIV are also taking away money originally earmarked for family planning and mother and child initiatives. More money is needed across the reproductive health field to ensure new activities can be funded and to ensure traditional areas of need will not be further compromised.

3. Ageing

The changing population age structure in developed countries

is likely to be on the agenda for ICPD+10. There is increasing concern about the economic and social implications of 'greying' populations (please see insert 10 for more information).

4. Policy development

Although there is an increasing understanding of reproductive rights as described in the ICPD Programme of Action, policies do not yet consistently reflect human rights approaches. Nor is there always sufficient political commitment for developing and implementing such policies.

In many countries existing laws and regulations also impede the implementation of the Programme of Action in specific areas such as sex education and the access of young people to reproductive health information and services. Denying them information and services leaves young people highly vulnerable to HIV infection.

The donor community

Funding for reproductive health programmes has to be sought from a wide variety of sources. Private foundations are becoming increasingly important, and many are stepping up their commitment to funding projects.

But governments have to meet their responsibilities. Many are now having to make rapid adjustments to their spending in the light of the HIV/AIDS pandemic.

The agencies of the United Nations have also agreed to collaborate more closely to avoid duplication and share expertise.

Since ICPD, the European Commission (EC) has become a major partner in resourcing the implementation of the Programme of Action. EC investment in Health, AIDS and Population

(HAP) assistance has grown from barely one per cent of total EC development assistance in 1986 to a current eight per cent. Despite the EC's commitment to focusing on health and education as priority sectors, there is a need for an increase in staff with expertise in social and human development, in particular health and reproductive health, HIV/AIDS and gender issues.

Summary

When ICPD set its benchmarks for progress in 1994, there was a full realisation that many of the issues which impact on reproductive health could not be resolved quickly.

The inter-relationships between women's empowerment, literacy, gender, reproductive health and alleviation of poverty, require long-term development policies and, in some cases, new legislation.

However, without international fora, progress would be much less coherent and less focused.

There should be a forum for ICPD+10 to re-establish the priority areas, re-examine the resource problems and to address some of the new and emerging issues as outlined in this fact sheet. The growing needs and vulnerability of under-served groups, including young people and refugees, will also be important agenda items.

However, ICPD+10 must be robust and safeguard its stance. There is continuing opposition to its language and the Programme of Action, and there are constant attempts to erode its achievements. A vocal minority cannot be allowed to destabilise such a powerful global commitment.

ICPD+10 can, and should, set the foundations for the reproductive health agenda for the 21st century.

For sources, please see insert 13.



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