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Seminar on Women's Health and Nutrition Best Practices

Bellagio Conference and Study Center, Lake Como, Italy: May 17-21, 1993

Sponsored by the World Bank

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Subject: Trip to Bellagio, Italy to attend the Seminar on Women's Health and Nutrition Best Practices held May 17-21, 1993 at the Rockefeller Foundation's Bellagio Conference and Study Center at Lake Como.

Background

Since the Safe Motherhood Initiative, launched in 1987, maternal health has received increased attention within the framework of primary health care and equitable development. Broader reproductive health issues and women's health and nutrition concerns, however, have been relatively neglected, and are in need of similar focused attention. To improve planning and programming in safe motherhood and women's health and nutrition, the World Bank, one of the major sponsors of the Safe Motherhood Initiative, is developing a work program on women's health with the following objectives:

- To expand and strengthen the analytical base for policy and program implementation to improve women's health, in particular by gathering, analyzing, and disseminating data on:
 - the extent, causes, and distribution of women's morbidity and mortality;
 - the economic, social, and legal constraints to improving women's health; and
 - the relative effectiveness, impact, and cost of alternative strategies;
- To increase policy and program support and coordination among governments, international agencies, and the broader development community.

The major expected product of this program will be the publication of a paper on "Women's Health and Nutrition Best Practices", which will draw attention to women's health problems and identify priorities for action. The paper will review the issues related to women's health— biological, social, economic, and cultural— and offer strategic guidance for designing programs based on the lessons learned in significant areas, such as disease control (sexually transmitted diseases and cancers), family planning, and the special health and nutritional needs of young girls. Issues of cost and effectiveness, utilization, programming and policy considerations, and strategic approaches to women's health will be included in the paper.

Purpose

The purpose of the seminar was to review background papers on best practices in women's health that have been commissioned by the World Bank, identify priority issues, and make program and policy recommendations to guide the Bank's programmatic strategy in the area of women's health and nutrition.

Seminar Format

The 23 participants at the seminar represented a wide range of women's health specialists from all the continents (see list of participants in annex). Sub-Saharan Africa was represented by four participants. (I was included as a representative of Francophone Africa!)

The seminar covered women's health and nutrition problems and needs throughout the life cycle (childhood, adolescence, reproductive age, and post-reproductive age). The background documents contained more information and issues than were possible to cover.

Each participant was asked to lead one of the overview sessions or discussion groups (see agenda in annex). For each subject area, a participant presented to the group a synthesis of the main issues and lessons learned from country-level activities, drawn from personal experience and background materials. The discussion group sessions attempted to identify strategy and intervention options to deal with women's health and nutrition problems, to recommend program priorities, and to identify public and private mechanisms for implementation.

The staff of the Study and Conference Center at the Villa Serbelloni was keen on keeping everything on schedule.

General Issues and Discussions**1. World Development Report 1993**

The focus of the upcoming World Development Report 1993 is health. The Report uses a "global burden of disease" model to quantify the loss of healthy life from about 100 diseases and injuries in 1990. To measure the total burden of disease, including death and disability, the Report uses the disability-adjusted life year (DALY) which combines healthy life years lost from premature mortality with those lost from disability.

General Issues and Discussions

The global burden of disease model, although disease-oriented and not perfect, does provide some tools for setting priorities. As an example, women have a smaller burden of disease from premature death, but a larger burden from disability than men. Another important finding is that for many of the major burdens of disease in women aged 15-55, there are highly cost-effective interventions to address those problems, in contrast to the major disease burdens for men of the same age group. Some of those findings are the driving force behind the Bank move for women's health and nutrition best practices program.

The Report is scheduled to be released in early July 1993. The Bank has already started marketing some of the concepts developed in the report. There are program development and operations research needed to guide implementation of some of the report's recommendations.

2. The Minimum Package of Women's Health Services

During the course of the seminar, participants were asked to identify a minimum package of public health interventions and essential clinical services that could produce substantial health and nutrition gains for women at different stages of the life cycle. There was a consensus that the elements of such a package would vary with local conditions and country's resources.

In general, the package should include:

- nutrition education;
- essential obstetric functions;
- family planning services;
- anemia prevention and control;
- prevention and control of reproductive tract infections (with focus on adolescents);
- referral system;
- management of unsafe abortion complications;
- access of girls to interventions to combat childhood diseases; and
- community-based care and health education.

3. Emerging Issues

The participants supported advocacy to increase awareness, studies to document the extent, and training of health workers to identify and care for the following emerging issues of women's health:

BELLAGIO

a. Cervical cancer

Some estimates put the death toll of cervical cancer in developing countries at about 500,000 women per year. Studies have documented the role of cervical cancer in increasing the risk of HIV transmission. Few developing countries have cervical cancer screening and treatment services. Cost-effective approaches for early detection and treatment exist. Pilot trials of those approaches are needed.

b. Occupational health

The occupational health issues for women in developing countries that need attention are of different kinds, among them are:

- Double-load work related health hazards;
- Family planning and STD control for commercial sex workers;
- STD prevention and control among migrant workers in order to protect their wives; and
- Child/girl labor.

c. Mental health

Studies to better document the following mental health problems among women in developing countries are needed:

- Stress, especially for rural women working long hours in the field;
- Psychological burden of infertility, especially in Sub-Saharan Africa;
- Depression, especially among post-reproductive older women; and
- Psychological effects of unwanted pregnancy.

d. Violence and traditional practices

Little is known about the type and frequency of violence against women in various cultures and settings in developing countries. Studies to assess the situation are needed.

Traditional practices can be protective of or harmful to women's health and nutrition. Culture-specific studies may be necessary to identify and promote the protective practices and to discourage the harmful ones. Genital mutilation is an example of a harmful traditional practice.

4. Public and Private Mechanisms for Achieving Progress

The participants wished that there was more time to discuss this topic. For achieving real progress the public and private mechanisms for providing women's health and nutrition services must be synergetic.

Efforts should be devoted to improving public sector management and ensuring government finance for the essential package of women's health and nutrition services throughout the life cycle.

Governments need to facilitate efficient private sector involvement in women's health and nutrition. Advocacy, community mobilization, IEC, service delivery, human resource development are some of the areas in which the private sector organizations, especially NGOs and women's groups, have a comparative advantage.

Lessons learned from previous and ongoing women's health programs are sought to identify the best mix of public and private mechanisms for implementing women's health interventions. The best mix can only be defined at the country level, taking into account available resources and local preferences.

Conclusion

The participants congratulated the Bank staff for their efforts to move women's health and nutrition higher on the agenda. They recommended that the paper on women's health and nutrition best practices, to emerge from the Safe Motherhood Initiative, be field-oriented. As far as Sub-Saharan Africa is concerned, the World Bank is planning to take advantage of the First Regional Congress of the Medical Women's International Association, Near East and Africa Region, to be held in Nairobi 29 November–3 December, to organize a larger consultative group with African professionals to discuss the paper.

In organizing a working group for AFR/ARTS/HHR maternal health, SARA might want to include one of the Bank staff involved with the women's health and nutrition best practices program. This will improve coordination of efforts.

Seminar Background Documents

1. "Making Motherhood Safe" by A. Tinker and M. Koblinsky, which presents guidelines for safe motherhood programming.
2. Social, economic, cultural, and legal factors affecting girls' and women's health and their access to and utilization of health and nutrition services in developing countries by George Acsadi and Gwendolyn Johnson-Acsadi;
3. Adolescent fertility, health, and nutrition by Judith Senderowitz;
4. Cervical cancer by Jacqueline Sherris;
5. Reproductive tract infections by May Post;
6. Women and HIV/AIDS by May Post;
7. Women's access to quality health care services by Jill Gay;
8. Nutritional status of women by Kathleen Merchant;
9. Women's health beyond reproductive age by Mary E. Young;
10. Violence against women by Lori Heise and Jacqueline Pitanguy;
11. Cost-effectiveness issues in women's health by Joseph Kutzin;
12. Unplanned pregnancy and abortion by Kajsa Sundström;
13. World Development Report 1993: Investing in Health, summary presentation by Helen Saxenian
14. A note on Healthy Mothers Healthy Babies by the HPN Department, the World Bank

Annexes

1. List of participants
2. Conference agenda
3. Selected summaries of background documents

Women's Health and Nutrition Seminar
Rockefeller Study and Conference Center
Bellagio, Italy
Sponsored by the World Bank

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PROGRAM FOR SEMINAR ON WOMEN'S HEALTH AND NUTRITION

Bellagio Conference and Study Center, Lake Como, Italy 17-21 May 1993

Monday, 17 May: Arrival of participants, dinner and introductions, review of seminar objectives and agenda (after dinner)

TIME	Tuesday, 18 May	Wednesday, 19 May	Thursday, 20 May
8:00 - 9:00 am	Breakfast	Breakfast	Breakfast
9:00 - 10:30 am	I. Women's Health and Nutrition: Biological and Cultural Issues <i>Overview on Nutrition:</i> J. Kevany <i>Working Groups:</i> 1) Special Nutrition Issues: Meera Chatterjee 2) General Gender Issues Affecting Nutritional and Health Status: M. Fuszara	IV. Reproductive Tract Infections (including HIV) <i>Overview and Discussion Chair:</i> J. Wasserheit <i>Discussant:</i> W. Grisuphan S. DUALE	VIII. Cross-Cutting Issues: The Minimum Package in Three Hypothetical Settings <i>Overview and Discussion Chair:</i> A. Langer
10:30 - 10:45 am	Break	Break	Break
10:45 - 11:15 am	Session I Plenary (working group reports)	V. Cancers and Infectious Diseases 10:45 - 12:00: <i>Working Groups:</i> 1) Cancers: K. Rogo 2) Infectious Diseases (malaria, TB, etc.): J. Fortney	IX. Public and Private Mechanisms for Achieving Progress <i>Overviews:</i> 1) Public: I. Pathmanathan 2) Private: a. Non-profit: C. Simone Diniz Grilo b. For-profit: M. Taguiwalo <i>Working Groups:</i> 1) Public: A. Dervisoglu 2) Private: S. Duale
11:15 am - 12:30 pm	II. Unplanned Pregnancy and Abortion <i>Overview:</i> A.A. Arkutu <i>Working Groups:</i> 1) Unplanned Pregnancy/Family Planning: A. Dervisoglu 2) Abortion: S. Kabir	12:00 - 12:30: Session V Plenary (working group reports)	
12:30 - 2:00 pm	Aperitif and Lunch	Aperitif and Lunch	12:30 - 3:15 Lunch Excursion on Lake Como 3:15 - 3:30 Break/Return from Excursion
2:00 - 3:30 pm	III. Reproduction <i>Overview:</i> J. Fortney <i>Working Groups:</i> 1) Pregnancy and Childbirth: M. Fathalla 2) Post-partum and Perinatal: F. Manguyu	VI. Emerging Issues <i>Working Groups:</i> 1) Cultural issues – Violence, Traditional Practices, Aging: C. Simone Diniz Grilo 2) Other Emerging Issues – Occupational Health, Mental Health: Mirai Chatterjee	
3:30 - 4:00 pm	Break	Break	X. Wrap-up Sessions VIII and IX, Final Discussion of Priorities and Strategies <i>Session Chair:</i> A. Tinker <i>Summing up:</i> M. Fathalla
4:00 - 5:30 pm	Session II and III Plenary (working group reports and discussion)	4:00 - 4:45: Session VI Plenary (working group reports and discussion)	
5:30 - 6:00 pm	Special Session: World Development Report 1993 – Analysis of Women's Health and Nutrition H. Saxenian	4:45 - 5:30: VII. Monitoring, Evaluation and Research <i>Overview and Discussion Chair:</i> A. Faundes	
7:30 - 8:00 pm	Aperitif	Aperitif	Aperitif
8:00 pm	Dinner	Dinner	Dinner
		Special Issues: Women's Reproductive Health in the Former USSR – A. Popov	

05/13/93

SUMMARY
MAKING MOTHERHOOD SAFE
by Anne Tinker and Marjorie Koblinsky

I. GENERAL ISSUES: PROBLEMS AND NEEDS

The complications of pregnancy, childbirth and abortion cause extensive maternal and infant mortality and morbidity, as illustrated below*:

CAUSES	MATERNAL MORTALITY AND MORBIDITY	INFANT MORTALITY AND MORBIDITY
Unsafe induced abortion (25 million)	70,000-200,000 deaths <u>Morbidity:</u> Permanent disability, infertility	
Post-partum hemorrhage (10-20% of pregnancies)	104,000 deaths <u>Morbidity:</u> anemia	
Pregnancy-induced hypertension (pre-eclampsia, eclampsia)	60,000 deaths <u>Morbidity:</u> paralysis, blindness, chronic hypertension, renal failure	<u>Morbidity:</u> prematurity, asphyxia
Obstructed labor	40,000 deaths <u>Morbidity:</u> fistulae, uterine prolapse, infection	<u>Morbidity:</u> Asphyxia, birth trauma, infection
Infection	40,000-115,000 deaths <u>Morbidity:</u> Pelvic Inflammatory Disease, infertility, ectopic pregnancy	7,000,000 deaths (tetanus) <u>Morbidity:</u> pneumonia, neonatal sepsis
TOTAL	500,000 deaths <u>Morbidity:</u> 54,000,000 cases of acute morbidity; millions more suffer chronic morbidity	7,000,000 deaths <u>Morbidity:</u> 3,600,000 cases of asphyxia 21,000,000 low birth weight infants

* Cases/deaths per year

II. LESSONS LEARNED

In industrialized countries, socio-economic development had little impact on maternal mortality and morbidity. In Sweden, maternal mortality levels fell in the 18th and 19th centuries due to an increase in the availability of midwives trained to assist with births in the home and to the introduction of aseptic techniques. In England and Holland, levels did not fall after 1930, following the introduction of blood transfusion services, improved cesarean techniques, and, somewhat later, antibiotics. In more recent times, modern family planning and safe abortion services have had a significant impact on maternal mortality.

Family planning reduces maternal mortality because it reduces the number of pregnancies; its impact on maternal mortality is particularly significant when the number of unwanted and high risk pregnancies is reduced. However, substantial reductions in maternal mortality require additional efforts to reduce the risks that women face once they are pregnant through improved maternity care.

A recent study analyzed available information on the effectiveness of prenatal and obstetric care. There is substantial information available on the most effective interventions to prevent mortality when a woman

suffers complications during labor and delivery. Prenatal interventions, however, have not been sufficiently evaluated in terms of their impact on maternal mortality, and some studies suggest that certain interventions are not very effective. For example, recent research has found that identifying women as "high risk" based on such indicators as age and parity is often not a cost-effective strategy: most women identified as "high risk" do not suffer from serious complications; and most maternal deaths occur to women at "low risk."

The evidence suggests that the following prenatal interventions are very effective in terms of their impact on maternal mortality:

- Detection and management of chronic anemia;
- Detection, investigation, and referral of hypertensive disorders of pregnancy;
- Detection and treatment of certain types of infection, especially sexually transmitted diseases; and
- Detection and management of women who face a high risk of obstructed labor based on height and/or poor obstetric history.

Developing Country Illustrations:

- In the rural Matlab district of **Bangladesh**, maternal mortality fell 30 percent in 10 years due to a community-level family planning program. But the conventional maternal health care provided had little impact on the risks faced by pregnant women. To reduce these risks, professional midwives were posted in the community to assist women during pregnancy and home births. They were equipped with supplies to manage complications and had access to transport and referral services to ensure adequate treatment of complications requiring such care. This project succeeded in reducing the maternal mortality ratio by 68% in three years.
- In **Indonesia**, traditional birth attendants (TBAs) who had been trained but did not have access to referral services did not have an impact on maternal mortality.
- In **Zaire**, delegating obstetric care – including cesareans – to nurses has increased the coverage of care, with an impact on maternal mortality.
- In **Nigeria**, a radio campaign was developed to inform women and their families about the risk of a labor lasting more than 24 hours. The prevalence of unattended prolonged labor and its negative sequelae has fallen in the catchment area of the campaign.
- In **Kenya**, the introduction of manual vacuum aspiration to treat abortion complications has improved the outcomes of the procedure, reduced the duration of women's hospital stay, and reduced associated costs between 23 and 66%.

III. STRATEGY AND INTERVENTION OPTIONS

Following are the fundamental strategies to reduce maternal mortality:

- 1/ Family planning and safe abortion services (safe management of abortion complications and, where legal, safe services for pregnancy termination).
- 2/ Trained assistance during pregnancy, delivery, and postpartum.

- 3/ Referral services equipped and staffed to manage complications during pregnancy, delivery, and postpartum; an emergency alarm and transport system is a key component of a functioning referral system.
- 4/ Information, education and communication to promote positive health, family planning and nutrition practices; health education is particularly important to ensure that women and their families recognize danger signs during pregnancy, delivery and postpartum, and that they seek the services they need.

IV. PRIORITIES: PROGRAM AND POLICY RECOMMENDATIONS

Both policy and program priorities will depend on the epidemiological, demographic, infrastructural, cultural, and other characteristics of any given setting. The paper illustrates the manner in which these factors can be built into the policy making and program planning process using three hypothetical settings. This summary will provide a far briefer illustration and examples of key program and policy recommendations using two of these settings.

In **Setting A** women are particularly isolated. There are few community-level health services. A hospital may exist in the district but it does not have the capacity to provide adequate management of obstetric complications. In addition, it is not used by the community due to distance, lack of transport, cost, cultural barriers, and/or other reasons. Deliveries are attended by the woman's husband, a relative, a traditional birth attendant, or no one at all. There are no family planning services available. As a result, contraceptive prevalence is low, unsafe induce abortion is common, and fertility and maternal mortality levels are high.

A. Program Recommendations

Community-based distribution of contraceptive methods (oral contraceptives, condoms) and family planning education are the most important interventions for reducing maternal mortality in this setting. Other interventions that should be considered include:

- Developing basic community-based maternal health services;
- Training traditional birth attendants;
- Establishing linkages between the community and existing referral services;
- Improving the capacity of referral services to manage obstetric complications; and
- Developing maternal health information, education and communication activities to support these health service interventions.

Program costs: Assuming a population of approximately 500,000 and the prevention of 20% of all maternal deaths in less than five years, an analysis estimated the cost of all new recommended interventions in this setting to be approximately \$1 per capita, \$12,000 per maternal death averted, and \$1,700 per maternal and perinatal death averted.

B. Policy Recommendations

Policy issues in this setting include:

- Promoting delayed age at marriage and first birth;
- Expanding the role of midwives through training and community-level deployment, and delegating responsibility for the treatment of obstetric complications (for example, to nurses and midwives);

- Developing strategies for emergency transport to referral facilities; and
- Bringing the perspective of community leaders — especially women — into service design.

Women in **Setting C** tend to be educated and mobile. Public and private health infrastructure is well developed. The referral hospital is overwhelmed with routine deliveries, but the poorest women, who tend to face higher risks, do not use its services. In addition, the quality of services is poor. Health personnel lack adequate training, supervision, and management protocols. Contraceptive prevalence is high, but marginalized groups, such as poor women and adolescents, lack adequate access to services; unsafe abortion is common among these groups. Maternal mortality is lower than in the other settings, but can be reduced far more.

A. Program Recommendations

Priority interventions should focus on improving the quality and efficiency of services by, for example:

- Decentralizing services;
- Delegating essential obstetric functions and surgical family planning services to other trained professionals (eg., nurses);
- Referring women who require routine family planning and delivery care to alternative sites;
- Improving the supervision, training, and refresher training of health professionals, with an emphasis on quality of care;
- Providing health personnel with management protocols;
- Providing safe abortion services;
- Reaching out to marginalized groups to provide them with services; and
- Developing maternal health information, education and communication activities to support these health service interventions

Program costs: Assuming a population of approximately 500,000 and the prevention of 80% of all maternal deaths in less than five years, an analysis estimated the cost of all new recommended interventions in this setting to be approximately \$1 per capita, \$22,000 per maternal death averted, and \$3,000 per maternal and perinatal death averted.

NB. The cost-effectiveness of recommended interventions is highest in middle setting B (\$7,000 per maternal death averted and \$1,000 per maternal and perinatal death averted).

B. Policy

Policy issues in this setting include:

- Reaching a consensus on the provision of abortion services, ensuring effective care for incomplete and septic abortions and post-abortion counselling and services;
- Authorizing delegation of medical responsibility — for example, IUD insertion or manual removal of the placenta — to more accessible providers, such as midwives, and training and licensing such providers; and
- Diversifying family planning programs to meet the varying needs of women of different ages, and providing service through a variety of channels.

SUMMARY
**SOCIO-ECONOMIC, CULTURAL, AND LEGAL FACTORS
AFFECTING GIRLS' AND WOMEN'S HEALTH AND
THEIR ACCESS TO AND UTILIZATION OF HEALTH AND
NUTRITION SERVICES IN DEVELOPING COUNTRIES**

by George T.F. Acsádi and Gwendolyn Johnson-Acsádi

I. GENERAL ISSUES: PROBLEMS AND NEEDS

PROBLEMS

- ▶ There are few programs for women outside of the framework of motherhood. Nutritional and nutrition/health care programs focus on children under five, and pregnant and lactating women.
- ▶ Women's illnesses and pain, including that resulting from domestic violence, are considered "women's problems" and "women's lot" in many developing countries, often by the women themselves.
- ▶ Insufficient attention is given to supervision at each level of program implementation and to quality evaluation of programs and to program impact. This imposes serious impediments to the achievement of health and nutrition program goals.
- ▶ Illegal abortion is widespread in many developing countries. Many seek abortions to avoid dismissal by their employer or from school, increasing rates of clandestine abortion and maternal death.
- ▶ Men dictate the timing and terms of coitus, and women may not have the right to refuse intercourse with their partner or demand the use of a condom. Women are therefore commonly exposed to STDs.
- ▶ Cultural phenomena deter access to and utilization of family planning services, even where these are available, in all developing countries.
- ▶ Access by women to family planning services is also constrained by women's poverty or lack of control over money to finance even minimal care costs.
- ▶ Family planning providers are often insensitive to the cultural preferences of their clients.
- ▶ Programs have too often been exclusively directed at women, bypassing the unmet need to involve and provide services for men.
- ▶ Family planning services are often centered around maternal and child health clinics, which excludes men, adolescents, unmarried women, and married women who are not pregnant, who are unlikely to visit these clinics. In many countries, services are denied to young and/or unmarried women.
- ▶ The majority of women in developing countries do not have access to legal abortion services, resulting in 100-200,000 maternal deaths. Many of these women are adolescents or unmarried women who did not have or were denied access to family planning services, increasing the rates of clandestine abortion.
- ▶ Although it appears that hospitals rarely, if ever, refuse to treat a woman for botched abortions, there is evidence that premature discharge is common and occurs in all regions, primarily to lower the costs incurred.
- ▶ Traditional customs that govern the care and nutrition of pregnant and childbearing women (such as reduced calorie intake during pregnancy), impose obstacles to the utilization of prenatal health services.
- ▶ Anemia is prevalent in 47% of women aged 15-49 in developing countries and in 59% of pregnant women.
- ▶ Women's health needs over age 49 are not met, and are paid scant attention by policy-makers.

NEEDS

- ▶ Mobilization of political will to modify cultural traditions that hamper improved health and nutrition for women.
- ▶ Provision of better and more complete information on girls and women, in terms of their relative status to men in health, nutrition, mortality, and socio-economic factors at critical life stages.
- ▶ Compliance with laws affecting women's rights, including the provisions of international conventions such as the Convention on the Elimination of All Forms of Discrimination Against Women. Enforcement of existing laws that can have a beneficial impact on the health and lives of females.
- ▶ Equal treatment for girls and boys in allocation of available food and health care.
- ▶ Sensitization of men to the plight of women, their rights, and the effects of maternal illness and death.
- ▶ Improve knowledge of, access to, and utilization of contraceptives, and provide family planning information and services in culturally acceptable circumstances, including for adolescents and unmarried women.
- ▶ Educate the public about AIDS prevention, including in the earliest school grades that culture will allow.
- ▶ Greater awareness among government officials of the need to protect females from violence.
- ▶ Change customs that promote marriage at an early age, which is detrimental to girls' health and that of their children.

II. LESSONS LEARNED (INCLUDING COUNTRY ILLUSTRATIONS)

- ▶ Program effectiveness is constrained when programs are designed without due consideration for culture.
- ▶ Women need to be autonomous to have access to and utilize good health care. Where there is genuine female autonomy, women are more likely to secure better health and nutrition for themselves and are less likely to discriminate against their daughters.
- ▶ Earning income does not necessarily improve a woman's status, especially if she is employed in the informal sector and if she does not have control over expenditure decisions.
- ▶ Nutrition programs are more successful when they form part of a larger initiative. A program in India that combined food and food supplements with the study of nutrition saw an improvement in the diets of women participants.
- ▶ A nutrition program for children with poor growth patterns in Bangladesh showed that the benefits accrue to sons more so than to daughters.
- ▶ A program in India demonstrated one successful approach to ensure that food allocation was not discriminating against girls. When children with weight deficiencies were not taken to the centers, health workers would go to the home and feed the children themselves, overriding the family food allocation system.
- ▶ The margin in good health care that boys enjoy over girls is greater when mothers are better educated, and poorer women in some studies have proven to be fairer in meeting their children's health needs. Increased education for the mother reduces child mortality, but does not reduce boys' advantage over girls.
- ▶ Special legislation may be necessary to eliminate life-threatening traditional practices against women. In India, the Commission of Sati Prevention Act punishes any person who commits sati (burning or burying alive a woman with her deceased husband).
- ▶ Community organization can have a powerful impact on changing traditional practices that are harmful to female health and well-being. The Malaysian Joint Action Group Against Violence Against Women enlisted the support of the media and especially trained women police officers to deal with rape women in a campaign to enforce harsher penalties for

offenders. The incidence of these crimes notably decreased. Women's groups in a village of Maharashtra State, India, used public ridicule of male offenders to curtail men's violent acts against women.

- ▶ Male-female teams of health practitioners in Afghanistan, Senegal and other countries have been successful in overcoming cultural barriers to female health care. In the Guatemalan Family Planning Association, family teams were found to be 30% more effective than persons working alone.
- ▶ Good health practices can be introduced through cost-free, conveniently located seminars or workshops that are widely publicized. The Philippine's Woman Health Movement held a two-day workshop in Manila which provided education on contraceptives, anatomy, and pregnancy, before the women received clinic services (e.g. pap smears, pelvic examination, general check-up). Woman participants demanded similar efforts be arranged in their communities.
- ▶ Home self care may be successfully promoted in certain circumstances. China's Longhus Commune may serve as a model; health professionals visited homes to teach pregnant women and their husbands how to monitor pregnancy and to determine whether medical recourse was necessary. Substantial decreases in prenatal and postnatal maternal mortality and complication rates, and improvements in fetal health, are all attributed to the project.
- ▶ Casa Materna in Nicaragua offers training courses on childbearing, breastfeeding and family planning for parturient women. They participate in housekeeping chores and income-producing activities until delivery. None of the 216 women who have been cared for in these centers since 1988 has died of childbirth related complications. A "maternity village" in Nigeria, where women stay for the last trimester of their pregnancy, is given credit for reducing maternal mortality rates at the hospital next door from 10 to 1 per 1000 deliveries, and stillbirths from 116 to 20 per 1000 deliveries.
- ▶ Several nutrition and health programs have demonstrated that the participation of men in their design and implementation is a successful strategy to pursue. The Nigerian Institute of Child Health organized Fathers' Clubs which promote immunization, good nutrition, and child growth monitoring. The Zimbabwe National Family Planning Council developed a program to increase men's knowledge and understanding of contraception based on workshops and informal discussions with carefully selected male leaders. Over 60% reported a change in attitude.
- ▶ To meet the family planning needs of adolescents, Family Planning Associations in Mexico, Guatemala, and Costa Rica train adolescent counselors to promote family planning. Multi-service youth centers offer family planning information and services along with job-related and recreational activities.
- ▶ AIDS prevention programs in Uganda have revised school curricula for primary and secondary grades to include health education and information about AIDS.
- ▶ To increase female school enrollment rates, the Government of India is giving priority to training female teachers, since parents in villages will not send their daughters to male teachers. The program provides special incentives, providing books, uniforms and scholarships, for needy girls. In Bangladesh, all new primary-level teaching recruits will be female. In Pakistan, Home Schools have been established for girls who are not able to go to formal schools.
- ▶ In Jamaica, adolescent mothers and expectant mothers receive academic schooling and training in marketable skills, along with health and family life education classes. The program resulted in a change in official education policy, so that now pregnant girls are allowed to stay in school and are able to return after their children are born.

III. STRATEGY AND INTERVENTION OPTIONS

- ▶ Programs to improve women's lives in developing countries aimed at changing cultural practices are the most likely to fail.
- ▶ Culture can be altered by the introduction of the simplest technology and advances in education. Strategies should focus on identifying issue areas that are most susceptible to change and developing programs and policies to exploit that margin of susceptibility.
- ▶ The public must be educated about the rights and needs of females. Community-level men and women leaders must be organized to address governments on these issues to encourage change or enforcement of legislation.
- ▶ Programs that aim to improve the status of women should obtain men's support and participation, for example in the implementation of health and nutrition programs for women.
- ▶ Community involvement and participation of the media and prominent persons should be encouraged in the planning, implementation and quality control of family planning programs to sustain acceptance and use of contraceptives.
- ▶ Family planning services should be provided in culturally acceptable places; for example, for men in workplaces, men's clubs and coffee houses; for unmarried women in general health clinics and hospitals.
- ▶ Special family planning service programs must be organized for adolescents.
- ▶ Medical and nutrition interventions are jointly necessary to ensure healthier pregnancy and safer childbearing.
- ▶ Nutrition programs should be addressed to family members, such as husbands and mothers-in-law, who determine food allocation in the family.
- ▶ Education empowers women with the will and ability to circumvent customary barriers. Parents must be encouraged to provide formal schooling for their daughters if they are to deal adequately with their own and their children's health problems, and to break the cycle of discrimination against their own daughters.
- ▶ A variety of health interventions that are culturally-sensitive should be considered to ensure that all women have access to health care, such as periodic visits by female health practitioners or male-female health teams that respond to cultural barriers and issues.
- ▶ The potential impact of TBAs in improving maternal health must be carefully assessed; they should also be provided with more training, and their effectiveness must be closely supervised.
- ▶ Prenatal screening programs must have adequate referral systems in place to be effective. Waiting homes for pregnant women with expected complications or home visits to indigent families are good support systems that have proven effective.

IV. POLICY, PROGRAM, AND RESEARCH RECOMMENDATIONS

- ▶ Governments and international organizations should gather and publish gender-specific statistics on socio-economic and health phenomena for all ages.
- ▶ Researchers must be responsible for reflecting gender differences in their work to facilitate programs that aim to eliminate discrimination against women. Multi-disciplinary symposia and round tables of scholars should be sponsored, aimed at public health officials, population census planners, survey researchers, and others involved in the collection of data and design and implementation of programs.
- ▶ Women must be empowered to act independently where their health or well-being is concerned. Gender gaps in secondary school enrollment must be eliminated. Governments and international organizations should ensure that women receive their share of education and travel scholarships, loans and grants.

SUMMARY
**ADOLESCENT FERTILITY, HEALTH AND NUTRITION:
ISSUES AND STRATEGIES**

by J. Senderowitz

I. GENERAL ISSUES: PROBLEMS AND NEEDS

- Adolescents are generally healthy, but serious problems, especially for girls, result from
 - gender discrimination
 - nutritional deficiencies
 - lack of access to health services
 - lack of education.
- Girls who are abused, and therefore especially vulnerable, tend to:
 - initiate sex earlier (with an increase in STDs, HIV)
 - are more likely to become pregnant
 - are at risk of unsafe abortion and suffer a disproportionate number of abortion complications
 - drop out of school, which in turn leads to social ostracism and harmful practices including drug abuse, alcohol and prostitution.
- Standardized data are lacking. Operational research, combined with qualitative studies, are needed for policy and planning.
- There is a significant unmet need for family planning-related services for adolescents.
- There is a problem with distortion by mass media on issues regarding sexual behavior.

II. LESSONS LEARNED: COUNTRY ILLUSTRATIONS

Broad Lessons:

- Education, especially for girls, is vital.
- Primary education, health education, and family life education can all be helpful, especially if done with (adolescent) peers in active, participatory programs.
- Collaboration between governments and non-governmental organizations, especially women's groups, can be helpful.
- Family planning programs, especially when supported by IEC and peer education programs, have been very important.

Country Illustrations:

- Youth counseling in **Ethiopia**, using films, drama, non-prescriptive contraceptives as part of a referral network is interesting in that it is part of a trend to focus solely on adolescents.
- **Zimbabwe's** national family planning program has a special Youth Advisory services Unit which operates a center in the capital which offers family planning counseling and services with significant IEC support.

- University students in **Nigeria** are trained in sex education and family provide counseling and contraceptives to peers.
- CORA, in **Mexico**, operates a series of multi-service centers which are "adolescent friendly", offering recreation along with counseling and services on adolescent development, pregnancy prevention, STDs, substance abuse and mental health. Adolescents themselves are involved in planning the activities.
- Similar experiences in **Sri Lanka** and the **Philippines**.
- **World Scouts, IPPF, YWCA** and other agencies conduct outreach programs, with significant IEC components to teens through the media, with street theater and a variety of educational materials.
- The media and other IEC efforts can be very important in promoting positive health behaviors among teenagers. Combinations of film, pamphlets, songs and TV/radio can inform and motivate teenagers. "Under Twenty" radio programs in 16 **Caribbean** islands and "The Blue Pigeon" on television has had a positive effect on sexual knowledge and attitudes among 10-15 year old viewers in **Latin America**.
- Adults rarely communicate effectively with adolescents. "Young people respond more effectively to those who are non-judgmental, confidential, knowledgeable, enthusiastic, caring and creative."
- Telephone counseling services for youth in **Korea** and **Indonesia** have shown improved levels of knowledge about reproductive health, improvement in problem solving and less aggression and emotional disturbance.
- Collaboration among donor agencies and NGOs can be very important in creating a multiplier effect, with greater results from improved coordination and focus.
- Policy attention by **international, multinational** agencies helps set the stage for legal and social change nationally.

III. **STRATEGY AND INTERVENTION OPTIONS**

- Education, especially for girls, is the most important investment.
- Expand and improve health services, including family planning and health education, particularly reproductive health education.
- Pass laws to raise the age of marriage.
- Support programs that reach adolescents with peer counseling, education and multi-purpose programs for adolescents.
- Support programs for nutrition supplements coupled with education.

- ▶ Increase minimum legal age at marriage — the primary deterrent to female autonomy — and enhance educational and formal economic opportunities for women, as basic elements to improve female health.
- ▶ Development plans should include provisions which ensure that women are employed in the formal sector rather than the informal sector to counteract the adverse effects of structural adjustment programs that result in women's economic losses.
- ▶ Design and execute international surveys on violence against females to determine the type of violence and legal recourses that exist with a view to inviting government action.
- ▶ All legal and logistical restrictions to the use of family planning methods should be eliminated.
- ▶ To avoid waste and lost opportunities for effective program results, donors need to find ways of cooperating with governments to ensure equitable distribution of and access to food and health programs. NGOs and international agencies need to share information fully, and sustainability and replication of projects should be strengthened in program design.

- Support broad IEC efforts with the mass media, integration and cooperation with NGOs for the promotion of healthy behaviors.
- Combat the promotion and use of drugs, alcohol and tobacco.

IV. PRIORITIES: POLICY AND PROGRAMS RECOMMENDATIONS

- Promote increased age of marriage, delayed childbearing, equal education and employment opportunities for girls. Allow pregnant girls to remain in school.
- Expand family planning services available to adolescents through outreach, community-based distribution and existing health centers.
- Educate the public on disadvantages of too-early childbearing, advantages of good care during pregnancy, danger of unsafe abortion and alternatives to adolescent pregnancy.
- Develop communications programs to transmit useful information about safe/responsible sex, delayed childbearing and school continuation.
- Involve youth in planning, implementing health programs for peers, and preparing materials.
- Adolescents have particular *prevention* needs. The health services system concentrates on curative efforts. Develop medical specialty of adolescent medicine.
- Develop joint efforts with coalitions and networks of NGOs to reach youth.
- Provide improved health care delivery systems that attract, serve and retain adolescent clients free of actual and psychological barriers with integrated health and nutritional services and prevention of risk-taking behaviors. Workers trained to deal with needs of adolescent women are important.

SUMMARY

CERVICAL CANCER IN DEVELOPING COUNTRIES

by J. Sherris, E. Wells, V. Tsu, and A. Bishop

I. GENERAL ISSUES: PROBLEMS AND NEEDS

Cervical cancer is the second most common cancer among women worldwide and the leading cause of death from cancer among women in developing countries. At least 500,000 new cases develop each year; 80 percent of these occur in developing countries. Available data suggest that at least 3.5 million women have terminal cervical cancer in developing countries, and 12 to 20 million have carcinoma in situ (CIS), the most advanced precancerous stage of the disease.

The problem is most severe in East and Middle Africa, the Caribbean, tropical South America, and parts of Asia. About 200,000 women die from the disease each year; if current trends continue, this implies a loss of about 470,000 person-years of life lost in developing countries by the year 2000. As the prevalence of HIV and sexual transmission of infection increases, and as populations increase and age over the coming decades, the number of cases can be expected to increase significantly.

Because cervical cancer develops slowly and has a detectable and treatable precursor condition, it can be prevented by screening and treating at-risk women. Some 40 to 50% of women in developed countries have been screened in the past five years, compared to only 5% in developing countries. The authors' review of cervical cancer control efforts in 25 developing countries confirmed that these efforts have had limited success. Reasons include:

- Limited screening services: in many countries, services are only offered through central or district hospital gynecology or antenatal units and university teaching hospitals.
- Failure of programs to target at-risk populations and limit frequency of screening.
- Inadequate training in how to recognize symptoms and administer Pap smears.
- Inadequate laboratory services, trained personnel, and Pap smear supplies.
- Difficulty in client follow up (e.g., in **Nigeria**, only 60% of women with positive Pap smears could be located).
- Inadequate follow-up diagnostic services (e.g., in **Kenya**, no colposcopy services are available and biopsies are not routinely done).
- Inadequate treatment services (e.g., in **Nigeria**, treatment of invasive disease was delayed up to 9 months).
- High service costs.
- Limited awareness of cervical cancer as a health problem.
- Cultural obstacles to providing services (e.g., women fear pelvic exams or find them unacceptable, especially if not symptomatic, and fear diagnosis).

II. LESSONS LEARNED AND COUNTRY ILLUSTRATIONS

- In many western countries, incidence and mortality have been reduced 60 to 90%, through screening of all sexually active women based on routine Pap smears (every one to three years) and rigorous follow-up and treatment of women with precancerous conditions. In the **United States**, the death rate has fallen more than 70 percent since screening was introduced. In the **Nordic** countries, the largest fall in mortality was associated with widest population coverage, and vice versa.
- It was once commonly thought that mild and moderate dysplasias were precursors to cervical cancer, and most Pap smear classification systems were based on this premise. Data now indicate that most mild-moderate dysplasias regress to normal spontaneously. Therefore, current thinking supports a clinical strategy aimed at detecting and treating severe dysplasia/CIS and monitoring mild and moderate dysplasia.

- Data support the view that the primary causal agent is genital infection with the Human Papilloma Virus (HPV). The commonly accepted risk factors for cervical cancer (including history of STDs and history of multiple sexual partners) are probably indicators of HPV.
- Evidence is mounting that HIV puts a woman at higher risk of HPV and, if she has HPV-linked cervical dysplasia, at higher risk of invasive disease. The risk of invasive cancer is particularly high in areas where HIV-2 is common.
- How such risk factors as high parity, smoking, and steroid contraceptive use interact with HPV infection in the development of cancer remains unclear.
- Studies in **Costa Rica, Chile, Singapore, Taiwan** and other areas confirm that CIS is generally identified between the ages of 35 and 44.
- Data from eight developed countries indicate that the cumulative rate of invasive cervical cancer could be reduced by about 84% by screening women aged 35 to 64 every five years, and 64 percent by screening every 10 years.
- Even under optimal conditions, Pap smears may fail to detect cervical cancer and its precursors 15 to 40 percent of the time.
- Preliminary data from **India** indicate that unaided visual inspection of the cervix may detect about two-thirds of early cancers.
- Researchers in **Italy** evaluated a variation of the unaided visual inspection technique with the aim of identifying precancerous conditions. They concluded that the approach could serve as a "helpful supplement," but that the Pap smear should be viewed as the fundamental approach.
- Early evaluation of aided visual inspection of the cervix using a small magnifying device ("gynoscope") suggests that it may be a low cost alternative for the identification of cervical abnormalities. The approach is currently being evaluated in field trials in **Indonesia**.

III. STRATEGY AND INTERVENTION OPTIONS

It is often argued that screening is not feasible in many developing country settings due to inadequate infrastructure and treatment services for cancerous and precancerous conditions. However, these concerns are based on the implementation of a Western screening model. A large proportion of cervical cancers can be prevented through a much more limited approach.

Screening:

Targeting as many women as possible in the 35-40 age range, when advance precancerous lesions (but not invasive cancer) are most likely to occur. In some countries, such as those with a high incidence of STDs and HIV, screening from age 30-35 may be warranted. Screening can be relatively infrequent (.e.g, every 10 years or once per lifetime where resources are limited).

In many areas, the Pap smear will be the screening method of choice. Many now recommend that endocervical brushes replace cotton-tipped swabs as a means of collecting endocervical cells for Pap smears. While this technology enhances the collection of cells, thereby reducing the need for repeat smears and the cost of screening, it is significantly more expensive. The method of air-drying smears (rather than fixing with commercial spray fixatives or immersion in 95% ethyl alcohol) has been used successfully in one program with considerable cost savings.

In some settings, a less costly, simpler screening method may be necessary. Approaches that are currently being evaluated include unaided visual inspection of untreated cervix to detect early stage cancer and aided visual inspection of acetic-acid treated cervix to detect advanced dysplasia. CIS, using a "gynoscope." Automated Pap screening and cervicography are not appropriate to most developing countries due to cost and/or technical requirements.

Treatment:

Simple, relatively inexpensive treatment approaches for women with advanced dysplasia/CIS, including cryotherapy and/or loop electrode excision procedures LEEP (see paper for details), should be considered. These procedures are generally used in conjunction with colposcopes, which are expensive. The low-magnification "gynoscope" discussed previously may be a feasible alternative. Other excisional methods, such as cone biopsies, must be performed in hospital settings under general anesthesia. Other destructive methods, such as laser therapy, are much more costly.

Treatment and/or pain control therapy for women with invasive disease should be available where feasible. Advanced invasive cervical cancer requires radiotherapy and/or radical hysterectomy for treatment, which require expensive equipment and highly skilled medical staff.

IV. COST-EFFECTIVENESS ISSUES

Cytology-based cervical cancer screening has been identified as a moderately cost-effective intervention compared to other adult health interventions, and a very cost-effective intervention compared to other cancer control efforts, at an estimated average cost of US\$200 per discounted healthy life year gained (DHLY). Cost-effectiveness is highest in regions with the highest incidence, in programs targeting high-risk groups (women over age 35 with a history of STDs) and where cervical screening services are integrated with programs that have ready access to sexually active women in their thirties. Increasing the screening interval from five to ten years would reduce the cost per DHLY to \$130; reducing the screening interval to once in a lifetime would reduce it to \$60 per DHLY.

IV. PRIORITIES: PROGRAM, POLICY AND RESEARCH RECOMMENDATIONS

The authors recommend a three-phased approach to the implementation of screening programs, and emphasize that their recommendations will need to be reevaluated periodically as our understanding of cervical cancer evolves. Low income countries (e.g., Bangladesh, Ghana) may be unlikely to move beyond a Phase I level pending socioeconomic improvements; lower middle income countries (e.g., Dominican Republic, Thailand) may reach Phase II but have difficulty expanding to Phase III; middle to upper-middle income countries (e.g., Brazil, Malaysia) may be expected to achieve Phase II relatively easily and move toward Phase III. In some cases, programs already offer services in excess of those described. It will be important to examine these programs in light of the recommendations that follow and make changes based on a rational use of resources.

As efforts to improve screening are undertaken, adequate treatment services (palliative care, counselling) must be made available. Given the high costs of treatment of advanced disease, this is not recommended as routine practice, especially in low-resource settings.

PHASE I - Research and Pilot Program

- Assess the need for screening services (collect data on the incidence and prevalence of CIS and cervical cancer, including information about risk groups to be served).
- Educate policy-makers about the potential impact on women's health and cost-effective program approaches.
- Implement a cytology-based pilot program in an existing facility likely to serve high risk women. This will require:
 - Training providers in cervical sampling techniques; alternative screening approaches (e.g., visual screening), with cytological follow-up, may be an appropriate way to begin in some settings.
 - Counseling clients about the procedure and the implications of test results.
 - Where the capacity to read Pap smears in-country does not exist, send out of country for analysis.

- Treating all cases of CIS and, where feasible, invasive cancer. Preinvasive conditions should be treated using cryotherapy or LEEP.
- Following up all abnormal cytology reports and treated cases.

PHASE II - Establish a limited screening program

- Based on the results of the pilot program, begin a screening program in a limited area. The program should aim to:
 - Screen women at high risk (e.g., women over age 35, and, possibly, women at risk of STDs and those of high parity)
 - Screen only once; as resources allow, expand to once every 10 years.
 - Integrate into existing health services, beginning with channels that will reach women at high risk, and expand as resources allow.
 - Inform targeted women of the need for and availability of services.
 - Initiate or improve an in-country cytology facility.
 - Centralize laboratory facilities, train and supervise staff, and institute quality assurance measures.

PHASE III - Expand services to women in more areas

- Improve program participation by adding new types of service delivery sites.
- Re-evaluate the recommended screening interval and age at first screening based on effectiveness and resource availability, with the ultimate aim of screening all women every five years, beginning at age 35; the age can gradually be reduced as resources allow.
- Improve the efficiency and accuracy of cytology laboratory services (ensure that a sufficient volume of slides is processed by staff to maintain skills; establish in-country training programs).
- Improve the availability of appropriate diagnostic and treatment services.
- Improve outreach through better IEC.
- Improve information system for service delivery and data collection (development of linked client record systems or women-retained record cards; establishment of cancer registries).

RECOMMENDATIONS FOR ONGOING RESEARCH

- Collect and analyze data on the incidence and prevalence of CIS and cervical cancer.
- Investigate potential cost savings associated with use of simple treatment technologies.
- Evaluate the feasibility and cost-effectiveness of visual screening, combined with cytological follow up, in rural areas.
- Evaluate women's understanding of cervical cancer and prevention strategies.
- Investigate the predictive value of various risk factors in targeting high risk groups.
- Investigate the most appropriate ways to reach women at risk.
- Investigate the link between cervical cancer and HIV, with an emphasis on how high prevalence of HIV affects recommended age at first screening and the screening interval.
- Gather cervical samples for HPV testing to increase knowledge about the role of HPV infection in cervical cancer and precancerous conditions.
- Evaluate the medical establishment's resistance to new screening and treatment approaches.
- Develop and assess cancer registry systems for recording disease incidence and mortality.

REPRODUCTIVE TRACT INFECTIONS¹

Summary

Background

Reproductive tract infections (RTIs) are common diseases with profound health and social consequences for third world women. Women are more susceptible to acquiring infection and are also more likely to experience complications from the primary infection because these infections are often asymptomatic in women and thus go untreated. They may be lower RTIs or upper RTIs. The majority are sexually transmitted and worldwide each year, about 250 million new infections are sexually transmitted with seven major STDs outranking AIDS in both the numbers of people infected and the annual increase in new cases. However, the non-sexually transmitted infections are equally as important. For example, bacterial vaginosis is notable for its potential role in pelvic inflammatory disease, infertility and adverse outcome of pregnancy. Other non-sexually transmitted infections causing RTIs include iatrogenic RTIs due to infection caused by dilation of the cervix, be it by induced abortion, improperly performed intra uterine device (IUD) insertion, unhygienic delivery practices or simply by childbirth. The prevalence of untreated lower RTIs in most developing countries is sufficiently high that procedures such as IUD insertion or events such as childbirth are likely to exacerbate existing infection and facilitate entry and spread of pathogens into the upper reproductive tract.

Sequelae of RTIs

Although post-partum infection and post-abortal infection play important roles, spread of untreated lower RTIs is the major cause of **pelvic inflammatory disease (PID)** with serious consequences for the pregnant woman as well as for the non-pregnant woman. In the pregnant woman, consequences include **adverse pregnancy outcomes** such as fetal wastage (both spontaneous abortion and stillbirth), low birth weight (due to prematurity, intrauterine growth retardation IUGR or both) and congenital infection as well as **ectopic pregnancy**, a potentially life threatening complication. Swedish data report that ectopic pregnancy is 6 to 10 times more common among women with a history of PID compared to those who have never had upper tract infection and in the U.S., ectopic pregnancy is one of the two leading causes of maternal deaths. The situation is worse in resource poor developing countries, where women were not able to receive timely emergency assistance because the ectopic pregnancy was not diagnosed. Ectopic pregnancy can also lead to recurrent ectopic pregnancies or infertility. A study in Finland found the risk of recurrent ectopic pregnancy to be 20% while 15% failed to conceive.

PID is also responsible for **chronic pelvic pain** as well as **recurrent episodes of PID** and data indicate that recurrent PID occurs in 20 to 25% of women following PID with each episode increasing the chances of recurrent infection and complications.

Infertility is yet another tragic and irreversible consequence of infection as a result of PID or due to post-abortal and post-partum infection. In a standardized clinical investigation of infertility by WHO on over 10,000 infertile couples in 25 countries, infection accounted for infertility in 36% of the cases in developed countries, 85% in Africa, 39% in Asia, 44% in Latin America, and 42% in the Eastern Mediterranean region.

RTIs, especially those which cause ulcerative lesions such as syphilis, chancroid and genital herpes are believed to be important factors in the acceleration of heterosexual transmission of the human immunodeficiency virus (HIV) which causes AIDS. As of 1990, 60% of global **HIV infections** have resulted from heterosexual transmission. This mode of transmission is increasing especially in groups with high rates of sexually-transmitted RTIs. AIDS is a systemic disease, not an RTI, but the association between RTIs and HIV is strong

¹ For detailed information, please refer to the full paper "Reproductive Tract Infections" by May T.H. Post.

enough to warrant increased focus on prevention of RTIs in the control of HIV.

Program Options

General principles of STD control at the primary health care level are: (1) to interrupt the transmission of STDs and (2) to prevent the development of complications. To date, most control activities have focussed on prevention of development of complications (secondary prevention), but prevention of transmission of infection (primary prevention) is now receiving increased attention because of the emergence of human immunodeficiency virus (HIV) and AIDS as a major public health problem and the identification of several sexually-transmitted RTIs as risk factors for the spread of HIV.

What Has Been Done

The most important step to improve STD care over the long run is **training health care providers at all levels**. Formal and informal training courses for all health workers including pharmacists, are important. Current issues in STD diagnosis and treatment as well as counseling about condoms to partner notification should be included in all continuing education and in-service training programs. Training should include not only primary health care workers but also traditional birth attendants.

To broaden the basis of STD control activities within the context of general health services, STD programs in some countries are providing services to women in the general population by **integrating STD activities** in MCH clinics, family planning clinics and primary health care clinics--places where women commonly seek health care for other reasons. A project in Zambia demonstrated that it is possible to **implement syphilis detection and management into antenatal care**, thus providing secondary prevention for syphilis during pregnancy and control of congenital syphilis. The services contributed to a decline in syphilis among pregnant women in Lusaka from 13% in 1983, the year before services were introduced, to 8% in 1987. The cost of each prenatal screening in the Zambia study was U.S. \$0.60 (including training, equipment, and health education material) with a cost of \$12 for each case averted.

The crucial role **family planning programs** can play in STD control and prevention as well as in infertility prevention should also be recognized. By counseling and promoting barrier contraceptives at family planning (FP) clinics, family planning programs can help prevent STD transmission--and providing other STD services such as diagnosing and treating STDs also offer significant opportunities for synergistic effects. For example, helping women have healthy babies by preventing or treating the infection is likely to increase women's acceptance of family planning.

Ocular prophylaxis of the newborn is also important. It is also the most feasible operational strategy and the most cost-effective approach to GON prevention. Ocular prophylaxis requires very little training, it is a one-time application and no laboratory backup is required since all newborns will be treated and no testing will be required.

Another option in STD control and treatment is **the syndromic approach**. Most facilities at the primary health care level have little if any laboratory equipment to aid diagnosis. Using the syndromic approach, primary health care providers can now treat STD patients without referring them to STD clinics for laboratory tests. Syndrome-based treatment is already being used successfully in a number of countries.

The cornerstone of STD control is adequate management of STD patients and adequate management depends on **adequate supplies of appropriate antibiotics** and innovative approaches are needed to maintain a constant supply. Drugs recommended in the flowcharts must be on the national essential drug list. For example, in Zimbabwe, national STD experts successfully lobbied for the inclusion of STD drugs in the

country's essential drug list and the drug distribution system was also decentralized to facilitate replenishment of depleted drug stocks. And in Cameroon, an innovative social marketing of antibiotics pilot project was launched in which pharmacies began selling antibiotics in a treatment kit for a STD.

The need for STD education is great. Most people know little about how STDs are transmitted, what their symptoms are or what long-term risks they pose. STD education involves not only informing the public about STDs but also educating them to change their behavior and to promote appropriate health seeking behavior such as condom use and seeking treatment if infected. The emphasis and approach of an STD education program must vary according to the population at greatest risk. Where funding is very limited, education should be directed at core groups.

Interventions targeting core groups are likely to be particularly cost-effective because they may have an amplifying effect. Moses and his colleagues offer an excellent example of the cost-effectiveness of a targeted STD prevention program--in a Nairobi prostitute population, STD diagnosis and treatment, in combination with condom promotion, reduced the mean annual incidence of gonorrhea from 2.85 cases per woman in 1986 to 0.66 cases per woman in 1989 and markedly reduced the incidence of other STDs including HIV infection in the CSWs. It was estimated that the program prevented 6,000 to 10,000 new cases of HIV infection, at approximately US\$8.12 per case prevented.

What More Can Be Done

There is indeed a lot more that can be done and that needs to be done--this paper however, will attempt to discuss only the "highlights" among the many research needs and priorities essential for RTI control programs in Third World settings.

Surveillance. More information is needed on the prevalence of RTIs as well as their antibiotic resistance patterns in women. Surveillance should be conducted not only in the high risk "core" population but in samples representative of the general population of sexually active women (MCH clients, family planning clients). In the latter population, surveillance on incidence/prevalence of certain selected RTIs can be conducted; this data will be useful in monitoring the effectiveness of program interventions.

Simple Rapid Diagnostics. Development of inexpensive, simple diagnostics which are accurate and can be performed in settings with limited resources and quality control are crucial. Technologies that require shipping specimens, specimens that are difficult to obtain, mailing reports or patient re-call are certain to be ineffective in most developing countries.

Female-controlled Prevention Technologies. A very high priority needs to be given to developing and field-testing a variety of products for women to use and control for prevention of pregnancy or RTIs. The products should be inexpensive and designed in a way that women should be able to use them with or without their partner's knowledge and consent. Although the Reality, a vaginal pouch, has been approved by the U.S. Food and Drug Administration and two other female condoms are being tested, continued technology research is essential to develop a wider range of products which are inexpensive and simple to use.

Integrated Services. The need for integrated services cannot be overemphasized. By integrating STD services in prenatal and MCH clinics and/or family planning clinics, women will be able to avoid the social stigma of having to seek treatment at a STD clinic or the need for a follow-up visit to another facility. Conversely, integrating family planning services in STD clinics can also be beneficial. For example, a 1988 survey of 516 consecutive clients at a Baltimore City STD clinic in the U.S. revealed that 63% would be interested in receiving contraceptive services at the STD clinic.

Increased Emphasis on Partner Notification. The control of STDs cannot be achieved merely by treatment of

people presenting at health facilities with signs or symptoms. Partner notification is essential in which the partners of those who are identified and are being treated as having an STD are traced, informed of their probable exposure to infection, and offered medical and counseling services. For gonorrhea and chlamydia specifically, partner notification leads to treatment of asymptomatic infected female partners of men with proven infection, preventing complications in women such as PID, infertility or ectopic inflammation. In developing countries however, partner notification is rarely implemented or emphasized in STD control programs because of sociocultural barriers concerning STDs and sex in general and because of lack of health care providers trained in partner notification.

Behavioral Interventions. Interventions to prevent the transmission of STDs through behavior change (sexual and health seeking behaviors) should be an integral part of any STD control program. Yet, in most developing countries, experience with behavioral interventions is limited and hardly any information is available on their efficacy in different societal contexts. More research is essential: (1) to define predominant norms and values regarding sexuality as well as specific risk behaviors in population subgroups; (2) to identify behavioral interventions that are culture-specific and reflect an understanding of the norms and "motivating" factors in the subgroups of each society and (3) to evaluate different behavioral interventions and their relative effectiveness with different target groups in different societies.

Advocacy, Policy Awareness and International Leadership. Information and data regarding women and RTIs need to be documented, synthesized and disseminated to focus attention of donors, governments and nongovernmental organizations. Projects should include women and STDs in their research and development efforts. Forums must be encouraged to provide a continuing dialogue between women from developing countries and their political representatives, donors and scientists to increase the understanding of the disease burden of RTIs and to identify the interventions that may be successful. Successful control of STDs in women will also require international leadership to encourage commitment at national levels. Increased effort needs to be put into working with host country governments to: (1) establish STD control as a national priority in countries with a high prevalence of STDs and (2) promote endeavors to alter the status of women in society with programs focussing on literacy improvement and economic well-being.

Certain conditions and situations such as low status of women compounded by low education status and limited employment opportunities in the urban labor market, local customs and traditions encouraging males to seek extramarital encounters, inadequate sex education, harmful traditional practices, put women at higher risk of STD/HIV infection. Increased attention need to be directed also on these issues and international leadership will be needed to develop initiatives addressing them.

Typological Strategies

In the most peripheral settings in which neither pelvic examination nor laboratory support are possible, treatment must be based solely on the patient's history and on the prevalence of different types of infection in the community.

In some settings in which a pelvic examination is possible but no laboratory evaluation is available, algorithms based on examination findings are recommended in addition to patient's symptoms and prevalent STDs in the region. In such settings where microscopy is unavailable, simple, inexpensive tests such as the dipstick testing, KOH odor testing and the swab test are also recommended, to improve the accuracy of diagnosis. The Rapid Plasma Reagin test for syphilis diagnosis can also be used in settings where laboratory support is not available.

In settings where pelvic examination is possible and microscopy is available, wet-mount microscopy (microscopy without stain) can differentiate between different types of vaginal discharges permitting treatment based on etiologic diagnosis. Where Gram staining is possible, gonococcal ophthalmia neonatorum

can be diagnosed using pus collected from the conjunctiva. Since culture facilities are usually not available at this level, Gram stains are also used to diagnose gonorrhoea in females although they are not ideal and have a very low predictive value.

In central-level settings, cultures, antibody tests, enzyme-linked immunoassays (ELISA) and other high level tests can be done to further improve diagnostic accuracy.

But in all situations whatever the setting, whatever the strategy used, STD control efforts must be supported by training of health personnel from STD clinical diagnosis to counseling about condoms and partner notification, STD education, provision of appropriate diagnostic tools and availability of effective drugs as well as by initiatives to adjust gender-power relations and attitudes towards women.

NOT FOR
CITATION

Annex 3.6

WOMEN AND HIV/AIDS¹

Summary

Background

According to a November 1991 press release issued by WHO, three quarters of global HIV infections are due to heterosexual transmission. This means women are increasingly being infected and WHO projects that by the year 2000, there will be a cumulative total of 30-40 million HIV infections in men, women and children and that the infection rate among women will be equal to that of men. Best estimates of current infection (as of January 1992) are that worldwide, between ten and twelve million are already infected with HIV, of whom over four million are women, and millions more continue to be vulnerable. Women with sexually acquired HIV infection are younger at the time they develop AIDS than are men, reflecting the typical age-gender distribution of sexually transmitted infections. And as with other sexually transmitted diseases (STDs), the risk per exposure for a woman acquiring the infection from her infected male partner is greater than the risk for a man acquiring it from an infected female partner.

The implications of HIV/AIDS on women takes many forms not limited to the increased mortality among women of reproductive age. Women who are unaware or uninformed of the risks presented by infection with HIV or other STDs or who do not have access to care and prevention, unintentionally contribute to a reversal of the precious gains already made in child survival. Many women will be unable to have children and many more will give birth to infants who will probably be infected (approximately 30%) and who will probably die before their fifth birthday. Worldwide, approximately one in every four babies born to infected mothers is itself infected and it is believed that by the year 2000, an estimated 10 million infants will have been born with HIV. Furthermore, because women already carry a heavy workload, both in the workforce or in the home as mothers, home makers and care-givers, the added burden of caring for AIDS-infected family members, plus the fact that many women can themselves become ill and die creating a new generation of orphans, is placing established social structures under stress and social disruption.

Certain factors increase the likelihood of heterosexual transmission for women. Receptive sexual partners, whether homosexual (receptive anal intercourse) or heterosexual (vaginal intercourse), are at highest risk of acquiring HIV from an infected partner. This means that an uninfected woman has a greater chance of acquiring HIV from an infected man than does an uninfected man from an infected woman. Both the susceptibility to infection and the infectiousness of an infected individual are increased several fold by the presence of other STDs, particularly those associated with genital ulceration. However, recent studies in Africa are suggesting that non-ulcerative STDs such as gonorrhea may also enhance susceptibility to HIV infection. This could have profound implications for women, since these non ulcerative STDs are often asymptomatic in women and are thus unrecognized. They are also far more common than genital ulcer disease (GUD). And, because of the social stigma attached to STDs, women are less likely to seek medical care and more likely to harbor the infection for longer periods of time. Gender mechanisms also have an important impact on women's vulnerability. Women are especially vulnerable to HIV infection because of their generally subordinate role in family and society. Cultural and social values tend to lock women into dependant positions, leaving women without bargaining power in their relationship with men from which they seek support in order to attain status as wives and mothers as well as economic support. While this lower status differs in detail and in degree from country to country, it restricts women's ability to protect themselves from sexual transmission of HIV because they often have little autonomy and little say about sexual matters. And in areas where male migration is common and female and children are left behind, the economic support from the migrant husband is oftentimes not enough, necessitating women to use sexual favors as a means of obtaining economic or social support. The problem is further compounded by women's inferior legal rights and lesser access to health care,

¹ For detailed information, please refer to the full paper "Women and HIV/AIDS" by May T.H. Post.

education and social services.

Less attention has also been paid to the fact that once infected, women are affected by conditions that predisposes them to shorter incubation periods and shorter survival times. Pregnancy, prolonged breastfeeding, all play roles in progression of HIV in women.

HIV and Pregnancy

The decision regarding whether or not to bear children is highly complex. The presence of HIV infection is likely to complicate this decision even further. Infected women should be fully informed regarding the health risks of pregnancy in the presence of HIV and should also have access to a full range of effective methods of contraception to prevent pregnancy.

HIV-infected women or women at high risk who do become pregnant should be advised about the risks of having an infected child. In addition, they and their partners should be offered voluntary testing done with free and informed consent and accompanied by pre- and post-test counseling and a guarantee of confidentiality.

And if a woman decides not to continue the pregnancy, she should have access to safe abortion services where legal but the final decision must be made by the woman herself. In particular, where termination of pregnancy is not against the law, they should receive adequate counseling and support to enable them to make an informed choice. Thus, there is a need for strengthening the training of health care providers at all levels to enable them to provide on-going support, counseling and care.

Program Options

Preventive strategies for HIV/AIDS are relatively new. There is no standard package of best practices for women, no standard blueprint for how countries should respond to the epidemic. Given the scope of the problem, a diverse menu of potential interventions should and must be used.

What Has Been Done

Prevention through encouragement and promotion of safer sexual practices by men and women is one strategy that has been widely implemented. Promotion of safer sexual practices has been done through: (1) AIDS education and information (through mass media programs, HIV-infected educators, through theatre, through the work place); (2) condom promotion; and (3) increasing condom availability (through increasing distribution via new outlets, community-based distribution, decreasing costs and social marketing of condoms).

Targeted interventions for those at increased risk are also important strategies. Targeted interventions comprise programs for commercial sex workers, programs for intravenous drug users and programs for young adolescents. *Interventions for CSWs* should include condoms and counseling, peer education programs and STD treatment and control programs as well as programs reaching out to clients. Peer education is a popular targeted approach as well as a major strategy. And as proven by the project in Cameroon, when CSWs are involved in a project from the beginning (e.g. as peer educators, project staff) it increases their self-worth in the community which contributed greatly to the success of the project. The project began in 1989 and as of 1991, 120 peer educators have been trained, 2000 CSWs and 2000 patients attending STD clinics have been reached by the peer educators and the educators have been responsible for a remarkable 19% of the nearly 6 million condoms sold since the beginning of the project. Interviews with CSWs everywhere have always brought up the problem of "client resistance" to condoms; therefore, interventions targeted at clients should not be overlooked.

In countries like Thailand, many women are becoming infected by their husbands or sexual partners who are intravenous drug users (IVDUs). Thus, *programs for IVDUs* are important, not only to protect the drug users but to protect the women who are their wives or sexual partners and the children they will bear. Programs for IVDUs use several approaches which can be generally categorized as: (1) drug treatment and

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detoxification programs; (2) needle and syringe exchange programs; (3) street outreach programs and (4) drug users' networks.

Programs for young adolescents are also crucial. Education programs for young people need to make safer behavior attractive. Skills training--such as teaching girls how to say no--is very important. Skills training allows a young adolescent to practice ways to say no before an uncomfortable situation arises. School programs, programs for out-of-school youth and peer education programs are examples of various strategies being used to educate and inform young adolescents about HIV/AIDS.

STD control should be a vital component of any HIV/AIDS prevention program because of the role played by STDs in HIV transmission, and current STD programs at general health facilities or at designated STD clinics should be strengthened. Furthermore STD control programs should be integrated into family planning or MCH services to screen asymptomatic infections in women.

The theme of the 1992 World AIDS Day was "AIDS: A Community Commitment" and it has been proven many times that **community mobilization and commitment** can make a real difference. Programs are strengthened by the support of the community and people are more likely to change behaviors when they are encouraged to do so from a member of their own group. These were the lessons learned from a very successful community-based program implemented in Bulawayo, Zimbabwe.

Prevention of perinatal transmission of HIV can be achieved through: (1) preventing HIV infection in women of reproductive age and (2) making available a wide range of contraception to HIV-infected women, to avoid pregnancy. And, HIV-infected women who voluntarily decide to terminate their pregnancies in countries where this option is legal and safe will also avoid mother-to-fetus/infant transmission. But, in order for women to make such choices, they need to know their HIV status. In regions where HIV prevalence is high, the best policy would be to do **voluntary HIV testing and counseling** of all reproductive-age women and their partners, or at the least, pregnant women and their partners. Voluntary HIV testing with counseling has been shown to promote effective risk reduction in some high risk groups in the United States. A study carried out in Kigali, Rwanda, also showed that confidential HIV testing and counseling was associated with increased use of condoms and reduced rates of gonorrhea and HIV in urban Rwandan women. 26 percent of the women in the study brought in their male partners for HIV testing and counseling--and when compared with couples in whom only the woman was tested, couples in whom both partners were tested were twice as likely to use condoms. This study also emphasizes the point that targeting men is fundamental in AIDS prevention programs, especially in many developing countries, where women are not in a position, for cultural and economic reasons, to insist on condom use.

In addition, in areas where blood for transfusions may be infected with HIV and where blood screening is not possible, **strategies to reduce the need for blood transfusions** during pregnancy or at the time of delivery such as preventing and combatting anemia in pregnancy, eliminating unnecessary transfusions, encouraging use of plasma expanders which are safer, are especially important to reduce the risk of HIV infection in women and its subsequent perinatal transmission.

When transfusions are absolutely necessary, it is imperative to **provide a screened, safe blood supply**. In areas where blood banks and laboratories exist, screening of donated blood can be added for a cost of about 5% of the overall cost of transfused blood. But in many parts of the developing world where no blood banks exist, transfusions are often done on an emergency basis directly from donor to recipient. For such circumstances, rapid test strategies for HIV are urgently needed. An example is the HIV dipstick, developed by the Program for Appropriate Technology for Health.

To monitor the spread of HIV infection, **sentinel surveillance programs** need to be established. These programs are less expensive to conduct than surveillance programs among the general population. Sentinel groups may be chosen because they are thought to be representative of the general population (women attending prenatal clinics) or because they are considered to be at higher risk (CSWs, STD clinic attenders). In areas of

high prevalence, both high and low risk sentinel groups should be monitored. In areas of low prevalence, monitoring high risk sentinel groups will be a cost-effective way of tracking the incidence of HIV infection.

The important role played by **support networks** in the HIV pandemic cannot be overemphasized. One example is the Society for Women and AIDS in Africa (SWAA). Activities of SWAA branches include: (1) establishment of women's support centers; (2) counseling and assistance for sero-positive women; (3) youth-targeted activities; (4) training of IEC workers on women and AIDS issues and (5) needs assessments and care for AIDS orphans. Members of SWAA are now recognized as authorities on women and AIDS issues, not only at the national level but at the international level also.

What More Can Be Done

Women with HIV infection are generally without financial resources, education, community or political base and in some countries, they are intravenous drug-users or have partners who are drug users. The majority also reside in developing countries with medical and social stigmata, restricted access to information and care, and suboptimal health care. There is a lot more that needs to be done to develop HIV/AIDS prevention programs focusing on women. This section however, will attempt to discuss only those issues emerging as key concerns relating to women and HIV/AIDS in Third World settings.

Using the Right Communication Channels. Women need information about HIV/AIDS and reproduction. But, compared with men, women know less about AIDS, learn about it later, and are less likely to hear about it through the mass media. According to surveys women often hear about AIDS from other people, whereas men get more information from radio and newspapers. Experience has shown that, although labor-intensive and time consuming, the best way to reach women is through interpersonal channels of communication: personal contacts, either on a one-to-one basis or via group work involving other women. A good example of group work is the SWAA. Women can also be approached at places where they usually meet such as clinics, schools, market squares and in fields for agriculture activities. Other useful communication channels include grass roots organizations such as market women associations, women's media associations, women's clubs, church groups, etc. These organizations should be recognized, encouraged and AIDS prevention programs should make full use of them.

Focusing on Women as Recipients of Infection. To date, research has targeted mainly the role of women as transmitters rather than as recipients of infection. The focus of research has primarily been on CSWs and transmission from them to their male partners and on pregnant women and transmission from them to their offspring. The second decade of HIV/AIDS research work need to shift focus from the concept of women as transmitters to women as recipients of infection. The epidemic among women should no longer be relegated only to women presumed to be at "high risk". Research should include a wider range of women from the general population--women who may not perceive risk in their personal situations but who may unknowingly be at risk--taking into account the many complex factors that determine women's sexual and health behavior and the range of services and information required to empower women to protect and maintain their health.

Increased Emphasis on Gender Relations. In most societies, there is a significant power differential between men and women, both in the society at large and within the family. The social status of women in a society and the predominant gender power relations influence women's vulnerability to HIV/AIDS and STDs in important ways. The importance of gender relations should be recognized and initiatives to adjust gender power relations and attitudes towards women need to be incorporated into HIV/AIDS policies and programs. In this context, two strategies are increasingly being recognized as essential, if programs for HIV/AIDS are to be most effective in the long run. The first strategy is raising the status of women and the second is changing lifelong attitudes to men's and women's traditional gender roles. These strategies are inter-linked and are complementary to each other, further magnifying their synergistic impact.

Raising women's status would involve focusing on women's education and vocational training to

enhance women's economic independence. It would also entail reducing economic independence through measures such as increased labor force participation and access to income, land and credit. Empowerment strategies already proven effective will need to be identified and applied in the context of HIV/AIDS and further research to raise women's status and promote empowerment of women should continue to be a high priority.

Changing lifelong attitudes to traditional gender roles will also be essential in the fight against the HIV pandemic. Men will need to be intellectually and emotionally released from the cultural and social entrapments that require women to be submissive. They will need to see the advantages to themselves and their offspring in a new relationship with women. Starting at home and continuing through formal school programs or public education programs, attention should be focused on boys and girls and men and women simultaneously, to initiate a move towards greater gender sensitivity, to recognize a new perspective that seeks to enhance rather than to overpower the other.

Technology Research. Technology research must continue to be a high priority. Research to identify or develop female-controlled preventive technology such as female condoms, vaginal virucides is crucial. The development of vaccines as well as simple, rapid inexpensive HIV diagnostics are also high priorities. HIV diagnostics serve three purposes: to ensure a safe blood supply for transfusions, to diagnose HIV infection in adults, and for epidemiological surveillance. Affordable HIV testing should be easily available, if requested, to all women of reproductive age, so that they can receive care and make informed choices based on their HIV status.

Stronger Advocacy. Women need stronger advocacy in the battle against HIV/AIDS. To achieve this, networks of women's organizations, non-governmental organizations, national AIDS committees already established as women's health advocates and involved in women's health care need to be identified and their activities supported and strengthened--through funding, supporting international conferences and regional seminars, and through provision of information.

Health care and Support. In addition to prevention, initiatives to provide health care and support to AIDS patients are also critical. Humane and dignified care of AIDS patients is expensive. The harsh reality is that antivirals or antibiotic therapies for AIDS-related opportunistic infections are not going to be readily available in developing countries. Nevertheless, these conditions can no longer be ignored. A feasible solution identified has been the establishment of community care systems: neighborhood associations, women's groups, professional associations, unions--some with more outreach, some with stronger links to hospitals, some from the public sector, some delivered by NGOs--from all sectors of society, from all walks of life *sharing* the responsibility and the burden of care. Different models of community care will be needed for different communities and international leadership and assistance is essential to help countries assess the needs and managerial capacity of their health care systems and community care systems and to identify and develop affordable, relevant approaches across the care continuum from hospital to home not only to deal with the influx of HIV-related cases but to provide care and support for the very young and elderly left behind.

Conclusion

HIV/AIDS necessitates the involvement of both men and women in partnership against the further spread of the virus. Men and women share both the burden of AIDS and the responsibility for prevention. HIV/AIDS is not purely a "medical" and "health" issue that can be influenced by "medical" and "educational" interventions alone. It requires a multi-sectoral collaborative approach across various government departments and ministries, the private sector, different organizations as well as the community. An effective response to the epidemic will need a co-ordinated effort and a deeper understanding of the social, cultural and behavioral issues underlying the continued spread of infection.

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SUMMARY
**WOMEN'S ACCESS TO QUALITY HEALTH CARE SERVICES AND
EMPOWERMENT TO PROMOTE THEIR OWN HEALTH**

by Jill Gay

I. GENERAL ISSUES: PROBLEMS AND NEEDS

Women have greater need for health services than men because of their reproductive role, and less access to quality health services because of gender discrimination. Women's health needs are conditioned by:

- Biological factors – women's reproductive systems make them susceptible to a variety of medical conditions and diseases (regardless of whether they become pregnant or not); childbearing places women at risk of serious, life-threatening complications.
- Socio-economic factors – Women constitute a disproportionate share of the world's poor, and are therefore more vulnerable to health problems related to poverty (especially nutritional deficiencies). Gender discrimination increases women's risk of health problems through a variety of mechanisms (unequal access to food, income and other resources; heavy workloads; and unequal access to education, credit, training, and other services). For example:
 - In some regions (selected countries in Asia and the Near East) women are more likely to suffer from nutritional deficiencies (iron-deficiency anemia, protein-energy deficiency, iodine deficiency) than men.
 - In one 4-country study, women reported experiencing more sickness and disability and at an earlier age than men.

Women are generally less likely to make use of available health services; for example, population-based studies indicate that women are just as likely as men to be infected with malaria, but six times as many men as women attended malaria clinics. Women's utilization of health services is limited by three factors:

- 1) **Access:** Social, economic and physical factors limit women's access. These include: workload (which limits the amount of time women have to spend seeking out health care), poverty (which limits women's ability to pay the costs associated with health care, especially high-technology care), and physical distance from health facilities/lack of access to transport.
- 2) **Quality of services:** Inadequate infrastructure, inadequate numbers of personnel, and inadequate training all contribute to poor quality services. Maternal health services are inadequate; other reproductive health issues are neglected (infertility, STDs, adolescent health, female circumcision); and most health systems ignore women's non-reproductive health problems and needs (e.g., occupational health, violence). Aspects of the care-giving process also limit utilization; poor provider-client relationships discourage women from seeking health care. Studies in **Bangladesh, Jamaica, Peru, and Bolivia** found that women's perceptions of the quality of available health services had a major influence on their use of those services.
- 3) **Empowerment/women's control:** Women's lack of education, and their poor access to sources of information, is directly linked to their poor utilization of/access to services. Cultural factors often influence women's ability to make and act on decisions with regard to their health (and their use of health services).

II. LESSONS LEARNED: COUNTRY ILLUSTRATIONS

There have been examples on a small scale (none are national in scope) of programs that:

- Increase access to maternal care

- Ensure access regardless of women's ability to pay
- Address women's health needs comprehensively within existing service structures
- Target girls and other hard-to-reach groups
- Address quality of care issues (privacy, service hours, proximity, integration/acceptance of traditional beliefs and practices, respects and supportive treatment by providers)
- Train women providers
- Motivate "significant others/influentials" (husbands, mothers-in-law, etc.) concerning the need for services
- Include IEC/outreach by women's groups.

Experience in the family planning field has shown that it is cost-effective to focus on providing good quality care to a small number of clients, which keeps continuation rates high.

COUNTRY EXAMPLES OF SUCCESSFUL INTERVENTIONS:

- The **Bangladesh Women's Health Coalition** has been able to provide high-quality reproductive health services at per capita cost lower than that of the national family planning program. They have achieved this by using well-trained paramedical personnel rather than physicians for selected services (IUD insertions, pelvic exams, menstrual regulation). They provide integrated services (including gynecological exams, referrals for surgical contraception, prenatal care, treatment of childhood diseases, and immunization). BWHC has also invested in ensuring that the environment of their clinics is welcoming (keeping them clean, ensuring privacy), steps which are highly valued by their clients.
- The Country Women's Association of **Nigeria** uses a traditional credit system to ensure that its members receive immediate care at referral facilities.
- Training in inter-personal relations/counselling for family planning nurses in **Nigeria** led to a substantial increase in client satisfaction, and significantly increased the percentage of women who returned for follow-up visits.
- The Matlab program in **Bangladesh** reduced maternal mortality by 68% in 3 years by posting midwives in rural outposts and assigning them the responsibility for attending home deliveries, detecting and managing obstetric complications, and/or referring patients to appropriate facilities.
- A project in **Ethiopia** which integrated maternal and child health services "greatly" increased attendance by women.
- In **Peru**, a women's group designed and produced health education materials using participatory techniques; use of family planning increased by 50-100% in various sites. Other topics covered in subsequent publications included adolescent health, violence, sexual abuse, and community organization.

III. STRATEGY AND INTERVENTION OPTIONS

Improving the quality of care requires that:

- **Standards** of care be established;
- **Training** ensure that providers can meet these standards; and
- **Monitoring** be carried out periodically to ensure that the standards are being met.

A framework to improve women's access to quality services should address the following issues:

Access to services: In order to ensure that the maximum number of women are able to benefit from health services, the following factors must hold:

- Women understand the full range of services available to them through the health system;

- Women enter the health care system at the level most convenient and appropriate to them, i.e. the primary level if possible;
- Protocols for treatment and referral exist and are followed at each level of the system;
- Services are integrated so that women are able to use a variety of services (antenatal care, treatment of STDs, etc.) during a single visit;
- Administrative and logistical factors (for example, registration, overcrowding) are not obstacles to the timely delivery of high quality care;
- Travel time and costs do not prevent women from using services (e.g., emergency obstetric care should be no more than 3 hours away);
- Other costs (especially user fees) do not prevent women from using essential services.

Quality of services: Providing good quality health services for women and girls requires attention to the following factors:

- Provider competence, which includes
 - Technical ability — accurate knowledge about the disease, problem, or condition; technical proficiency in providing safe and appropriate clinical treatment; knowledge of procedures for referring cases which cannot adequately be managed;
 - Inter-personal relations — allowing clients to ask questions and express their concerns and preferences for treatment; providing full, accurate and understandable answers to these questions; treating clients with respect and avoid moral judgments; ensuring privacy and confidentiality.
- Supplies and equipment: [Various checklists are available, including one from PAHO for MCH, one from WHO for "essential obstetric functions at first referral level".]
 - Supplies and equipment corresponding to the level of care provided at each type of facility need to be provided, and in quantities sufficient to meet needs;
 - Systems for resupply, inventory control, and maintenance need to be in place.
- Information to clients/patients, which includes
 - An explanation of the diagnosis, full information on the disease or condition and the danger signals which require immediate medical attention;
 - Information, where medically appropriate and available, on treatment options;
 - Information on contraindications to and side-effects of all medications and drugs.
- Integrated care, which involves providing as many aspects of primary health care as is feasible and effective at whatever point the woman interacts with the health service infrastructure;
- Follow-up and continuity, which includes
 - Information on when to return, with a specific follow-up appointment when possible;
 - Information on other locations where services and medications can be obtained;
 - Home visits or other outreach by community-level workers (where possible and appropriate).

IV. PRIORITIES: PROGRAM AND POLICY INTERVENTIONS

Recommendations concerning access to care:

- Costs should be reduced; services should be provided free of charge or subsidized
- Physical accessibility should be improved through transport (to bring women to services) or through approaches such as maternity waiting homes, mobile services, or home-based care (to bring the services to women)
- Infrastructure needs to be improved through investments in equipment, building new facilities, and training staff
- Services should be integrated in order to decrease waiting time and enable women to meet all their (and their children's) health needs efficiently

Recommendations concerning quality of care:

- Train female health care providers
- Post trained health workers at the community level
- Re-orient training of health workers to include gender issues, and to be more woman-centered (i.e., include information on women's perceptions of health issues and problems)
- Train health care providers in inter-personal relations, counselling and communication
- Integrate care and provide comprehensive sexual and reproductive health services, including abortion, at appropriate health facilities
- Improve targeting: look specifically at the needs of girl and women within the framework of primary health care
- Improve supplies and equipment
- Arrange for privacy at health facilities, both for examinations/treatment and for counselling and education

Recommendations for empowerment of women:

- Carry out IEC/health education for women and "significant others/influentials"
- Involve women's groups in health education and in service programs
- Involve women's groups in advocacy with policy-makers, and with monitoring the provision of services
- Conduct IEC/health education to help women recognize and articulate their own health needs
- Increase the number of women involved in decision-making positions

CONTROLLING UNDERNUTRITION IN WOMEN

Background

There are 500 million women in the world who are stunted. Short stature usually occurs due to chronically low energy intakes during two important growth spurts--birth to three years of age and during adolescence. Short stature is associated with difficulty in giving birth (due to cephalo-pelvic disproportion). Inadequate intakes are associated with low birth weight and because maternal size impedes fetal growth during late pregnancy, short stature is also associated with low birth weight.

It is well established that healthy young children grow at similar rates. While there is individual variation within ethnic groups, there seems to be little variation in growth potential among ethnic groups at this early age. If stunting occurs before age three, it is difficult to reverse it later even with supplementation. Because of this, preventing impaired, early growth is an important intervention. This means that ensuring adequate food during early childhood will help girls maximize their genetic potential.

It is also important to assure that girls receive proper nutrition during adolescence because linear growth is not complete until age 18 and peak bone mass not achieved until age 25. In addition, the birth canal reaches its maximum size 2-3 years after linear growth is completed. Women who have children during adolescence bear a double burden of growth and pregnancy demands and are at particularly high nutritional risk.

That women gain the proper amount of weight during pregnancy is an important factor in ensuring good birth outcomes. Women with low prepregnancy weights need to gain adequate weight during pregnancy to lower the risk of having full-term babies of low birthweight (intra-uterine growth retardation).

Key Problems

Females of all ages need adequate food in order to meet high energy demands during growth, pregnancy, lactation, and the hard work that women in many developing countries are subjected to. In many parts of the world there is a distinct bias against females that is manifested in the unequal allocation of food at the household level, in breastfeeding and weaning practices, and the utilization of health services. In addition, pregnant women sometimes intentionally eat less for fear of having large babies and difficult deliveries. Food taboos often restrict women from consuming nutritious, high-energy foods during pregnancy and lactation when they need it most.

Due to tradition or because they are restricted in their movement, females do not receive their share of other amenities such as bedding, access to sanitary facilities, income, land, and social services. Girls miss opportunities for school because they are kept at home to care for younger siblings. Even though women are engaged in the cash economy, it is often their husbands who receive their income. There is a growing body of evidence that income controlled by women has a greater nutritional impact on the family than that controlled by men.

Women in developing countries often marry early and have many, closely-spaced pregnancies. This contributes to nutritional depletion because they do not have the time to recuperate from the nutritional demands of pregnancy and lactation. Iron and fat stores may decrease with increasing parity under these conditions.

Strategy and Intervention Options

Nutritional assessment can be used to identify those malnourished women most at risk for further nutritional depletion, complications during delivery and having babies of low birth weight. Ideally, this should begin as early as possible so that women don't enter pregnancy at a disadvantage. Programs to improve the nutritional status of adolescents, particularly those that delay pregnancy, such as family planning and improved school enrollment, are needed.

Food supplementation of pregnant and lactating women is an important intervention in controlling undernutrition. In Guatemala a longitudinal study on food supplementation found that women who were supplemented with a high protein and calorie drink during two consecutive pregnancies (about 180 kcal/day) and the intervening lactation period (245 kcal/day) had a 230 to 300 gram increase in the birthweight of their next child. In Gambia supplementing pregnant women with 431 kcal/day increased the average birthweight by 224 grams. In Nigeria, a trial using iron, folic acid and anti-malarial drugs found that primigravida teenage girls showed benefits in maternal and fetal growth.

If the resources for giving women extra food are not available, emphasis should be placed on improving the status of women through income generating programs, particularly in agriculture where women play a major role, educating men and women to improve intra-household food allocation and dietary habits of women, delaying pregnancy to beyond the teenage years, increasing the birth interval, decreasing the number of pregnancies, and decreasing energy expenditure through labor-saving technologies. Improving nutrition habits through social marketing efforts should be a priority.

Policy and program recommendations

Setting A: In this case there is undernutrition for females of all ages but the health system is unable to deliver adequate health services. Programs should be developed in other sectors (agriculture, education, social welfare, etc.) to give women more earning power and control over income earned. Ways to decrease the work load of women through labor-saving technologies can help reduce energy requirements for women. Mass media efforts to change intra-household allocation and consumption of food of both men and women should be developed.

Setting B: In this case there is undernutrition for females of all ages, but the health system is able to deliver adequate health services to communities. Growth monitoring and promotion programs to combat malnutrition in children under three years should be instituted. Food supplementation of children may be part of the program but should not take the majority of program resources and should be diverted through sectors other than the health sector. Targeting food to growth faltering children will increase the cost-effectiveness of supplementation. To ensure that girls receive adequate amounts of food, a strong educational component should be developed to overcome gender biases. A program for physical outreach to assure adequate coverage of girls should be devised.

Identifying underweight women during pregnancy can help target vulnerable women. These women should be encouraged to eat extra calories during their pregnancy to maximize weight gain. Supplementing pregnant and lactating women should be an intervention where resources are available. Developing programs to help women become self-sufficient in food or income should be a priority. Where it is not possible for women to eat extra food during pregnancy, concerted action should be taken to improve the nutritional status of girls during adolescence to increase prepregnancy weight. School-enrollment and family planning programs to reduce maternal depletion by delaying marriage and pregnancy in girls should be considered. Mass media campaigns that address malnutrition in females should be developed.

Box A: Controlling Undernutrition in Women

Setting	Action	By
A: Weak health infrastructure	Strengthen strategies for women within health system 7	Identify undernourished women through all possible routes (prenatal care, immunization programs for children, etc.) Emphasis on preventative care
	Address undernutrition in women through other sectors (increase access to resources, decrease energy expenditure, maternal depletion)	Increase access of females to education, income, family planning services, labor-saving technologies, agriculture extension, mass media campaigns aimed at men and women to increase status
B: Adequate health infrastructure	Increase access of poor women to health services	Address cost, location, approach of the health system
	Monitoring women for undernutrition	Using simple screening for height in adolescence if possible during pregnancy
	Supplementing undernourished girls before pregnancy and women during pregnancy	Food supplements should be diverted through sectors other than the health sector
	Creating special programs to improve the nutritional status of adolescents	Through health, education, agriculture, etc. Use mass media to reinforce educational messages

CONTROLLING IRON DEFICIENCY IN WOMEN

Background

Iron deficiency anemia (IDA) is the most common nutritional deficiency affecting women. Over 500 million women in developing countries are anemic due to iron deficiency. Caused by inadequate intakes of biologically available iron, excessive iron loss due to parasitic infections and menstruation, or elevated needs (pregnancy and rapid growth).

IDA causes fatigue, seriously impedes capacity to work and learn, impairs resistance to disease, negatively affects reproduction, and increases mortality due to hemorrhage from abortion, labor and delivery. The ACC/SCN estimates that 50% of maternal deaths in developing countries are associated with and 20% are caused directly by iron deficiency.

Key Programmatic Problems

Despite the serious consequences of IDA and the low cost of delivering iron supplements (\$2-4 per person per year¹), little has been done to control this deficiency. Although most countries claim to distribute iron pills through MCH programs, there is little documentation to show that these efforts have had an impact. It is assumed that program failure results from women refusing to take iron pills. In fact, patient acceptance is probably less of a problem than the supply of pharmaceuticals and quality of the iron tablets.

Supplies are inadequate because Ministries of Health underestimate the number of women who need the pills, transportation bottlenecks impede the delivery of pills to the clinic level where they are needed, pills are of poor quality due to inadequate storage facilities, and health workers are not committed to distributing and reordering supplements.

Strategy and Intervention Options

It is recommended that all pregnant women receive iron supplements in virtually every developing country and in most developed countries. To do this, existing iron supplementation programs must be strengthened by ensuring that pills are available at all levels in the health system (hospital, district, community health center, etc.). To improve the quality of iron pills, storage facilities are needed in the context of national iron supplementation programs. Quality can also be enhanced through changing the color, coating, and packaging of iron pills. Health workers need to be well informed about the importance of giving iron to pregnant women and trained to improve their counselling techniques.

Programs in Thailand and Indonesia have found that women who were counselled that side effects would subside continued to take their iron supplements. High levels of motivation of health care workers and pregnant women in Burma and Thailand were responsible for high levels of compliance in supplementation programs there.

Iron supplements will address only iron deficiency anemia, not iron deficiency itself. Consequently, iron deficiency has to be addressed more broadly through long-term approaches such as iron fortification of food consumed by pregnant and non-pregnant women, adolescent girls, and small children.

Policy and Program Recommendations

Ways to control iron deficiency anemia may differ according to the health infrastructure strength and economy in developing countries.

¹These costs are for one year of protection (includes transportation and delivery)

Setting A: In this setting the health infrastructure is weak and probably not able to delivery one more service effectively. If there is accessibility to processed food, fortification may over-ride the need for a strong health infrastructure. Criteria for selecting a food for fortification are: the food must be consumed in adequate amounts by most women in the country; supervision of fortification must be a possibility; it must be stable under extreme conditions likely to be encountered in storage and distribution; and it must not interfere with the utilization of iron and iron must not interfere with the food (shelf life, flavor, color, texture or cooking properties). If food markets are weak, targeted food supplements should be fortified with iron. Mass media campaigns to create demand for the fortified food should be developed.

Setting B: In this setting the health infrastructure is able to deliver adequate health services to the community level. Iron supplementation programs exist but are weak and have never been evaluated for impact. Diets consumed in the country contains inadequate, unabsorbable amounts of iron. Under this scenario commitment should be created at each level of government to ensure that supplies of iron pills are available for pregnant women attending hospitals and health centers. Health care workers should be well informed about the importance of taking iron and how to properly counsel women about the importance of taking iron supplements. Health workers should reassure women that side effects from iron are not serious and will subside over time. Health workers should also provide educational aids to help remind women to take pills, give appointment reminders so they will return for refills, and improve access to health centers by reducing waiting time and bringing treatment as close to the community as possible. Utilizing the private sector (traditional medicine network, non-governmental organizations, etc.) to deliver iron supplements can increase coverage. Monitoring systems should be instituted to assess impact and reevaluate activities iron status does not improve.

Setting C: In this setting the health infrastructure is able to deliver adequate health services and the food system contains foods that are high in iron of good quality and easily accessible to vulnerable groups. In this case, existing iron supplementation programs should be strengthen using the strategies under B. To ensure better iron status of adolescent girls and women over the course of their lives, they should be counseled to increase their intakes of iron from food.

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Women's Health Beyond Reproductive Age

Mary E-Ming Young, MD, DrPH
May 11, 1993

WOMEN'S HEALTH BEYOND REPRODUCTIVE AGE

Summary

Background

Health problems of older women will become an increasingly important issue in developing countries partially because of the sheer increase in absolute numbers. Today, two out of three of the world's 469 million women older than 50 already reside in developing countries. By 2020 three out of four will reside in developing countries, an absolute increase of 408 million.

Older women constitute a distinct population that requires interventions very different from those of younger women. To date, most of the emphasis has been on maternity care. But health problems of women are not homogeneous and cannot be all addressed through the traditional maternal and child health services. It is imperative to keep in mind the heterogeneity of developing countries.

The pattern of the health problems older women face reflects to a large extent the level of development of their region and country. A woman's well-being is a result of all her previous experiences, including factors such as urban or rural residence, marital status, number of children, education, income, and nutrition. Furthermore work has a tremendous influence on women's physical and mental health. Indeed, occupational health problems are emerging as a result of the increased number of women in urban industrial jobs.

This report confines the discussion of women's health to the major causes of disease burden, even though this is a narrow description of women's well-being. It presents possible policy directions and programs for prevention of mortality and morbidity among women older than 50 according to the typology of the country in which they reside.

Key Problems

The main diseases affecting women older than 50 in developing countries are predominantly chronic diseases such as cardiovascular and cerebrovascular diseases, cancer, injuries, and mental health problems and to a substantial extent in low-income developing countries, infectious and parasitic diseases. The World Development Report 1993, estimates that cardiovascular (including cerebrovascular) diseases accounted for 38.9 million disability-adjusted life-years lost (DALYs); cancer, 14.4 million; infectious and parasitic diseases; 10.2 million; neuro-psychiatric diseases, 7.4 million; digestive disorders, 5.1 million; and injuries, 4.7 million. Loss of visual acuity and hearing, osteoporosis, malnutrition, and anemia also contribute to substantial morbidity. In some developing countries, diabetes is becoming a leading cause of morbidity among the older population.

Strategy and Intervention Options

Many developing countries have started to deal with the needs of the older people, even though a comprehensive strategy is not yet widely implemented by most governments. A lesson learned from countries that are dealing with the needs of the older people, is to promote community participation and to increase women's capacity for self help. For example, HelpAge India, has emphasized educating and recruiting young people and children to work with older people and to take a responsible part in fund-raising programs. This concept has had similar success in the varying cultures of Sri Lanka, Kenya, and Colombia. Another example is the Center for the Welfare of the Aged in India, which promotes community-based services such as day centers for elderly people, often run by the elderly people themselves.

Planning for their care will need to take into consideration differences in urban and rural women cohorts. In rural areas emphasis on risks of undernutrition and infectious diseases is needed. In urban areas,

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the focus should be on health education for self care to manage chronic diseases. In general, the policy focus needs to shift towards health promotion, prevention and health education, at the national level and introduced in the communities. Some of the key preventive measures require changing behaviors early in life. Selected cost effective interventions, such as cervical cancer screening, could be introduced in phases. First target the program in limited areas to screen women considered to be at high risk, then expand services to more women in more areas and integrate the screening program into existing health services.

Policy and Program Recommendations

Ways to improve older women's health and well-being vary according to a particular country's economic, epidemiological, demographic, infrastructural, and cultural conditions, that influence the feasibility and effectiveness of the available public health interventions. It is not possible to provide a blueprint for the health care of older women (or for the older population in general). The paper discusses approaches in three different settings for which planners and managers can start assessing needs and implement a plan for the health care of older women.

Setting A: This setting includes the low-income countries in Africa, Asia, and Latin America and the Caribbean, such as Kenya, Nigeria, Pakistan, India, Egypt, and Bolivia, where government hospitals and clinics are often insufficient even for the provision of acute medical care and maternal health care. Moreover, primary care to meet basic health care needs in rural areas is scarce or nonexistent. Private providers consist mainly of religious nongovernmental organizations in Africa and private doctors and unlicensed practitioners in South Asia. Public spending on health in these countries is skewed toward high-cost hospital services that benefit mainly the better-off urban population. Furthermore, national policies to assist the elderly and community awareness of their needs is lacking. The elderly tend to be isolated, undernourished, and dependent on extended families.

Priority: Increase government and public awareness of the health problems of the aging population and develop a national strategy to focus on older women in rural and urban poor areas. (See Box A on Policy Directions and Programs)

Setting B: This setting includes most of the middle-income countries in Asia, Latin America and the Caribbean, and the Middle East. Both public and private services are available but are underutilized. Primary care services are available but are poor in quality and scarce in rural areas. There is little recognition of the needs of the elderly, and there are too few government and private programs designed to help the elderly. Resources are invested disproportionately in institutional care rather than in services for the community and home. There is lack of rehabilitation, physical therapy, and mental health care. Programs for health promotion and education are minimal, and those that exist are not geared to the specific needs of the elderly. Home care and home help services are not recognized as a "right" and hence are not included in the country's budget. Social insurance is available only for those employed by the government or major employers. There is also a paucity of legislation defining needs, entitlements, and mandated services for the elderly.

Attitudes toward the elderly are changing as result of urbanization and modernization. Furthermore, rural areas will have a higher proportion of elderly due to migration of young workers to urban areas. Urban housing problems will worsen.

People in general are unaware of the necessity for improving their own health. Insufficient attention is given to nutrition of the elderly. Arteriosclerosis is responsible for much disability and death in later life. Recognition of the necessity for health promotion programs is growing but systems are not yet widespread.

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Priority: Orient the government and the private sector to regard all efforts to improve later life as a medium-term investment in human capital. (See Box B)

Setting C: This setting includes the former socialist countries in eastern and central Europe, former USSR, and China. These countries have an extensive network of hospitals, rehabilitation facilities, and public health facilities. However, the health care delivery system is inefficient and ineffective. Governments have been slow to regulate workplace safety and environmental pollution and have put little emphasis on health promotion through campaigns against unhealthy behaviors such as heavy cigarette consumption. In recent years the collapse of social safety nets has led to problems in providing assistance to the disabled and to people unable to support themselves. In China the collapse of cooperative medical insurance has led to deterioration in the provision of preventive health services.

Priority: Promote and maintain independent functioning of the elderly. (See Box C)

BOX 2: Policy Directions and Programs for Setting A CountriesCommunity-Based Services

- Promote traditional family attitudes toward the elderly, particularly older women. Maintain and extend customs by which the elderly assume some of their traditional roles in the community.
- Increase the capacity and role of women in identifying and promoting positive health behavior, such as adequate nutrition and hygienic measures.

Education and Training

- Incorporate information about the normal aging process into mass literacy campaigns.
- Introduce geriatrics in undergraduate medical education.
- Train community health workers in the care of the elderly that focuses on family participation.

Organization and Finance

- Establish national-level leadership focused on the needs of the elderly.
- Establish the objectives and structure for health promotion and health care of the elderly.

Research and Evaluation

- Evaluate policies and health care objectives to meet changes expected by 2010.

Improving health programs for older women

- Initiate health education programs under government and voluntary agency sponsorship with emphasis on promoting positive attitudes toward the elderly.
- Develop cadres of health professional and paraprofessional workers who are committed to work with the elderly.
- Encourage nongovernmental organizations to initiate community programs oriented toward older women.
- Use primary care as the basic approach and existing village women's organizations as the entry points for chronic disease prevention programs.
- Educate women on behavioral risk factors and the importance of good nutrition.

BOX B: Policy Directions and Programs for Setting B CountriesCommunity-based services (focus on prevention)

- Increase emphasis on community-based programs for health care for the elderly.
- Institutionalize measures to assist local authorities and voluntary organizations to expand needed services for the elderly.
- Emphasize health promotion and disease prevention in community health and social services and occupational settings.
- Promote an interdisciplinary approach to services, including medical, social, and psychological care for older women.
- Provide secure and suitable housing such as rooming units for the elderly to enable them to stay close to their families.
- Encourage and coordinate mutual help groups so that the elderly can rely to some extent on their

Education and Training

- Introduce in health workers' curricula the safe and effective use of drugs for the elderly.

Organization and Finance

- Cover all the needy elderly with some form of health insurance.
- Expand surveillance data gathering to include older women's health and health care needs.
- Evaluate ongoing programs directed to improve the health of older women.
- Educate the adult working population on health promotion measures such as adequate nutrition and physical activity.
- Introduce health counselling and screening programs at the work place.
- Implement cervical cancer screening programs according to local conditions.
- Establish day care centers and homes for the aged.
- Introduce palliative measures for the management of terminally ill patients.
- Increase the numbers of health education programs at the workplace.
- Conduct vision screening.
- Educate women on the safe and effective use of drugs such as antidepressants and tranquilizers.

BOX C: Policy Directions and Programs for Setting C CountriesCommunity-based services (focus on prevention and self care)

- Develop a more comprehensive strategy for women's health, with particular attention to mental health and the prevention and treatment of chronic diseases.
- Increase focus on self-care in preventing chronic diseases.
- Redirect focus from hospital based to community-based care for the elderly.
- Promote the strengthening of a spectrum of support services—home helps, home nursing care, nutritional programs.
- Promote suitable housing.
- Influence women's groups to actively participate in planning for the care for older women.
- Develop social safety nets.
- Emphasize preventive measures against health hazards at work.
- Reinforce positive health behaviors such as physical activity that currently exist in the society.

Education and Training

- Educate physicians in geriatrics and gerontology.
- Train nurses for home health care.
- Train health workers in basic rehabilitation skills.
- Integrate retirees into productive activities through training programs.
- Incorporate volunteer activities as part of schooling and adult life.

Organization and Finance

- Reorient health care to decentralized management and provision of services.
- Coordinate public and private insurance so that benefit packages and reimbursement approaches are comprehensive and standardized for the vulnerable age groups.

Research and Evaluation

- Formulate a monitoring system on the social and health status of women.
- Undertake research to identify needs specific to various age groups, relationships of women's ages with changing role in health, and mental health problems.

Improve Health Programs for Older Women

- Implement community based screening for major diseases, e.g. cancers of the cervix and breast, hypertension.
- Promote experimenting with alternative community care models such as day care and short hospital stays tailored to the elderly.
- Conduct vision screening.
- Improve efficiency of chronic care service management with options for day care and day hospital.
- Educate women to improve self-help skills to manage chronic diseases such as diabetes and hypertension.
- Provide systematic education programs for women on changing needs of aging, in nutrition, environmental health, smoking and alcohol abuse, oral hygiene.
- Educate women to increase their awareness of the impact of working conditions on health.
- Encourage middle-aged women to participate in sports.
- Educate women on stress management, side effects of drug misuse, and addiction to tranquilizers, sedatives, and antidepressants.
- Introduce palliative measures for the management of terminally ill patients.
- Establish geriatrics functional assessment in health care facilities.

SUMMARY
VIOLENCE AGAINST WOMEN AS A HEALTH ISSUE

by Lori Heise, Jacqueline Pitanguy, Adrienne Germain

I. GENERAL ISSUES: PROBLEMS AND NEEDS

UN draft definition: "any act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life."

Violence is a priority issue for women in both developed and developing countries. It was cited as the number one health issue by the Black Women's Health Project in the U.S.; as one of two priority issues at a meeting of Asian women; and as one of five priorities for the Association of Women in Development. Violence was named the worst aspect of being female by participants at a workshop in China, and the first priority for future funding by Canadian women's groups.

A. Prevalence

Violence against women is grossly under-reported, and the health impact of abuse has not been fully explored. Relying on women to self-define abuse underestimates its incidence and effect.

The most endemic form of abuse is by intimate male partners — between 25-50 percent of women surveyed in a variety of studies report such physical abuse.

According to several studies of college-aged women (in Canada, New Zealand, U.K., U.S., Korea), between one-fifth and one-quarter of women have suffered completed or attempted rape.

Experiences of child and adolescent sexual abuse are reported by high numbers of women (25-62 percent). Investigation into STDs in children under five and between five and sixteen, and pregnancy in girls under 16, also indicate significant levels of rape and incest.

Harmful "culture-bound" practices are global. In developing countries, practices such as genital mutilation and child marriage subject hundreds of millions of girls to severe health problems, trauma and death. In industrialized countries, willful behaviors such as bulimia, anorexia, and cosmetic surgery (all designed to make a woman into an acceptable, attractive, sexual partner for men) place millions of women at risk of health problems and death.

There are societies in which violence against women does not exist.

B. Effects

Women aged 14 to 44 lose more Discounted Healthy Years of Life to rape and domestic violence than they do to breast cancer, cervical cancer, obstructed labor, heart disease, AIDS, respiratory infections, motor vehicle accidents or war. The loss is roughly equivalent to that of tuberculosis and sepsis during childbirth. (Preliminary calculations prepared for the 1993 World Development Report).

Many women experience multiple episodes of violence. Studies have linked early abuse with higher incidences of future violence, drug and alcohol abuse, high-risk behaviors and increased risk of rape. The effects of sexual abuse and assault are long-term; studies have found symptoms up to 6 years later.

Health consequences:

- Physical health: STDs, injury (between 20-35% of hospitalizations), PID, unwanted pregnancy, chronic pelvic pain, headaches, gynecological problems, alcohol/drug abuse, asthma, irritable bowel

syndrome. Genital mutilation causes health problems in 83% of 'circumcised' women; one study found that between 10-30% of women die from the procedure.

- Mental health: post traumatic stress disorder, depression, anxiety, sexual dysfunction (50-60% of rape victims), eating disorders, multiple personality disorder. (Victims of violence are five times more likely to seek psychiatric treatment than women who have not been victims.)
- Suicide and homicide: Violence is one of the most common precipitating factors for suicide, and is a major risk factor for murder. Suicide and homicide (such as honor killings and bride burning) are culturally recognized responses to marital difficulties.

The impact of violence and abuse on the health care system is significant; women who have been raped or beaten have medical costs that are twice as high as non-victimized women.

Pregnant women are prime targets for abuse, and abused women are less likely to seek prenatal care and more likely to have low birth weight babies; it may be responsible for a sizeable portion of maternal mortality.

C. Social and legal context:

In many countries, laws sanction violence, limit women's freedom, and/or do not recognize the problem. Although violence is entirely preventable in theory, very few programs have been undertaken on a wide scale.

Where virginity and chastity in women are prized, a claim of rape or sexual assault may lead to ostracism, further violence, forced marriage between victim and attacker and prosecution and imprisonment.

Women are beaten or otherwise abused when they don't comply with men's sexual or childbearing demands (which has an impact on family planning use and incidence of STDs), and in an attempt to reverse the process of empowerment.

II. LESSONS LEARNED: COUNTRY ILLUSTRATIONS

Legal conditions:

In **Guatemala**, laws give husbands the right to prohibit wives from working outside the home; in **Ecuador**, a husband can force his wife to live with him; in **Chile** divorce is illegal even in cases of extreme violence; and in **Pakistan**, four male Muslims must corroborate an accusation of rape, and women are 'incompetent' as witnesses and are vulnerable to prosecution for fornication if they cannot prove rape. Injury is also a legal factor: in **Latin America**, assault is defined by an 'incapacitating' injury of a set number of days, which may not apply to women who do not work outside the home; in **India**, only 'grievous harm' (permanent injury) is a recognizable offense.

Other barriers include: restricting legally acceptable medical evidence to Forensic Medical doctors located in large cities (**Latin America** and parts of **Asia**); extremely narrow definitions of rape; and defining rape as a crime against public morality or property, not a person (**African** customary law). Universally, laws are biased against women who are not virgins.

Recent progressive rape laws have been adopted in **Mexico** and the **Philippines**. **India** passed a law against the sexual and physical harassment of girls and women in public places, **India** and **Pakistan** have laws against dowry harassment and **Bangladesh** has a law against acid-throwing, although none are strictly enforced.

Prevention and support programs, and assistance for victims:

In the **U.S.**, gender-bias task forces, comprising judges and community members, have been formed in half of all states to uncover and attack sexism in courts. They have found significant abuses, and led to the recall of some judges and to increased training for judges and prosecutors.

In **Zimbabwe** and **Costa Rica**, programs to train and sensitize leaders about domestic violence and rape reach local police, prosecutors, judges, lawyers and/or other professionals.

In **Malaysia**, "women-only rape teams" have been formed, largely due to a coalition of women's organizations. Police on these teams have been specially trained, hospitals have special rooms, volunteers provide counseling and advocacy; the police take the woman's report at the hospital and only one doctor examines the victim.

Some industrialized countries, the **U.S.** and **Canada** for example, have introduced the notion of "coordinated community intervention," in which all relevant agencies develop a coordinated response to domestic violence, which includes advocates to help women through the legal system and social service agencies, local shelters and safe homes, training for staff, batterer treatment and monitoring.

In **Jamaica**, popular theater is used as a vehicle for preventative education around gender violence. In Ontario, **Canada**, the Ministry of Education has developed a Violence Prevention Initiative that includes a school curriculum, a handbook for prevention of violence, a training program for school personnel and a number of awareness-raising projects. In Brooklyn, **New York**, the Anti-Violence Education Project uses self-defense training to introduce violence prevention into public schools.

In Toronto, **Canada**, Education Wife Assault works with immigrant and refugee women to help them develop culturally appropriate campaigns for their communities. They include skills workshops, and technical and emotional support for women leaders.

In 1989, **Mexico** created specialized agencies to provide legal, medical and psychological care for victims of violence.

In **Costa Rica**, 'Ser y Crecer' trains teachers, therapists and social workers to run self-help support groups for victims of sexual abuse. It also trains local leaders to identify and refer victims of abuse, and other professionals to conduct prevention education in their communities. CEFEMINA, another Costa Rican agency assisting women, reports that 60 percent of women who attended their support groups were able to achieve a violence-free life within six months.

In **Belize**, Garifuna women surround the house of a man beating his wife to publicly shame him. They may also help a woman escape by providing her with sanctuary. In Mira de las Flores, a shanty town in **Peru**, women have organized a neighborhood watch committee, blowing whistles to alert others in case of attack. In Manitoba, **Canada**, women from the Hallow Water Reserve are using the tribe's Circle of Healing to confront abusers, make them acknowledge their crimes, and offer healing for the victim and abuser (the latter often includes punishment).

III. STRATEGY AND INTERVENTION OPTIONS

Gender violence requires a life cycle approach, examining and dealing with the issue through prebirth, infancy, girlhood, adolescence and adulthood. It also requires a multi-dimensional approach, and collaboration from many sectors, public and private, including the justice system, the health care system and

providers, and victim-assistance agencies and support groups. An effective program must be site-specific and emerge out of the cultural and political realities of each country.

Violence must be made visible. Interventions must:

- Eliminate attitudes and beliefs that legitimize violence and justify male control of female behavior;
- Treat the symptoms and effects of abuse; and
- Improve women's access to power and resources.

A comprehensive strategy should have three goals:

Prevention:

Increase the social cost through enforced laws and public humiliation.

Change attitudes and perceptions using media, public education, family life and parenting skills programs in schools, religious institutions, all male clubs and after-school programs.

Encourage non-violent resolutions through schools and the media.

Alleviate social factors through regulating alcohol sale and treatment, gun control and support groups for men in transition.

Utilize health care providers to discourage violence, sex discrimination and harmful practices, counsel women and refer them for legal or psychological support, and help document the incident of violence and its impact.

Improve women's alternatives, through skills training, access to income, low-income housing and all-female spaces.

Victim Assistance:

Protect women through laws, emergency housing, self-defense training and safe public spaces.

Empower victims through self-help support groups, legal and psychological counseling and use of women's advocates.

Respond constructively by training for professionals and educators and implementing protocols to recognize and respond to gender violence.

Knowledge:

Document prevalence of violence through population-based surveys.

Fund research into causes and correlates of violence.

Evaluate innovative approaches to prevention and victim support.

IV. PRIORITIES: PROGRAM AND POLICY RECOMMENDATIONS

The most important step is to support nascent initiatives already underway (as described above), whether by government or through autonomous efforts by women's organizations. A minimal investment of resources would strengthen these NGO programs, now being undertaken by at least 379 organizations globally.

Specific Recommendations for Governmental Action

Actions for the National Secretariat on Women (countries that do not have a high level office on advancing the status of women should establish one)

- Develop a national initiative on gender violence
- Provide technical and financial support for NGOs offering services to and on behalf of women, especially those working from a feminist perspective
- Implement a coordinated campaign with other Ministries
- Improve women's access to productive resources
- Sponsor a national media campaign to classify violence as unacceptable.

Actions for the Ministry of Health

- Create health care protocols for identification and referral of victims, and train staff in counseling, examining victims and collecting evidence
- Research the incidence and prevalence of violence, its mental health consequences and associated health care costs
- Integrate questions on violence into on-going health surveys
- Introduce consciousness-raising materials and training into curricula for health care workers.
- Establish a clinical profile of abused women
- Incorporate violence-related themes into popular health education materials such as soap operas
- Sponsor sensitivity training for Forensic Physicians
- Discourage alcohol and drug abuse and expand treatment programs.

Actions for the Ministry of Justice

- Criminalize domestic violence, marital rape and other crimes against women, facilitate prosecutions and amend laws that force women to remain in violent relationships
- Document how laws related to gender violence are enforced
- Allow licensed health care providers to examine victims and collect legal evidence. Extend and improve medical and legal services
- Require crime statistics to be broken down by gender and record the relationship between the victim and the abuser
- Support NGOs providing human rights education and legal literacy training for women
- Provide training for police, prosecutors and judges.

Actions for the Ministry of Education

- Replace gender bias and stereotyping in all curricula and teaching materials with gender awareness training, parenting skills and non-violent conflict resolution
- Work with the media to portray positive images of equitable relationships and remove gratuitous violence.

Actions for the World Bank

Sponsor research into the nature, extent and causes of gender-based victimization in order to increase the visibility of violence and facilitate analysis of the problem. Lend visibility and legitimacy to the issue through working papers, meetings and discussions. Urge governments to take action.

SUMMARY
COST-EFFECTIVENESS ISSUES IN WOMEN'S HEALTH

by Joseph Kutzin

The paper has two primary components:

- 1) Priorities for investment in women's health interventions in different settings, based on their costs and effectiveness; and
- 2) An analysis of the ways in which existing health services can be reorganized to improve women's access to and utilization of services, thereby increasing their cost-effectiveness.

FINDINGS: COST-EFFECTIVENESS OF INTERVENTIONS

This section of the paper was motivated by the cost-effectiveness rankings contained in Jamison et al. (forthcoming), Disease Control Priorities in Developing Countries, which suggest that health services directed at women are among the most cost-effective available. Improving women's health, and particularly maternal health, yields benefits beyond the woman receiving the intervention, and these benefits are greater than those achieved through untargeted interventions or interventions aimed at men. The rankings in Jamison et al. are organized by medical condition rather than by intervention, thereby understating the cost-effectiveness of supplying single interventions that have multiple beneficiaries or address more than one condition, as is the case for many women's health interventions. As noted in the chart below, data on the impact of disability adjusted life years gained to children is generally available, while comparable information on the intervention's impact on women is not, or vice versa. Many of the interventions were nonetheless found to be among the most cost-effective. A summary of these rankings is provided below.

INTERVENTION	CONDITION AFFECTED	COST EFFECTIVENESS (Cost per Disability Adjusted Life Year Gained)*
Tetanus Toxoid Immunization	Neonatal tetanus, non-neonatal tetanus	\$6 (estimate for neonatal tetanus only)
Iron/folate Supplementation	Iron deficiency anemia	\$13 (estimate for children only)
Breastfeeding promotion	Acute respiratory infection (ARI), diarrhoeal disease control, micronutrient deficiencies, birth spacing	\$17 (estimate for ARI and diarrhoeal diseases, i.e. excludes impact on women)
Iodized oil for women of repro age	Iodine deficiency	\$20 (estimate for children only)
Food supplementation of pregnant and lactating women	Protein energy malnutrition	\$25 (estimate for children only)
Treat STDs with antibiotics	STDs and AIDS, cervical cancer	\$28 (estimate for all adults)
Family Planning (increase condom use through education & subsidation)	Excess fertility, STDs and AIDS, cervical cancer	\$45 (estimate for children only)
Manual breast exams and treatment, annual	Breast cancer	\$50 (estimate for women)
Condom subsidies and IEC for STDs	STDs and AIDS, cervical cancer	\$56 (estimate for adults and children)
Family planning by insertion of IUDs or disbursement of oral contraceptives	Excess fertility	\$90 (estimate for children only)
PAP screening and treatment, 5 year intervals	Cervical cancer	\$100 (estimate for women only)
HIV blood screening	HIV/AIDS	\$126 (estimate for adults and children)
Antenatal and delivery care	Maternal and perinatal health	\$140 (estimate for mother and children)
Manual vacuum aspiration	Incomplete abortion	No data
Postpartum care	Hemorrhage, infection	No data

* Minimum, median estimates

Cost-effectiveness issues related to selected women's health interventions (paper covers all relevant interventions, providing information on conditions addressed by the interventions; beneficiary groups; and cost-effectiveness):

- **Manual vacuum aspiration:** MVA, combined with changes in patient management, is more effective and lower cost than sharp curettage.
- **Oral iodized oil or salt to women of repro. age:** Low cost addition to existing services. Mass-dose supplements very cost-effective.
- **Prenatal education for health, nutrition and pregnancy-related warning signs:** Potentially low cost if effectively delivered by neighborhood organizations or TBAs. Difficult to assess effectiveness.
- **Iron/folate supplements to pregnant women:** Low cost and highly effective if taken regularly.
- **Essential obstetric care at the district hospital:** Relatively expensive but cost-effective if referral system functions well. Actual cost-effectiveness usually much lower than potential. Marginal cost-effectiveness greatest where contraceptive prevalence high and health system well-developed.
- **Maternity waiting homes:** Low recurrent costs once constructed. Effectiveness depends on reliable transport and communication.
- **Postpartum health and nutrition care for mothers:** Most effective way to detect and treat postpartum infections and prevent secondary infertility. Postnatal vitamin A and iron/folate supplements are low cost additions to service package.
- **Referral level neonatal care:** Likely to be high cost and of limited effectiveness. Unwise use of government resources in poor countries.
- **Cervical cancer screening and treatment:** Early detection and treatment during non-invasive stage very effective at moderate cost. Effectiveness reduced where incidence and mortality rates are low, laboratory facilities poor, and access to adequate facilities for follow-up procedures limited. Cost-effectiveness declines for testing under age 35 and more frequently than every 3-5 years.
- **STD treatment programs:** Highly cost-effective if targeted to high-risk groups. Effectiveness is higher in areas of high prevalence. High prevalence also improves cost-effectiveness of presumptive treatment relative to the combination of diagnosis and treatment.

FINDINGS: ACCESS TO CARE

A full cost-effectiveness analysis of an intervention should include the cost that users incur in gaining access to that intervention. Women face gender-specific obstacles related to their status and lack of control of household resources. Non-gender specific obstacles such as inequitable health sector resource allocation and the price of obtaining care may have a disproportionate effect on women because they form a disproportionate share of the poor, have less access to cash, and have less "free" time.

RECOMMENDATIONS: PRIORITY INTERVENTIONS

All Settings:

- General education for females is perhaps the most important measure to improve women's health

Low Income, High Fertility, High Mortality Settings:

Family Planning: IEC and contraceptive supplies (especially condoms) to promote both family planning and STD-prevention are highly cost-effective; while not cheap in terms of the absolute level of resources required, potential to be very inexpensive relative to gains in women's health, infant health and nutrition, and STD control.

At health center/post level:

- TT immunization
- Iodized oil supplementation for women
- STD treatment for women and men (presumptive treatment where prevalence high, otherwise clinical diagnosis plus treatment if indicated)
- One-time pap test to women aged 35-40, if capacity to treat non-invasive cancer in place
- Antenatal and delivery care:
 - health and nutrition education
 - iron/folate supplementation
 - antimalarial prophylaxis in endemic areas
 - TT immunization
 - safe abortion services
 - screening and treatment of STDs and RTIs
 - management of routine deliveries
 - screening and referral of high risk pregnancies and complications (if referral level capable of responding)
- Postpartum care
 - management of hemorrhage and infection
 - breastfeeding promotion
 - family planning
 - iron/folate and vitamin A supplements
 - food supplements to malnourished lactating mothers

District hospital level must be equipped and staffed to support the above activities by providing services to back up screening. Mechanisms for effective communication and transport are essential.

Middle Income, Lower Fertility, Lower Mortality Settings:

Family Planning: Further efforts to reduce fertility likely to be less cost-effective than focusing on the quality of prenatal and delivery care.

Health services:

- Construction/expansion of maternity waiting homes warranted if transport network can support.
- Capacity to diagnose infections at lower levels of system probably greater; presumptive treatment of STDs in pregnant women probably not warranted.
- Targeting preventive and curative interventions to core STD transmission groups remains appropriate.
- Promoting breastfeeding important, as practice may diminish as incomes rise.
- District hospital should have capacity to remove tissue affected by breast and cervical cancer prior to invasive stages.
- Frequency of Pap tests can be increased to once every 5 to 10 years among women aged 35-55.
- Manual examinations by trained provider to screen for breast cancer after age 35 appropriate (much more cost-effective than mammography).

RECOMMENDATIONS FOR IMPROVING ACCESS TO CARE

Long-run measures: In the long-run, efforts to bring about cultural, social and economic change will bring the costs men and women face in gaining access to care closer together.

Short run measures:

Reduce economic costs (including travel costs, opportunity costs of time):

- Providing services to women through home visits by trained female health workers, mobile services, and outreach in locations where women gather on a regular basis.
- Developing/expanding maternity waiting homes.
- Developing multi-purpose facilities to provide integrated child and women's health interventions.
- Shifting resource allocation from urban-based, tertiary care to community-based care.
- Improving quality of community-based care.
- Integrating (or, at a minimum, coordinating) primary and secondary care facilities to improve logistical and referral linkages.
- Restructuring pricing and exemption policies. Fees should:
 - provide correct signals for utilization.
 - provide services with benefits beyond the person receiving treatment at subsidized or no cost (this would include many women's health services).
 - Link fees to tangible improvements in quality.
 - Ensure that fees are consistent with ability to pay and do not prevent access.

Address cultural barriers:

- Upgrade the skills of traditional care providers and integrating them into the formal care system.
- Design services to supplement and strengthen existing patterns of care.
- Increase the supply of women health care providers.

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SUMMARY **UNPLANNED PREGNANCY AND ABORTION**

by Kajsa Sundstrom

I. GENERAL ISSUES: PROBLEMS AND NEEDS

Abortion is one method of birth control, as vital to women's physical, mental and social health as other fertility regulation methods. Women will resort to abortion, no matter if it is dangerous or forbidden.

The prevalence of safe and unsafe abortion:

Between 36 and 60 million women resort to abortion worldwide each year (accounting for 20-30 percent of all pregnancies). More than half of all abortions are clandestine and/or performed under unsafe conditions.

Due to under-reporting, all estimates of abortion and abortion-related complications and issues are likely to be low. Generally, abortion estimates are based only on the number of women who manage to reach a hospital.

Human and economic costs of unsafe abortion:

In most developing countries, unsafe abortion is the leading cause of pregnancy-related morbidity and mortality, accounting for 150,000 to 200,000 maternal deaths annually.

Unsafe abortion can harm a woman's mental, emotional and physical health and future fertility, and can have negative social consequences. Teenagers are particularly vulnerable to these effects.

The economic cost of treating complications from illegal abortions are substantial and significant. Emergency services to treat complications are much more expensive than medically safe abortion services.

Termination of early pregnancy, provided by trained personnel, is one of the safest surgical procedures known. A study by a former U.S. Surgeon General seems to have found that U.S. women who had clinical abortions did not suffer any negative medical or psychological consequences.

The legal status of abortion:

Legal situation: 40 percent of world's population lives in countries with no restrictions on abortion; 23 percent lives where abortion is allowed for social and medical reasons; 12 percent lives where the life and health of the woman and injuries of the fetus are grounds for abortion; 25 percent live with restrictive laws where abortion is permitted only when the life of the woman is at stake, and where it may be criminalized or forbidden.

The international agenda:

Key health and fertility issues are understood and interpreted differently. In exploring the definition of these terms, an emphasis on demographic goals over individual goals, and on family-oriented and married-women oriented indicators is revealed. For the past two decades, actors on the international arena have been ambiguous about abortion as a method of fertility control and as a health issue.

Following the 1984 Population Conference in Mexico, the U.S. position on abortion has had long-lasting effects on efforts to reduce the vast number of illegal abortions in the developing world and on the increasing

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number of teenage pregnancies in the U.S. Scientific research and surveys on abortion have slowed considerably; many independent agencies (WHO and UNFPA) have avoided controversial statements and played down the role of abortion in their programs; abortion has been separated from other reproductive health services; prevention of unsafe abortion is not included in programs to reduce maternal mortality and morbidity.

"Unsafe abortion" has been the focus of increased discussion and concern in recent years from the World Bank and the Safe Motherhood Initiative and at major conferences; however, this concern has not been translated into action. For example, of 51 World Bank reports addressing population, family planning and/or health, only one — on Brazil — includes abortion as a key issue. World Bank lending for "Safe Motherhood" in 1992 and 1993 does not extend to provision of safe abortion management.

II. LESSONS LEARNED: COUNTRY ILLUSTRATIONS

Legalization of abortion is a necessary but not sufficient condition to ensure women's reproductive freedom and health. Insufficient resources, inaccessible services, lack of information and personnel shortages all restrict women's access to abortion even where it is legal (**Zambia and India**).

In **Nicaragua**, where abortion is illegal and clandestine abortion is very common, the Ministry of Health integrated manual vacuum aspiration (MVA) into the national health program. It is now available in four of the country's eight regions, including primary health centers. This has resulted in significant decreases in the use of hospital resources and in hospitalizations.

In **Zambia**, where abortion is legal for health reasons, many women resort to unsafe abortion because the rules for application are difficult to understand. An MVA training program for hospital staff, combined with the simplification of the approval process, resulted in a decrease in the demand for hospital emergency care and reduced the ratio of legal abortion to treatment of incomplete abortion from 1 to 25 to 1 to 5.

In **Kenya**, a study comparing two methods (vacuum aspiration and dilation and curettage) used to treat incomplete abortion up to 14 weeks found that VA is a safe, simple, quick method for treating incomplete abortion at relatively low cost. Over the course of one year, the saving of treating 3000 patients with VA over D&C was estimated at US\$300,000.

In **sub-Saharan Africa**, abortion is a serious, unattended health issue, characterized by restrictive but frequently violated laws, high and under-reported rates of abortion, and deficient health and family planning services. Although men control issues of sex and reproduction, they are seldom targeted for family planning services and information; in fact these services are almost exclusively targeted to married women. Adolescents have no realistic sex education, and sexual exploitation is a common fate among young African women. Abortion laws are left over from colonial times, and although there is a long tradition of fertility regulation in Africa, modern contraceptives are not widely used. Medically safe abortions are legally restricted, far too expensive or simply not available.

In **Gotland** (a Swedish island in the Baltics), a three-year communication and information program that approached abortion in the context of sexuality, gender roles and interpersonal relations led to a general ten-year decline in teenage fertility and a fall in the number of teenage abortions. Training and education were fundamental for social, school and health personnel; person-to-person communication was the main method employed with teenagers. Contraceptives were also provided.

III. STRATEGY AND INTERVENTION OPTIONS

Reproductive health programs should be planned and organized by the public health sector, and must include abortion services in three areas:

a. Medically safe, legal termination of pregnancy:

Abortion technologies for first trimester — vacuum aspiration (VA), dilation and curettage (D&C) and anti-progestin drug RU 486 — have different requirements:

- VA is the method of choice in the developed world; it is low-cost and can be performed at primary health centers. In the developing world, VA is "widely used" to treat incomplete abortion. When performed in the first seven weeks of pregnancy, it is called menstrual regulation and can be performed without dilation or anesthesia, even in the patient's home.
- D&C, a surgical procedure performed up to the 14th week of pregnancy, is the most commonly used clinical abortion technique in developing countries. It has a higher complication rate, and requires general or paracervical anesthesia and advanced equipment and training; it must be reserved for general hospitals at the first referral level.
- RU-486, in combination with a prostaglandin analogue, is effective within the first 49 days of a pregnancy. It requires three visits for examination, monitoring and follow up. A health care center at the primary level is adequate if cold storage is available. RU-486 has the following drawbacks: it cannot be used alone; the financial, time and transportation costs are high; there is prolonged bleeding of up to a week.

After 14 full gestational weeks, a two-step procedure is preferred: induction of uterine contractions and opening of the cervix, followed by expulsion of the fetus spontaneously or by surgical or medical means. Second trimester abortions need to be handled at the first referral level by trained personnel with resources for hospital care and surgical backup.

b. Treatment of incomplete abortion and abortion complications

The first priority in treating incomplete abortion is evacuation of uterus.

Uncomplicated incomplete abortion, up to the 15th week of pregnancy, should be treated by manual vacuum aspiration. Dilation of the cervix is seldom necessary. In the late second trimester, a two-step process should be used. Uncomplicated abortions can be treated on an outpatient basis at the primary level.

Abortion complications (excessive bleeding, shock, toxic reaction or sepsis) require adequate resources for emergency medical treatment, referral and transport.

c. Post-abortion counseling, including family planning counseling.

IV. THE PRIORITIES: POLICY AND PROGRAM RECOMMENDATIONS

A. Policy

International health organizations have a responsibility to disseminate information on the extent of the problem and increase awareness of the consequences of unsafe abortion on women's health and social life. International health advocates, organizations and donors have an important role to play in supporting,

promoting and implementing innovative programs to decrease the number of illegal abortions and ensure access to legal and safe abortion for all women.

The World Bank should:

- Give priority to abortion-related maternal mortality projects;
- Initiate studies on the epidemiology of abortion;
- Constitute a task force for developing methods of data collection;
- Support clinical trials on new technology; and
- Formulate guidelines for abortion management and the integration of abortion services in public health care.

Nationally, health authorities and professionals, politicians, women's organizations, pressure groups and male and female activists should collaborate to prevent unwanted pregnancies and unsafe abortions. The necessary actions to reduce abortion-related mortality and morbidity are:

- Decisions on legalizing induced abortion,
- Provision of appropriate services for contraception and abortion.

National policy issues include:

- Laws and regulations to guarantee equal rights for men and women, and ensure women's reproductive rights (including legal access to abortion and contraception, the responsibility of fathers toward children, and the right for pregnant girls to education).
- Sex education in the basic school curriculum.

B. Programs

Reproductive health services should aim to promote women's health, prevent unwanted pregnancies and reduce abortion-related mortality and morbidity by providing safe and effective contraceptives, and safe, legal termination of pregnancy as a backup.

Programs must be country- and community-specific. Strategies and priorities have to be locally adapted. Community leaders and influential people should be consulted. Participation of lay people from the community in planning and management is crucial. Top-down programs with strict demographic goals should be avoided in favor of health programs implemented by small-scale organizations, which are more effective in terms of sustainability and quality.

A multi-disciplinary approach is called for. It is essential to establish common ground at an early stage of planning by inviting collaboration.

Studies and research should be both quantitative and qualitative. They should focus on incidence and prevalence of abortion; and its consequences; behaviors, perceptions and needs; and gender and women's status issues. They should draw on official and community-based reports, and include studies on the economic and human costs of abortion to society. Formal and informal rules and laws should also be studied.

Program implementation should include the following:

- * The target population must be defined to include all groups in need of contraception, not only married women of reproductive age.

Health education and training in communication skills must be emphasized to raise awareness and promote responsible behavior. For issues like sexuality and fertility, person-to-person dialogue is the main approach.

Easily accessible services are needed. Services must include:

- a. Safe and reliable contraceptives, information and education. Family planning should be directed to those at highest risk of resorting to unsafe abortion in case of unplanned pregnancy.
 - b. Medically safe termination of pregnancy, adequate treatment of incomplete abortion and abortion complications, and post-abortion contraceptive services.
- Services should be people-oriented, not method- or number-oriented. Indicators for quality of care ought to be developed and assessed. Elements include multiple methods, skill and training of service providers, communication skills and the hierarchical structure of the health care system.

Abortion care should be carried out by adequately trained personnel at the lowest possible level. Consideration must be paid to access, quality of care, training, and choice of appropriate technologies. Information and services should be decentralized and easily available. The minimum requirements at the primary level are equipment to perform a complete evacuation of the uterine cavity and organized emergency transport.

Irrespective of the legal status of abortion, appropriate services for emergency care should be available at every service site in the health care system.

Vacuum aspiration should be the method of choice for termination of pregnancy and treatment of incomplete abortion up to 14 weeks; in particular, its wider use in developing countries is recommended. Before RU-486 is offered to women in Southern countries with rudimentary health services, it must be further developed, and clinical trials and acceptability studies must be conducted.