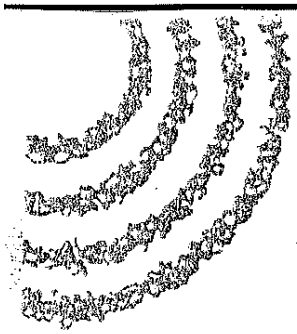
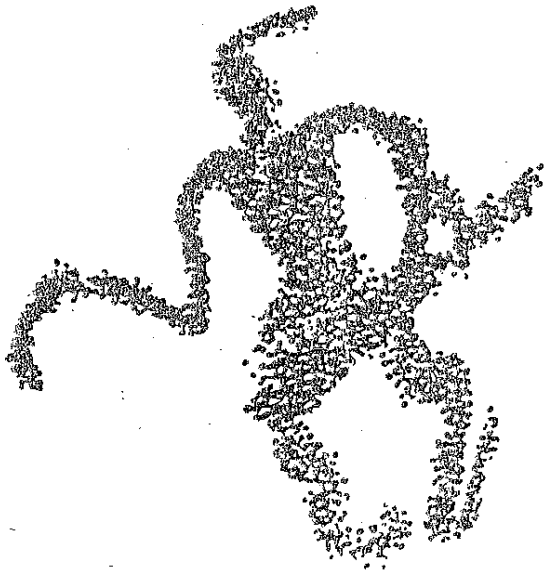
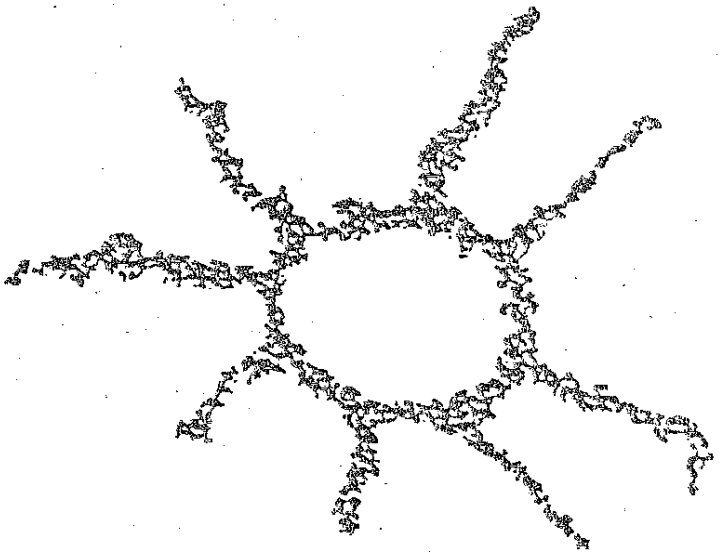
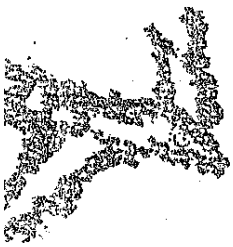




SEXUAL AND REPRODUCTIVE HEALTH

Development cooperation to promote Sexual and Reproductive Health – an Action Plan of the Health Division at SIDA





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Sexual and Reproductive Health

Health Division Action Plan

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THIS ACTION PLAN is part of a process to formulate a policy. A group of staff members at the Health Division together with consultants have prepared this document. The document is a working paper that will be revised by the Health Division during 1994/95. Any comments or additional contributions are welcome.

February 1994

Contents

1. Background

1.1 WHY AN ACTION PLAN FOR SEXUAL AND REPRODUCTIVE HEALTH

In the last few years, a number of formerly tabooed topics have surfaced in international public discussion, mainly in connection with the HIV/AIDS pandemic, which concerns all sexually active people.

In the wake of the Decade of Women in the 1980s, many organizations and networks have emerged, focusing on women's health. Thus, sexual and reproductive health has come to the fore. Consequently, mother and child health and family planning are areas that have to be expanded and redefined. Mainly thanks to the women's movement, sexual violence, aggression, degradation and genital mutilation has come to light.

Up until now, adolescents have been largely neglected and left out of traditional family planning programmes. Unwanted pregnancies among girls can have devastating consequences such as discontinued education, dangerous abortions, and death. Today, adolescents discuss both abortions and sexually transmitted diseases (STDs) including HIV/AIDS more openly.

Similarly, men have been excluded from traditional family planning programmes. The targets for such programmes were mainly women. But here too, attitudes are changing.

Experience tells us that complex and novel issues like these need special attention and support. Since Sweden has had a long term commitment in this field, we are fortunate in being able to emphasize these areas within the framework of development cooperation and to pursue them in international fora.

This Action Plan is part of an ongoing process at SIDA to develop methods, definitions and contacts to increase and improve development cooperation in the area of *Sexual and Reproductive Health*. It will primarily be used as a working document to guide the Health Division in identifying, assessing and preparing activities designed to promote *Sexual and Reproductive Health*.

In preparation for the International Population and Development Conference in Cairo in September 1994, SIDA is also in the process of developing an overall policy for development cooperation on population and development.

1.2 THE STRUCTURE OF THE ACTION PLAN

The objectives of this document are:

- to define central concepts for *Sexual and Reproductive Health*
- to identify areas of particular concern to SIDA, and
- to provide guidelines for shaping SIDA's support for the promotion of *Sexual and Reproductive Health* in the next few years.

Central concepts are presented and defined in Chapter 2.

Chapter 3 contains a description of six priority areas for SIDA's support in the next few years. These areas are adolescent sexual health, women's health, contraceptive methods and safe abortion, STDs including HIV/AIDS, capacity building, and legislation. Each section contains a brief description of the area, a summary of Swedish experience within each area and proposals for the direction of Swedish support.

2. What is sexual and reproductive health?

2.1 MANY NEW CONCEPTS

The inclusion of both *sexual health* and *reproductive health* suggests that old demarcation lines need to be redefined, that traditional areas such as maternal health and family planning be expanded to women's health in general and that STD control, including HIV/AIDS and safe and legal abortions, will feature more prominently. This means that unmarried, divorced, elderly as well as adolescents of both sexes are included.

SIDA uses the concept *Sexual and Reproductive Health* in a very broad sense – as a common denominator of all the concepts described below.

• *Sexual health*. This concept is used in terms of psychosexual development, sexuality, sex roles, family life and human relationships. Sexuality is seen as a positive force in peoples' lives, having intrinsic value, not necessarily connected to reproduction. The need for the concept has become particularly clear against the backdrop of the HIV/AIDS pandemic and the risk of STDs.

• *Sexual ill-health* is manifested not only by the occurrence of STDs but also by other reproductive tract infections and cancer of the cervix. During the last few years, the increasingly sexualized violence including physical abuse and violations against women and girls has become identified as a serious threat to women's health. Social evils play a large role in this type of violence. To prevent such violence a number of preventive measures both within and outside the health care system are necessary. In Africa, female circumcision or female genital mutilation is a major cause of physical and psychological damage to women's health and sexuality. It also affects reproductive health, the normal growth of girl children and is a cause of maternal mortality and morbidity.

• *Reproduction* in the broadest sense includes biological, medical, social, psychosocial and cultural aspects. It relates to the ability and possibility for giving birth and raising children and covers both men and women at different stages of life.

• *Reproductive health* encompasses opportunities for safe pregnancy and labour, the healthy survival of mother and child, and good resources available for breastfeeding.

• *Reproductive ill-health* manifests in the form of sickness and death in connection with pregnancy and birth but also STDs and their consequences, e.g. infertility.

• *Reproductive Rights* are central in a new strategy for human development and social and gender equity. The most well-established of these rights is the right to decide when not to have a child, i.e. the right to safe and effective contraceptive methods. This right was already included in the UN Declaration of Human Rights in 1968, and was further endorsed at the UN Population conference in Bucharest in 1974. Acess to safe and legal abortions is a reproductive right. The right to free abortions is, however, still far from established. Furthermore, there are other ethical issues which deserve more attention such as: sanctions against pregnant women (e.g. girls forced to leave school and women their workplaces), sexual abuse of children, female circumcision and prostitution. Complex ethical and legal issues also arise in connection with artificial reproduction and antenatal screening.

• *Women's health* has for long been and still is badly neglected worldwide. Women's health goes beyond maternity and reproduction problems and should be seen in a life cycle. In addition to the diseases specific to women such as pregnancy-related complications, causes of poor health include

cervical cancer and osteoporosis, as well as those that disproportionately affect women such as anemia. The cultural and socioeconomic context within which women live has a substantial influence on their health and on their experience of the consequences of disease and injury and on their acess to health care. As a consequence more attention and emphasis has to be given to women's health in general.

• *Maternal health care* forms part of women's health. Maternal health care is a well-known concept. Mother and child care is one of the eight elements of the primary health care strategy. The objective of maternal health care is to ensure the birth of healthy children and to decrease pregnancy- and labour-related morbidity and mortality and to ensure the health of the baby once he/she is born. Maternal health care of high quality includes health education, prevention and treatment of deficiency conditions and disease in pregnant women and the possibility to identify risk pregnancies. Such a system also includes safe and secure childbirth, whether or not there are concomitant complications, as well as care during the ante- and post-natal period and good conditions for breast feeding.

• *Family planning* is often rather imprecisely used to describe many different types of programmes in developing countries – in connection with counselling, distribution of contraceptives and sterilization programmes. As an alternative to this term, SIDA proposes *fertility regulation*. However, as far as possible the contents of activities and inputs in a programme are to be described in proper terms such as contraceptive delivery services, and/or councelling.

• *Counselling* is a concept used for contraceptive advice, sexual counselling and psychosocial support activities in connection with HIV/AIDS. Special counselling is needed to identify and combat violence. Psychosocial counselling is also important to persuade individuals and families away from genital mutilation. Thus, the actual content of the counselling will vary considerably according to the situation in question; from straightforward practical advice to in-depth consultations of an intimate and sensitive nature. The demands placed on a counsellor vary accordingly.

• *Sexuality and gender education* as it is taught in Swedish schools includes issues such as sexual, emotional and social relationships. Many developing countries have established programmes for "family life education", "family health education" and "population education". Such programmes vary considerably in content and scope and may demand inter-sectoral co-operation.

2.2 OPERATIONAL CONCEPTS

In operational terms, activities in the field of *sexual and reproductive health* can be summarized as follows:

- Health promotion programmes targeted at adolescents, particularly in relation to sexual health;
- Sexuality and gender education;
- Women's health programmes over the life cycle, particularly related to sexual and reproductive health;
- Maternal health care programmes, ante-natal delivery and post-natal care;
- Programmes for the care of newborn infants as well as measures to support, protect and promote breastfeeding;
- Information and health care programmes for gynaecological problems related to sexual activity, age or multiple and complicated births and infertility;
- Information and health care programmes for STDs including HIV/AIDS;
- Counselling on sexuality, contraceptive

methods, abortions, infertility, infections and diseases;

- Assistance to genitally mutilated women. Physical care, psychological support, and counselling against the circumcision of daughters.
- Programmes supplying a wide selection and continuous monitoring of safe contraceptive devices and methods with the least abuse potential;
- Health care programmes for safe abortions;
- Measures aimed at men to increase their responsibility for their own sexual behaviour and fertility and for the effects of that behaviour on their partner's and children's health and well-being.

3. The future focus of SIDA support

The objective is to improve sexual and reproductive health in orders to decrease the burden of disease and death associated with sexuality and reproduction. A concerted strategy is needed to reach this objective. Within the framework of this strategy, Swedish development cooperation will focus on certain fields. Several of these areas have been neglected or completely overlooked, whereas others have already received considerable support.

These are the six areas SIDA intends to prioritize in the next few years:

Two priority areas are target group specific:

- Adolescent sexual health
- Women's health care incl maternal health care

Two are subject specific:

- Contraceptive methods and safe abortions
- Control of STDs including HIV/AIDS

and two are function specific:

- Capacity building
- Legislation

3.1 PREREQUISITES OF GOOD DEVELOPMENT COOPERATION

For development cooperation to achieve expected results, specific prerequisites are necessary. These prerequisites must prevail when an activity is planned and be continuously monitored. The following prerequisites are necessary for the promotion of *sexual and reproductive health* as well as for other health sector support.

- Issues must be clarified from *the perspectives of both women and men,* according to a *gender analysis.*

Women's and men's mutual relationships and roles need to be explored. Men's roles as fathers must be supported, as well as increasing men's knowledge of and responsibility for their own sexual and reproductive health and that of their partners. Economic and sexual equality must be promoted, and asymmetrical power relationships opposed. For this purpose, women are to be involved at all levels; as service end users, as health care personnel, as decision-makers, in pressure groups and as

consultants in planning and assessing activities.

• Each activity is adapted to the needs and resources of respective *group*, according to a situation analysis.

The needs of men and women differ from each other. Similarly, married couples do not have the same needs as single people, adolescents experience different needs from older people, single women who head households have different problems and needs from families with two bread-winners, etc.

Different socio-economic, cultural and religious groups vary in the degree to which they are able to influence their situation and change their behaviour.

• It is necessary to adopt a *holistic and cross-sectoral perspective* in approaching the problems. This means that activities within the health sector must be co-ordinated with measures taken within *other sectors* such as education, the mass media and legislation. The civil society may have an important role to play in preventive work. In terms of development cooperation, this implies collaboration between the different sector divisions within SIDA.

This also means that measures taken *in the health sector* must be coordinated. SIDA must e.g. support *integrated efforts* in women's health and maternal care, the struggle against STDs, HIV/ AIDS, contraceptive counselling, abortion counselling and medically safe abortions.

• It is vital to find the *right channel for development assistance* and the most conducive collaborative partner.

The areas of sexual and reproductive health and related human rights issues are sometimes sensitive. The development cooperation with governments should be complemented with support through other channels. The most innovative activities are often initiated by NGOs and networks. UN agencies should be strategically supported by e.g. earmarking funds for important and under-financed areas.

The scope for cooperation with university faculties, medical and non-medical, should be investigated. Innovative and technically skilled lecturers and researchers are important in the context of development cooperation. Cooperation with the Swedish Agency for Research Cooperation, SAREC, is recommendable for both country and organizational support.

• It is important to improve the *knowledge and experience* among both SIDA staff and consultants. A major training effort is essential during the coming years.

3.2 ADOLESCENTS' SEXUAL HEALTH

Every year 15 million children are born by teenage mothers. 80 per cent of these births occur in developing countries. More than half of the women in these countries – 65 per cent in Africa – give birth to their first child before the age of 20. Maternal mortality is 2-3 times higher for teenagers than for women in the age group 20-24 years. The rate of abortion is high. Between 50 000 and 100 000 teenage girls die each year due to illegal abortions. STD prevalence among teenagers is increasing, and accelerating the spread of the HIV/AIDS pandemic. The sexual violation of very young girls by older men contributes to teenage girls having twice the rate of HIV infections as that of boys in African countries. A 100 million girls have suffered genital mutilation and are increasing at the rate of 2 million a year. They are also at higher risk of HIV/AIDS and their sexual and reproductive lives are permanently scarred by these operations.

Up until now, adolescents have been neglected. Due to the HIV/AIDS pandemic more attention has been given to this increasingly serious problem. Thus, it is vital

to take necessary action in those countries where adolescent fertility is not accepted. The sexual relationships of adolescents are often a difficult subject for adults, including parents, to deal with, and so the topic is avoided. This means that young people, boys and girls, do not receive counselling, correct and adequate information, and access to means of contraception. School curricula are either non-existent or irrelevant for the real situation and lives of teenagers. Ministries of Health and of Education rarely cooperate, and youth organizations are typically weak. These are some of the factors contributing to unwanted teenage pregnancies, the spread of STDs including HIV/AIDS, and to dangerous and botched abortions.

These problems have received attention internationally and some countries are developing programmes, aiming specifically at adolescents.

Swedish Experiences

In the last few decades societal norms and attitudes towards adolescents' sexuality have gradually changed from very restrictive to liberal. There has been a simultaneous improvement in the provision of information and services to adolescents. Compulsory sexuality and gender education was introduced in Swedish schools in 1954. Experience from Sweden indicates that it is important to provide sexuality and gender education already in school. Experience shows, that teenage abortions and pregnancies have dropped as a consequence of information and education in this area.

In Sweden, there are special centres for adolescents outside the school system, where young people can go to get information and advice about contraception and STDs, prescriptions and contraceptives. These centres are open to both girls and boys.

THE FUTURE FOCUS OF SIDA DEVELOPMENT COOPERATION SHOULD BE;

- support to youth organizations and other NGOs involved in informational activities for adolescents or working with adolescents' health issues in other ways.
- cooperation with influential international organizations.
- support to initiatives to develop methods for reaching adolescents with education and service through cooperation between different groups in society.
- Support to collaboration between ministries of Health and at Education in the joint programmes for sexuality and gender education.
- promotion at the importance of adopting a gender perspective in all activities related to adolescents.

3.3 WOMEN'S HEALTH INCL MATERNAL HEALTH CARE

Improvement in women's health crucially depends on making progress in enhancing women's position in society altogether; women must get educational opportunities, economic self-determination and, by these and other means, increased control over their own lives including their fertility. The high figures for maternal morbidity and mortality mirror the overall situation of women.

Women in developing countries are exposed to considerable risks in their sexual and reproductive role. Half a million women die and one hundred million women suffer severe medical trauma every year in connection with pregnancy and childbirth. Of these women, 99 per cent live in developing countries, and 1 per cent in the rest of the world.

Although infant mortality has decreased and the level of general health has improved in the last 40-50 years, maternal mortality has remained at an alarmingly high level. The figures for Africa have been estimated at 600/100 000 live births, the same level experienced by Sweden one hundred years ago.

The ultimate aim of maternal health care is to safeguard the health of the woman and the newborn child by reducing morbidity, deficiencies and mortality in connection with pregnancy, childbirth and in the post-natal period. Deficiency diseases can be prevented. Screening procedures can identify at-risk mothers for referral to more qualified levels of care. In practice, all women do not follow the advice they receive, or cannot follow it due to lack of transport or financial problems.

It is worth noting that, using presently available screening methods, maternal health care services are only able to identify half of the pregnant women who will develop acute disease resulting in death. These complications occur unexpectedly and require immediate medical treatment. In order to reduce maternal mortality certain medical procedures should be available at the first referral level of care. Examples of such procedures are caesarian section, anaesthetics, blood transfusions, use of the vacuum extraction by the ventouse, obstetric forceps, manual removal of placenta and treatments of incomplete abortions. Access to trained staff and other resources is necessary if this is to be achieved. In addition, transports must function satisfactorily if the woman is to get the care she needs quickly (this scenario is not always possible in poor countries).

Well-functioning hospital care is thus crucial for the dramatic complications which are typical of obstetric care. Rapidly available operation facilities and a functioning blood bank are also required. The dependence on hospital facilities differentiates maternal care from child health care, which to a greater extent can be provided on an outpatient basis.

Post-natal care is important to avoid puerperal fever, to care for the newborn child and to create a supportive environment for breast feeding. Counselling on preventing unwanted pregnancies is also an important part.

Gynaecological problems after multiple or difficult births are common and do not receive much attention in developing countries.

Certain countries have programmes for training Traditional Birth Attendants – TBAs. The objective of the training is to achieve good obstetric hygiene and the identification of risk mothers so that they can be referred to higher levels of care. TBAs have a very limited capacity to help in the case of emergency delivery complications. In order to save mothers lives, TBAs have to be organised into a maternal care programme and provided with continuing education and educational material and equipment for deliveries.

The volume and quality of maternal health care in the world varies considerably between countries and even between regions in the same country. Generally, however, this area of health care has been grossly neglected. In 1987, a number of international organizations took a global initiative – *The Safe Motherhood Initiative* – with the aim of decreasing maternal mortality. This initiative has contributed to the inclusion of women's reproductive health on the international agenda, the beginning of research and the start of some development assistance projects. However, much more needs to be done to improve women's quality of life.

Women's health in general has to receive more emphasis - girls and young women and women who are not mothers and women after menopause have special health problems that need considerably more attention.

Swedish Experiences

In Sweden, there was a sharp drop in maternal mortality in the 1940s, and since 1970 the annual average has remained at 5 deaths per 100 000 deliveries. This positive development is primarily the result of an increase in the standard of living and level of education in general and improved women's health in particular. It is also largely attributable to the provision of maternal care services, which have been an integral part of public primary health care since the 1930s. The high standard of midwifery education and technical development within obstetric care have also contributed to decreasing maternal mortality. The passing of the first abortion law in 1938 was an important factor, allowing for the interruption of pregnancy if the woman was ill. The present abortion law permits interruption of pregnancy on the women's own demand for any reason.

Public maternal health care, led by a midwife, is the result of developments in the last decades. Now, almost all mothers-to-be visit maternal care centres and receive parental education during pregnancy, often in company with the father of the child. Health care has come to focus more on reproductive health in the broadest sense of the term. However, even in Sweden women's health in general merits more research and attention.

THE FUTURE FOCUS OF THE SIDA DEVELOPMENT COOPERATION SHOULD BE:

- Support to programmes with increased attention to women's health in general and sexual and reproductive health in particular.
- support to efforts to ensure that maternal health care referral systems are organized so that pregnant women with varying health care needs are taken care of, and that maternal care actively cooperates with obstetric care.
- support to programmes for postnatal care, infant care and for mothers with childbirth-related gynaecological problems.
- support to activities for the promotion of breast feeding by training and information in accordance with ratified international declarations.

3.4 CONTRACEPTIVE METHODS AND SAFE ABORTIONS

According to the Alma Ata Declaration, counselling and access to contraceptives was a component of primary health care and considered within the framework of maternal health care. Programmes have focused on modern contraceptive methods like the pill, IUDs, injections and implants and to a lesser degree on the so called barrier methods condom and diaphragm. Information about the importance of breastfeeding as a birthspacing method has been part of maternal and child health care.

Globally, the availability of good contraceptive methods for different target groups is far from satisfactory. This is both a question of quality and an insufficient choice of methods. In developing countries access is limited for economic and structural reasons.

Previously, the right to contraception was

mostly justified in terms of birth control. More recently, however, the dramatic increase in HIV/AIDS and other STDs has emphasized demands for preventive education and services in order to combat sexual infection. The strategies for fertility regulation and infectious disease control are to some extent different.

Traditional so called population programmes have been criticized on several counts. In many countries, these programmes have been promoted separately and primarily for reaching demographic targets. Countries where coercion measures have been applied, have been heavily criticized. A general criticism concerns the limitation of these programmes to include married couples only.

Adolescents and unmarried persons often receive neither counselling nor access to contraceptives since they do not constitute a family in the traditional sense. In practice, the location of these programmes, within maternal health care has also tended to exclude men in stable relationships.

However, in addition to men and women in stable relationships, programmes should cover adolescents who are not yet ready to become parents as well as men and women who do not live in stable relationships or are temporarily living separately. These are groups with the same rights to counselling of good quality and access to appropriate contraceptives as couples in stable relationships.

Abortions, performed in different ways, are used in most cultures to terminate unwanted pregnancies. In Sweden the rate is one abortion to three births, in USA one abortion to two births. In Eastern Europe the number of abortions has for a long time exceeded the number of births. According to WHO, 36-53 million abortions per year are performed world-wide, half of which are illegal and medically hazardous. Illegal abortions account for a large share of maternal mortality – in certain urban areas in the developing countries for almost half of all maternal deaths.

New initiatives on post abortion counselling and contraceptive services are important and help protect women from the repeat cycles of unwanted pregnancy and abortions. Post abortion services must address all causes of unplanned and unwanted pregnancies including socio-economic and sexuality issues as well as knowledge and use of contraception.

A simple and medically safe abortion method has started to be disseminated in many developing countries. It is often called menstrual regulation and is performed by manual vacuum aspiration. It is mainly used to deal with the medical consequences of illegal and incomplete abortions.

This is politically sensitive and the right of a woman to safe abortion is by no means guaranteed. The heated debate over abortion has, e.g. meant that several UN-agencies as well as other organizations have been prevented from working with safe abortions and even with contraception services.

Swedish Experiences

Sweden has internationally been regarded a pioneer country in this field. The right to information about and access to affordable methods of contraception was promoted as early as the 1930s by RFSU (the Swedish affiliate of the IPPF) and contraceptive counselling has been available within public health care for a long time. The abortion issue was also raised in the 1930s and abortion was permitted on certain indications. In 1975, the right to free abortion was legally established in Sweden. A law regarding access to free contraceptive counselling was passed at the same time. A number of other measures were also taken to prevent unwanted pregnancies. Contraceptive counselling services were extended using midwifes as counsellors and

the government appropriated funds for a long-term educational programme for sexuality and human relations.

This was to demonstrate that the provision of contraceptives is a responsibility for a society, where abortion is allowed. The idea behind the legislation is that the individual has the right to determine his/her own fertility and that this should primarily be carried out through preventive measures with free abortion as a complementary service.

In the 1960s, Sweden signed the first bilateral international agreement in the family planning field. Sweden also worked actively within the UN, at an early stage, to put family planning on the international agenda. Sweden was the major supporter behind the formation of UNFPA and IPPF.

The Swedish attitude to family planning was, from its inception, that programmes should be based on the welfare and needs of the individuals and families concerned. Later development has highlighted the need to enlarge the concept of family planning to sexual and reproductive health. The increased attention to adolescents and other neglected groups necessitates a conceptual change from the term family planning to fertility regulation or contraceptive services and counselling.

THE FUTURE FOCUS OF THE SIDA DEVELOPMENT COOPERATION SHOULD BE;

- support to extended services for contraceptive methods to all individuals regardless of age, sex and marital status.
- support to the development of user controlled contraceptives, particularly so called barrier methods which can be controlled by women and which provide protection against STDs.
- support to programmes for medically safe abortions and those making menstrual regulation methods available
- highlighting the abortion issue in international fora and in the development cooperation dialogue
- support to groups working to prevent unwanted pregnancies and promote the right to safe and legal abortion.
- support to programmes for integrated post abortion family planning service responsive to women's needs.

3.5 CONTROL OF SEXUALLY TRANSMITTED DISEASES INCL HIV/AIDS

Globally, 250 million new cases of STDs occur every year, contributing substantially to the increasing morbidity among women and men in developing countries. Among urban populations in certain African countries STDs, including HIV/AIDS, make up 20 per cent of all diseases. Women are affected to the same extent as men but since the symptoms are not as obvious in women, the infections are not diagnosed and treated in time. STDs are generally a more difficult social problem for women than for men.

Diagnosis can be more difficult in developing countries as laboratory resources and knowledge are insufficient. STDs (excluding HIV/AIDS) have often been

considered a curable disease without side effects. There are, however, a wide spectrum of consequential conditions, especially for women which can, for example, affect women's health in connection with pregnancy, childbirth and post-natal care. Epidemiological studies have also proven a strong correlation with extrauterine pregnancies and chronic conditions such as infertility, cervical cancer and HIV/AIDS.

Globally, the number of HIV infected individuals is estimated to increase from the present 10-20 million to 30-40 million by the year 2000. The HIV/AIDS pandemic in developing countries has affected men and women to the same extent. The infected men are mainly found in the age group 25-40 years, whereas there is a considerable overrepresentation of infected females in the age group 10-20 years. In many cases a monogamous woman's only risk behaviour is to have an HIV infected partner.

The HIV/AIDS pandemic has spread more in countries where the frequency of STDs is high. These diseases have often been neglected by developing countries and also by donors. This is maybe because STDs are not immediately fatal and that treating them was considered too expensive and complicated. These diseases are furthermore associated with sexual behaviour which was considered difficult to change. They were often not getting attention within the traditional family planning and maternal and child care programmes so as not to stigmatize these programmes.

Therefore, there is a growing need to coordinate programmes for STDs and HIV/AIDS. The existing STD programmes in developing countries have emphasized the curative side. However, in order to prevent the spread of these diseases, measures to influence sexual behaviour – particularly of men – should be integrated into these programmes.

Several developing countries have initiated vertical programmes for STD control aimed at groups with special risk behaviour patterns such as commercial sex workers and their customers.

Vertical programmes for control of STDs/HIV/AIDS must be part of the primary health care system and be integrated with programmes for fertility regulation into broad approaches for sexual and reproductive health, which are cost-effective and relevant for all sexually active in a population.

Swedish Experiences

In Sweden, the Communicable Diseases Act and other legislation on control of communicable diseases has been implemented specifically with STD control in mind. Programmes for information, preventive measures, diagnosis, and treatment of STDs are integrated into primary health care. The HIV/AIDS pandemic has entailed a stronger focus on information about human relations, sexuality and the spread of infection. For the HIV positive individuals, advice and counselling are emphasised.

Experiences in Sweden have shown the advantage of coordinating measures for preventing unwanted pregnancies with prevention of STD, including HIV/AIDS. One example is the education on sexuality and gender relations given to all school children.

Special measures have been developed for reaching groups with high risk behaviour for HIV/AIDS, e.g. homosexuals and intravenous drug users.

THE FUTURE FOCUS OF THE SIDA DEVELOPMENT COOPERATION SHOULD BE;

- support to method development in the field of education on sexuality and gender relations.
- promotion of research and development related to preventive programmes for STDs including HIV/AIDS combined with fertility regulation programmes.
- support to development of women controlled methods against STDs including HIV/AIDS.
- work towards integration of health specific components of HIV/AIDS programmes into primary health care.
- promotion of integration of STD/HIV/AIDS information in programmes on sexuality and gender education and contraceptive counselling.

3.6 CAPACITY BUILDING (MANPOWER DEVELOPMENT)

As a consequence of the broader definition of *sexual and reproductive health and rights* capacity building of many different professional groups need to be supported. In addition to the various categories of health care staff, teachers, educators and social workers also have obvious roles to play.

In Sweden there is one staff category, midwifes, that have thorough knowledge and extensive experience of sexual and reproductive health. However, midwifery training and competence vary from country to country – from fully qualified nurses with special midwifery training to traditional midwifes with no formal schooling. A broad range of different types of training programmes is therefore necessary.

Male nurses constitute an important category to impart information and knowledge to male clients. For this purpose they need special training. Another group needing special attention is physicians who supervise pregnancies and births. From experience it is known that they tend to provide excessive treatment , e.g. by prescribing unnecessary drugs or proposing caesarian sections for various reasons – even when they are not necessary.

Swedish Experiences

Midwifery training has a long tradition in Sweden. Government recommendations during 1850-1890 initiated all Swedish parishes to employ trained midwifes. Due to the introduction of competent midwifes in the whole country maternal mortality decreased drastically.

The midwife plays a key role within maternal care, obstetric care, contraceptive counselling and adolescents' centres. The work is performed independently. However, there is close cooperation with a gynaecologist in more complicated cases.

THE FUTURE FOCUS OF SIDA DEVELOPMENT COOPERATION SHOULD BE;

- support to staff training programmes, basic training and continued education in the form of courses and seminars in the broad area of *sexual and reproductive health*. This applies to training within the health sector as well as to training within other social sectors, e.g. of teachers and social workers.
- support to training programmes that strengthen the role of the midwife and her abilities to work within the entire range of activities included in sexual and reproductive health.

3.7 LEGISLATION (RELATED TO REPRODUCTIVE RIGHTS)

Reproductive rights are central for human rights endorsed by the UN in 1968. Furthermore, country's legislation influences *sexual and reproductive rights* directly and indirectly the health in both positive and negative sense. Female circumcision of young girls is an example of a practice that need national and international legislation as part of the efforts to abolish it.

Abortion laws vary from country to country. In many countries, abortion is totally forbidden or permitted in extremely limited cases, e.g. if the mother's life is in immediate danger. In other countries abortions are permitted only under certain conditions, e.g. that permission must be granted by several doctors *and* by the woman's husband.

Strict abortion laws lead to illegal abortions. Romania is a classic example of this phenomenon. In Romania, the total banning of abortion was introduced with the intent to increase the birth rate in the country. During the period when abortions were totally forbidden, illegal abortions and maternal mortality increased dramatically. The birth rate, however, remained at the same level as before the banning of abortions.

Legislation concerning contraception also affects *sexual and reproductive health* and reproductive rights. In certain countries the use of modern contraceptives is still illegal. In other cultures women are discriminated against. Husbands have to give their permission before women are allowed to use modern contraceptives.

The way in which crimes like rape and other forms of sexual abuse and violation are dealt with, reflects the views of a society about the relationship between men and women, and their respective rights and responsibilities. Similarly, legislation regarding the sexual abuse of children reflects that the rights of children are largely ignored as compared to adults. Female circumcision of young girls is a blatant example.

Numerous laws exert an indirect effect on *sexual and reproductive health and reproductive rights* on patterns of fertility. Laws concerning the age of consent and family legislation can e.g. affect the age of a woman's first pregnancy and the number of children and risks in connection with delivery.

Labour laws which give women the right to maternity leave promote health and well being as opposed to laws that tolerate girls to be expelled from school or women to lose their jobs when getting pregnant. Such discrimination laws force girls to risk illegal abortions and hinders their further education and development.

Laws which discriminate against women in a more general way can have a negative influence on *sexual and reproductive health and reproductive rights*. The right to own land, inherit and take a bank loan under one's own name are other examples of laws which are often gender discriminating.

Swedish Experiences

Sweden has a Communicable Diseases Act which states that it is a criminal act to consciously transmit a disease through sexual intercourse. In order to prevent further spread of STDs all cases have to be officially reported for partner notification and treatment. This legislation has proven to be very effective for the prevention of STDs.

Based on past experiences in Sweden and abroad, Sweden has drawn the conclusion that strict abortion laws result in illegal abortions, human suffering and unwanted children.

From its own experience, Sweden has learned that legislation must be combined with other, preventive measures. When the new abortion law was passed by the Swedish government in 1975, it was therefore linked

to an expansion of contraceptive counselling, free contraceptive services, health education, and special activities for adolescents', women's and immigrants' organizations.

THE FUTURE FOCUS OF THE SIDA DEVELOPMENT COOPERATION SHOULD BE;

- support to measures that analyze laws from the perspectives of both women and men *and* especially from the perspective of adolescents.
- support to measures to improve existing legislation accordingly.
- support to studies and critical appraisals of laws related to *sexual and reproductive rights*.
- support to NGO's, women's groups and networks for their advocacy and advisory work to improve relevant legislation.