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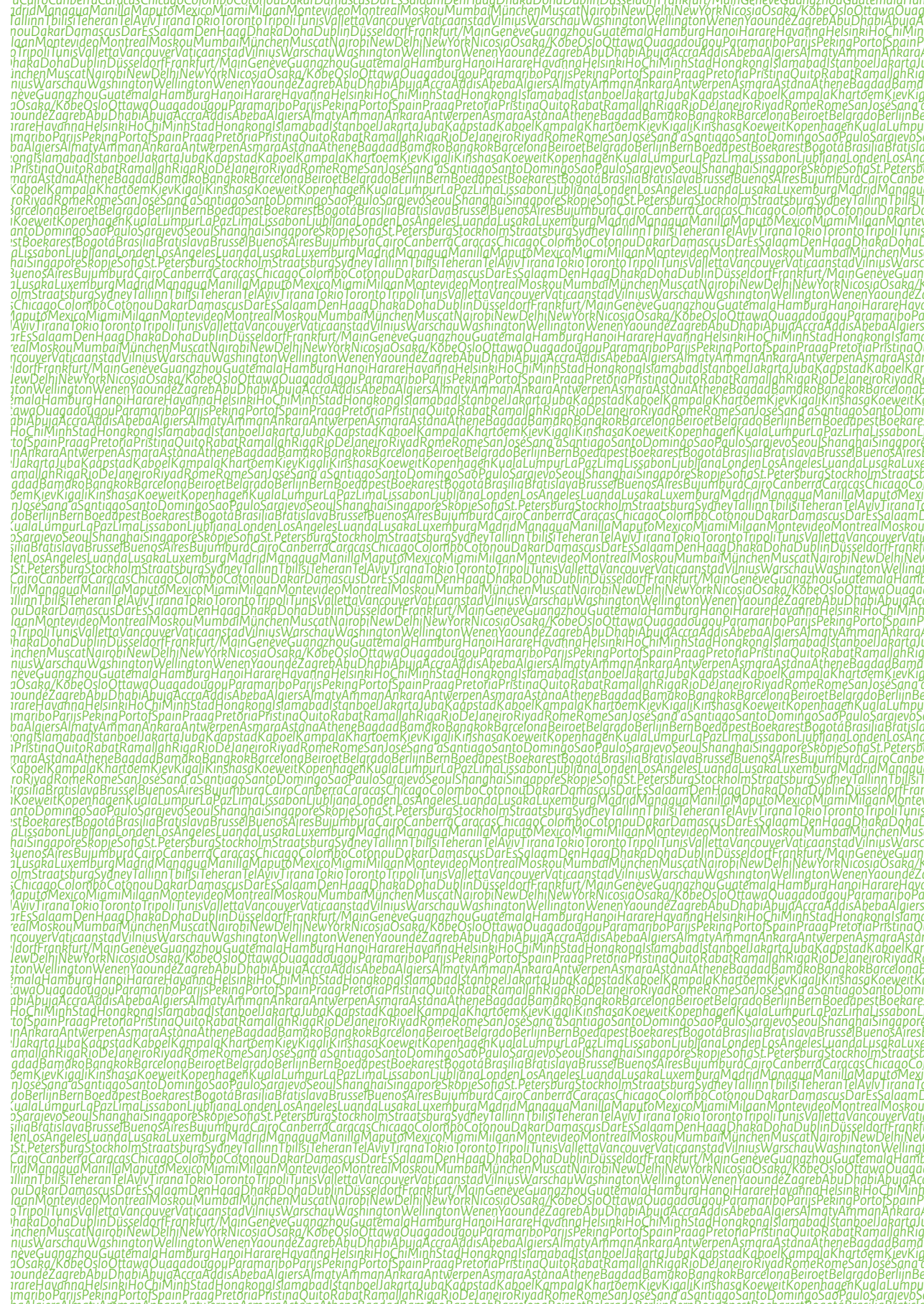
IOB Study

Synthesis of impact evaluations in sexual and reproductive health and rights

Evidence from developing countries



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Preface

Since the International Conference on Population and Development (ICPD) in 1994, both the realisation of sexual and reproductive rights of people and their sexual and reproductive health has progressed significantly. Nevertheless, for many women in countries in sub-Saharan Africa and South Asia there has hardly been any improvement: illness and death associated with pregnancy and childbirth – including unsafe abortion – is still unacceptably high. There continues to be a considerable unmet need for family planning, and strong taboos around sexuality.

In 2008, the Netherlands adopted its policy 'Choices and Opportunities' on HIV/AIDS and Sexual and Reproductive Health and Rights. It focuses on preventing human rights violations and increasing access to prevention against unwanted pregnancy, HIV-infection and unsafe abortion. The right to self-determination in matters of sexuality and reproduction is at the core of this policy. A two-tiered approach is proposed with on the one hand enhancing political involvement and on the other hand promoting a multisectoral response. Other important aspects of the Dutch strategy are access to information, contraceptives and health care, as well as gender equality, income for women, education and good governance.

The Policy and Operations Evaluation Department of the Ministry of Foreign Affairs (IOB) will carry out a series of impact evaluations in the field of sexual and reproductive health and rights. These impact studies are useful to determine whether and how the Dutch-supported interventions have been successful. They will provide constructive feedback on policy implementation and contribute to future policy formulation by the Health and HIV/AIDS Division of the Ministry of Foreign Affairs (DSI/SB).

In order to inform the selection of sexual and reproductive health and rights interventions, the target population and geographical area for the studies, an inventory of available impact studies was commissioned by IOB. This review concentrates on studies that compare intervention and control groups, thus providing evidence, or the lack thereof, of the effectiveness of specific interventions in the field of sexual and reproductive health and rights. The review aims to inform policy makers. It definitely does not provide a blueprint for the implementation of new sexual and reproductive health and rights policies. Rather, by looking into the effectiveness of interventions in specific circumstances, it can offer suggestions for fine-tuning and adapting existing policies and developing new policies in this field.

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Contents

Acronyms and abbreviations

AC	Antenatal Care
AIDS	Acquired Immunodeficiency Syndrome
AMTSL	Active Management of Third Stage of Labour
ANC	Ante Natal Care
ASRH	Adolescent Sexual and Reproductive Health
AYA	African Youth Alliance
BCC	Behaviour Change Communication
CEDPA	Centre for Development and Population Activities
DHS	Demographic and Health Survey
DMT	Decision-Making Tool
EmOC	Emergency Obstetric Care
FCI	Family Care International
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FHI	Family Health International
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IOB	Policy and Operations Evaluation Department
KIT	Royal Tropical Institute
LRIG	Liverpool Reviews & Implementation Group
MDG	Millennium Development Goal
MVA	Manual Vacuum Aspiration
PAC	Post-Abortion Care
PMTCT	Prevention of Mother To Child Transmission
PSI	Population Services International
RH	Reproductive Health
RTI	Reproductive Tract Infection
SCI	Skilled Care Initiative
SRH	Sexual and Reproductive Health
SRHR	Sexual Reproductive Health and Rights
SSA	Sub-Saharan Africa
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
SWAp	Sector-Wide Approach
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
WB	World Bank
WHA	World Health Assembly
WHO	World Health Organisation
YFS	Youth Friendly Services
YRH	Youth Reproductive Health

Executive summary

This synthesis provides an overview of recent *impact* studies in the field of sexual and reproductive health and rights (SRHR). It aims to supply knowledge about *which* interventions have proved effective and as such have contributed to furthering the sexual and reproductive health and rights agenda in developing countries, supported by evidence.

The evaluation is based on a review of relevant impact studies in this field, selected using criteria such as: the thematic area; design of the study (experimental, quasi-experimental, or systematic review); studies conducted in developing countries; published in English, preferably in the period between 2000 and 2008. The results of the review are organised around the five core aspects of sexual and reproductive health as described in the Global Strategy on Reproductive Health (WHA, 2004).[1] Issues pertaining to integrated services and adolescent sexual and reproductive health are dealt with separately. As such, the priorities of the Netherlands Ministry of Foreign Affairs' policy on sexual and reproductive health and rights are included.

Methodological issues

Overall, the number of impact evaluations in SRHR is rather limited: approximately 40 studies met the inclusion criteria. This comes as no surprise, given the costs and technical requirements of such undertakings. The limited number reflects in part a lack of (local) capacity to undertake rigorous impact studies, and financial constraints or other factors hampering the implementation of such research.

Maternal and perinatal health

The overview of impact studies in the area of maternal health focuses on antenatal care, skilled attendance at delivery and strategies at the community and household levels to enhance maternal and perinatal health. The seven impact studies in this area examined the effectiveness of, among other factors, a new model of antenatal care, access to and use of Emergency Obstetric Care and the implementation of the Skilled Care Initiative in Kenya, Tanzania and Burkina Faso. Studies in Pakistan and Nepal addressed home-based strategies, where the deployment of community health workers is seen as an intermediate or complementary alternative to intrapartum-care in health facilities. The results were positive in terms of newborn lives saved.

Family planning

The total unmet need for family planning is still staggering: in some sub-Saharan countries it exceeds 30% of all married women. Even though the safety and

1 Improving antenatal, perinatal, postpartum and newborn care; Providing high-quality services for family planning, including infertility services; Eliminating unsafe abortion; Combating sexually transmitted infections including human immunodeficiency virus (HIV); Promoting sexual health.

effectiveness of family planning methods is well established, the two main challenges to meeting the huge need remain increasing access to family planning and changing people's behaviour. The overview of impact studies on family planning comprises eight studies: one set of studies addressing interventions to increase knowledge (campaigns to change behaviour), and others looking at the effect of quality improvement in family planning programmes. Another group of studies assessed the effectiveness of interventions to increase access. Though many interventions include campaigns on family planning attitudes and behaviour, it is much more difficult to find evidence of their effectiveness, derived from rigorous impact evaluations. Also, limitations in experimental design or methodology make it impossible to draw sound conclusions. Interesting results on interventions to decline fertility rates are described in the studies on Bangladesh and Pakistan, which document the effectiveness of doorstep delivery of family planning services and franchised family planning clinics.

STIs

In terms of treating STIs, the most important intervention is the availability of cheap and accurate diagnostic tests, antibiotics and suppressive antiviral therapies. Unfortunately, many of these are either not available or not accessible in resource-poor settings. The two reviews discussed in this chapter address preventive interventions. The most notable are the studies in Uganda and Tanzania on the effects of community-based interventions to control sexually transmitted infections. Despite some optimism from a first study in Tanzania – which showed a 40% reduction in HIV infection rate – additional studies were less convincing regarding the effect of STD treatment interventions. They did, however, demonstrate the importance of the role of contextual factors in influencing the outcome of interventions.

Unsafe abortion

Almost all unsafe abortions take place in developing countries; they cause the death of close to 70,000 women per year. The precise impact of unsafe abortion on maternal mortality and morbidity is difficult to assess, mainly because of incomplete vital registration statistics on abortion-related complications and a general tendency to underreport, especially in countries where the procedure is illegal. The synthesis provides information on six impact evaluations, addressing the use of safer techniques, the effect of post-abortion care programmes and human resource issues in countries where the procedure is legal. Operational research has shown the effectiveness of coupling simple technologies performed by trained practitioners with interventions to increase access to these services. Research into post-abortion care (PAC) programmes has investigated how improvements in these services may impact on aspects such as access, patient satisfaction and post-abortion contraceptive use. However, more research is needed to identify the legal and structural (health systems) barriers impeding access to these services.

Reproductive rights, sexual health, gender issues and gender-based violence

One of the major achievements of the Cairo Conference on Population and

Development was the recognition that *sexual health* is fundamental and relevant throughout a person's life span, not merely during her or his reproductive years. Overall, the evidence base on successful approaches to reducing gender inequity and its effect on sexual and reproductive health is meagre. Three impact studies have addressed the issue of gender equity and gender-based violence. Despite the rhetoric around the importance of male involvement, there are few published evaluations of interventions addressing the role of men in sexual and reproductive health. Regarding gender-based and sexual violence, only one impact study specifically addressed the effect of a community programme on the prevention of female genital cutting.

Adolescent sexual and reproductive health

The number of programmatic responses in the area of adolescent sexual and reproductive health has increased hugely in the last ten years. Most of the interventions deal with primary prevention: for example, behaviour change and social marketing campaigns, and school-based educational interventions (on sex and HIV). Increasingly, attention is focusing on the creation of supportive environments and in involving adolescents. Eleven studies are discussed in the synthesis: most of them examined the effectiveness of curriculum-based health education and life skills programmes. A review of impact studies on sex and HIV education programmes discussed in this chapter argues that such programmes have the ability to increase *knowledge*. Evidence on their ability to bring about a change in behaviour is less clear-cut. Despite the generous funding of these types of interventions, this area still appears to be under-researched. In terms of increased access of adolescents to sexual and reproductive health (SRH) services, some promising examples include a voucher scheme for disadvantaged adolescent girls in Nicaragua. It has also been attempted to improve access to SRH services by establishing youth-friendly services; however, more evidence is needed to substantiate conclusions about their effectiveness.

Integrated services

In the aftermath of the Cairo Conference on Population and Development many countries embarked on a review of their national responses to reproductive health, and made an effort to align programmes and services to the 'new' approach that had been widely agreed upon: integrating SRH services within the public health system. Only three studies on this topic were available for review: the evidence they yielded on the efficacy of integrating services is described in chapter eight. The comprehensive review of the experiences of programmes to integrate sexual health interventions into reproductive health services examined the status quo regarding integrating services for women, men and adolescents, the violence related to gender, and sexuality and health system issues. The second systematic review included in this chapter dealt with the challenges of integrating sexuality into SRH and HIV/AIDS counselling. The third study reported positive experience with linking community activities to a clinic-based PCMCT programme in South Africa. The chapter concludes with health system challenges.

Conclusions

Chapter nine draws conclusions on gaps in evaluation evidence. Overall, not all aspects of sexual and reproductive health have attracted similar interest from researchers and policy makers. A relatively large number of studies described in this synthesis deal with aspects of improving maternal and perinatal health, family planning and sexual and reproductive health of adolescents, whereas other areas have received less attention.

The chapter presents the foremost gaps in evidence of effective interventions in five areas of sexual and reproductive health and rights. For *maternal and perinatal health*, the most notable need is for impact studies of interventions to increase the use of emergency services and access to skilled attendance at delivery in general (e.g. addressing supply and demand-side constraints).

In the area of *family planning* more research is needed on the scaling-up of proven effective approaches. Evidence is also needed on the impact of interventions stimulating male involvement in family planning and on the effect of mass communication and social marketing programmes on actual and long-term family planning behaviour changes and fertility.

With regard to *sexually transmitted infections*, the challenge for researchers is to undertake investigations that identify interventions intended to prevent and control STIs, including HIV, particularly in resource-poor and high-risk settings. This includes ascertaining the efficacy of rapid low-cost diagnostic and treatment technologies and addressing the interplay between social and behavioural determinants of condom use and treatment adherence. Furthermore, in light of the surge of female condom promotion interventions, more information is needed on factors associated with intentions to use and sustained use.

For obvious reasons, research into *unsafe abortion* has been difficult. Though operational research has shown the effectiveness of using simple technologies administered by trained practitioners, additional research could provide valuable information on barriers hampering women's access to safe abortion services.

Overall, the evidence base on successful approaches in reducing *gender inequity* and their effect on sexual and reproductive health is meagre. More research is necessary into the impact of male involvement on health outcomes, to substantiate the current view that men play a crucial role in sexual and reproductive health promotion.

Quite a number of impact studies addressed the effectiveness of interventions in *adolescent sexual and reproductive health*, though more research is needed on the effectiveness of behaviour change and life skills programmes. The quest is for effective interventions that go beyond knowledge increase and intentions to alter behaviour. There is also a need to address the effect of community and participatory approaches

on improved adolescent SRH. An area virtually unexplored is adolescent SRHR in conflict settings.

More impact studies are needed of interventions for *integrating services* e.g. the impact of integrating vertical family planning services into the public health system. The search for impact studies in SRHR failed to find impact studies on health system strengthening. Further impact research could focus on assessing, for example, the right conditions, dynamics, and possibilities of a public-private mix in SRH service delivery; the effect of financing and payment reforms on SRH services; new and innovative models for government contracting; and human resource challenges.

1
Introduction

1.1 Background and aim

Despite the challenges and setbacks in advancing sexual and reproductive health and rights, there are also successes to report. Most notable is the continuing widespread support given to the International Conference on Population and Development (ICPD) Programme of Action and the adoption of an additional reproductive health target *universal access to reproductive health* within the context of the fifth Millennium Development Goal (MDG) of improving maternal health.

The tasks ahead are to stimulate stakeholders to complete their unfinished agendas and to continue investing in research on interventions that investigates their content and constraints. Besides increasing our knowledge and evidence-base on *what* works, we face the challenge of implementing policies and effective interventions, especially in resource-poor settings.

This synthesis of impact evaluations in the area of sexual and reproductive health and rights (SRHR) aims to present a state-of-the-art overview of *what* has been documented on proven interventions in the field of sexual and reproductive health and rights. It focuses exclusively on impact evaluations[2] and systematic reviews, for two reasons:

- The Policy and Operations Evaluation Department (IOB) of the Netherlands Ministry of Foreign Affairs plans to conduct an impact study in the area of sexual and reproductive health in 2009. In order to determine the subject and focus for this undertaking, it was necessary to review the literature review, to ascertain the current evidence on successful interventions in SRHR and to identify research gaps;
- Impact evaluations are proven methods of assessing whether the intended outcome has been achieved.[3] Though they are primarily motivated by obligations of accountability, they also offer guidance to governments, donors and NGOs in selecting useful programmes. Or, in the words of Duflo and Kremer (2005) on the 'impact' of impact studies: 'by credibly establishing which programmes work and which do not, international agencies can counteract scepticism about the possibility of spending aid effectively and build long-term support for development. Just as randomised trials revolutionised medicine in the 20th Century, they have the potential to revolutionise social policy during the 21st'.

2 Impact evaluations are studies based on an experimental or quasi-experimental design. In experimental design, participants are randomly assigned to either an intervention or a control group; quasi-experimental designs use matching or reflexive comparison techniques in order to construct a counterfactual premise.

3 Defined by the World Bank (2007) as *the counterfactual analysis of the impact of an intervention on final welfare outcomes, whereas the intervention can refer to a project, programme or a policy.*

1.2 Method

The current document is based on the abovementioned literature review, which took place in 2008 and entailed searching databases and websites for relevant impact evaluations on sexual and reproductive health and rights. In addition, articles and reports were identified through cross-references. Candidate studies for the analysis had to meet the following criteria:

- experimental and quasi-experimental study design, systematic reviews;
- studies conducted in developing countries, preferably – but not restricted to – partner countries of the Netherlands;
- period: most recent, preferably published between 2000 – 2008;
- thematic area: sexual and reproductive health and rights[4];
- peer-reviewed articles, reports, books (in English).

The synthesis has been organised according to the five core aspects of sexual and reproductive health as described in the WHA Global Strategy on Reproductive Health (2004):

- improving antenatal, perinatal, postpartum and newborn care;
- providing high-quality services for family planning, including infertility services;
- eliminating unsafe abortion;
- combating sexually transmitted infections, including human immunodeficiency virus (HIV)[5];
- promoting sexual health.

Issues pertaining to adolescent sexual and reproductive health are dealt with separately. The aspect of sexual health has been broadened to include reproductive rights and sexual and gender-based violence and thereby to include the priorities[6] of the Netherlands Ministry of Foreign Affairs' policy on sexual and reproductive health.

4 Following the ICPD (1994) definition of reproductive health.

5 The strategy describes combating STIs, including HIV as well as reproductive tract infections, cervical cancer and other gynaecological morbidities.

6 Priorities include: combating violations of human rights (area of HIV/AIDS and sexual and reproductive health); increasing access to prevention; strengthening political leadership, the role and position of women, health systems; furthering the Cairo Agenda and a continuation of the dialogue on rights of young people and minorities and the prevention of unsafe abortion. Source: Ministry of Foreign Affairs/DSI (2008). Policy paper HIV/AIDS and sexual and reproductive health and rights in foreign policy – Choices and Opportunities (in Dutch).

1.3 Limitations

1) The current synthesis is limited in terms of discussing impact studies of HIV/AIDS interventions. Relevant studies pertaining to HIV/AIDS are discussed under STI prevention interventions. The decision to limit the synthesis in this regard was made in order to avoid overlap with a recently published 'Synthesis of Evaluations of HIV/AIDS Assistance'.[7] Also largely excluded from this document are biomedical studies or clinical trials which have tested the effectiveness of treatments, newly developed drugs or vaccines.
2) Ideally, a systematic review will find all studies addressing a specific search question: in this case, impact studies on sexual and reproductive health and rights. In reality, it is not always possible to find *all* the studies. Furthermore, it is difficult to know what you have missed. According to the Cochrane Collaboration[8], most systematic reviews are subject to this limitation, simply because studies with significant, positive results are easier to find than those without. This synthesis is no exception.

1.4 Guide to the reader

The following chapters discuss the available findings on successful and / or promising interventions in sexual and reproductive health. They provide an overview of evidence accumulated from impact studies in the core domains of sexual and reproductive health, addressing maternal and perinatal health (chapter 2), family planning (chapter 3), STIs (chapter 4), abortion (chapter 5), reproductive rights, sexual health, gender issues and gender-based violence (chapter 6), adolescent sexual and reproductive health (chapter 7), and integrated services (chapter 8). The final chapter 9 presents overall conclusions and identifies research gaps on the basis of the evidence available to date.

7 Kovsted and Schleimann, 2008. Published by the Ministry of Foreign Affairs of Denmark.
8 Cochrane Collaboration Open Learning Material: http://www.cochrane-net.org/openlearning/html/mod15-2.htm.

2
Improving maternal and perinatal health

2.1 Introduction

'Today, thanks to the Safe Motherhood Initiative and the work it has inspired, we know more on what works. We have also gained substantial experience in implementing effective approaches.'[9] Knowing what works in reducing maternal mortality certainly applies to the straightforward, common life-saving procedures in maternal health that are generally part and parcel of routine healthcare interventions – whether these are providing food or nutrition supplements to all non-pregnant women of reproductive age, or are more sophisticated interventions, such as caesarean sections and blood transfusions.

However, knowing what works is not enough. The general feeling among the international community can be summed up as 'the task is far from over'.[10] Accordingly, governments, civil society and development partners are urged to incorporate the knowledge of what works into effective strategies and interventions, and rather focus on the *how*. How do we assure women have access to life-saving interventions in time and in an affordable way? Here the issue becomes complex. Certain barriers around and within a health system still prevent women from accessing skilled care at delivery. It is hard to find a country that has a malfunctioning health system yet has low maternal mortality rates. In other words, the maternal health status in a given setting is regarded as the ultimate litmus test of a health system.

As Bhutta et al. (2008) comment, several recent reviews of maternal, newborn and child health and mortality have emphasised that a large range of interventions are available with the potential to reduce maternal and newborn mortality and morbidity. This chapter commences with the role of antenatal care and its effect on maternal and perinatal outcomes (section 2.2), then discusses skilled care at delivery (section 2.3) and the strategies at the community and household levels intended to enhance maternal and perinatal health (section 2.4).

2.2 Antenatal care

The introduction of special care for women during pregnancy through the public health services was a relatively late development in the history of modern obstetrics. Not until the late 1930s did the UK and Northern Ireland authorities decide that all women should be offered regular check-ups during pregnancy as an integral part of maternity care (Abou-Zahr and Wardlaw, in: WHO, 2003). In recent decades, evidence has been collated about the impact of antenatal care in reducing the risk of serious complications and maternal deaths. It has become increasingly clear that antenatal interventions have relatively little impact on maternal mortality. Though the risk

9 WHO press release (22 May 2007), commemorating the 20th Anniversary of the Safe Motherhood Initiative.
10 Ibid.

approach – identifying those most at risk during pregnancy – became the focus of maternal health, it has not proved particularly useful because most women who will develop life-threatening complications rarely present with apparent risk factors during pregnancy. And those identified as being at risk generally end up with uneventful deliveries (Abou-Zahr and Wardlaw in: WHO, 2003).
This insight does not nullify the importance of antenatal care, however. Abou-Zahr and Wardlaw (in: WHO, 2003) argue that the potential benefits may prove to have a significant impact upon the health and survival of infants. Furthermore, antenatal visits may facilitate access to skilled care during delivery, provide information on danger signs, and offer life-saving preventive measures, such as tetanus immunisation. Especially recognised is the potential of antenatal services as an entry point for HIV prevention and care.

Equally important to gathering statistics on the actual use of antenatal care is the collating of evidence on the quality of the antenatal care and the health system requirements that enable this care to be delivered. A randomised controlled trial set up in Argentina, Cuba, Saudi Arabia and Thailand (Villar et al., 2001) aimed to compare the standard model of antenatal care[11] with a new model for low-risk women (a four-visit programme of screening, intervention and health promotion at the first visit and then at 26, 32 and 38 weeks). Overall, the findings demonstrated that for women without previous or current complications, a reduction in the number of visits is not associated with increased risk for them or their infants. The provision of routine antenatal care by the new model appeared not to affect maternal and perinatal outcomes. The findings indicate a high acceptance rate, both from the side of the providers as well as from the women. The model potentially allows for cost reduction, by freeing up time for other services, extending existing services, or both. Wider implementation of the model was set in motion, for example in the scaling-up of the approach in Thailand.[12] The model is also being promoted as 'focused antenatal care' in Ghana, Kenya and South Africa, and is being introduced in Tanzania and Zimbabwe. It has been proposed to modify the model for the African setting by adding other components, including HIV counselling, testing and treatment (WHO, 2008 and WHO, 2008a).

2.3 Skilled attendance at delivery

Gradually, the focus of maternal health programmes has shifted from ensuring that *all* women receive antenatal care towards ensuring skilled care attendance at delivery,

11 The 'standard' or 'traditional western' model of antenatal care generally consists of a woman visiting the antenatal care clinic about once a month during the first 6 months of pregnancy, once every 2-3 weeks for the next 2 months, and then once every week until delivery. Under ideal circumstances, a women would have about 12 visits (Villar et al., 2001).

12 Described in a case study that was part of the external evaluation of HRP 2003-2007: 'Improving maternal and newborn health'. Affette McCaw-Binns. WHO, 2008.

addressing both the qualifications of the health professional as well as the enabling environment. There are high expectations of what could be achieved by skilled care at delivery; however, as Graham et al. (2008) observe, there is a lack of dedicated robust evaluation measures and mechanisms for capturing both the essential 'skilled' characteristics of providers (clinical or interpersonal) and environmental aspects. Additional studies have therefore been conducted, such as the impact study in Bangladesh and the impact evaluations of the 'Skilled Care Initiative' (SCI). These studies aimed to provide factual evidence on how to make skilled care more available and accessible in resource-poor settings.

Several studies have addressed the access and use of Emergency Obstetric Care (EmOC).[13] However, the study in Bangladesh (Barbey et al., 2001)[14] was the first to measure changes in access to and use of emergency delivery services resulting from interventions to enhance quality of care at health facilities combined with community mobilisation activities. It found more use of EmOC services in the intervention sites, and increased knowledge of danger signs. Specifically, the establishment of community support systems had a positive impact on the use of services; on average, more than one third of the village households participated in a community support scheme, such as emergency funds and transport to the health facility. Unfortunately because of limitations in the study design, it was not possible to document the effect of each intervention separately. The success of the Birth Planning Card programme led to the Government of Bangladesh incorporating the card into its health programme. Whether the card remains sustainable, however, depends on whether the staff remain motivated to train clients to use it and on the commitment of the government or donors to pay for it to be provided to clients.

The Skilled Care Initiative, a programme launched in Kenya, Tanzania and Burkina Faso, aimed to improve the availability and quality of care in the intervention districts.[15],[16] The interventions included facility-based improvements (such strengthening infrastructure, addressing shortcomings in supply and equipment, and improving provider skills) and actions at the community level (such as birth preparedness counselling and behaviour change communication). The impact studies in the three countries assessed changes in the access and use of reproductive health services (antenatal, normal and complicated delivery care) and the impacts on care-seeking behaviour (see: FCI, 2007). They also addressed issues regarding the financial and

13 Such as the 'inequality analysis' in Bangladesh (Iqbal Anwar et al., 2004). Secondary data were used to assess the utilisation of maternal health care services in Bangladesh. The higher and rising overall utilisation rates of maternal health care services in the intervention area (Matlab) indicated that the interventions had increased utilisation, but also that the inequality in utilisation of EOC services was still unacceptably great (even though the services were free). The authors suggest that there may be other indirect costs (transportation cost, cost of referrals, and attendants' lost time) adversely affecting the utilisation.

14 The Dinajpur Safe Motherhood Initiative (DSI) programme in Bangladesh.

15 Implemented by Family Care International (FCI) between 2000 and 2005.

16 For evaluations of the SCI at delivery in Burkina Faso see TM&IH. Volume 13, Supplement I, July 2008.

cultural accessibility of the interventions, and changes in use made of skilled care over time. The findings in all three countries show a modest improvement in access to emergency obstetric care, based on the Caesarean section rates. One of the significant improvements was increased use of skilled maternity care. There were differences between the countries, however: for example in Kenya, the use of skilled care among the poorest income groups actually declined, even among women who had high levels of household preparation for birth, which indicates that the high cost of delivery was a barrier to equitable access.

Most notably, the experiences from the Skilled Care Initiative illustrate the need to take local factors and circumstances into consideration when determining access to and use of maternal health services. Based on the findings of the SCI in Burkina Faso, Graham et al. (2008) argue that the concept of skilled attendance does not exist in a vacuum in space or time. The concept requires *context-specific approaches* that are based on the capacity of the health system and maternity care utilisation patterns of communities. The SCI evaluation clearly outlined the implications of bringing skilled care closer to women, ensuring continuity and availability of life-saving surgery.

22 Skilled attendance at delivery is widely regarded as the single most important intervention to promote safe motherhood in low resource settings. For its implementation it is essential to establish effective health policies that fit local resource situations and that ensure widespread access to critical health services. Bringing affordable and functional services closer to women, ensuring continuity and availability of life-saving surgery, and working closely with communities to identify context-specific barriers to accessing care are the policy priorities derived from the evaluation research of SCI in Burkina Faso.[17] The authors stress that though none of the policy messages are surprising, they are supported by community-based data presented in the studies on the Initiative.[18] In addition, they underline the need for the implementation of the policies as a package and as part of a wellness-resources programme, since none of these measures by itself is expected to make a huge impact on safe motherhood.

2.4 Home- and community-based strategies

In 'Strategies for reducing maternal deaths', Campbell et al. (2006) recognise that the concept of *knowing what works* in reducing maternal mortality is complicated by a huge diversity of country contexts and of determinants of health. They argue, however, that in spite of this complexity, only a few strategic choices are to be made, particularly the

17 Conducted by Immpact, a global research initiative for the evaluation of safe motherhood interventions (coordinated by the University of Aberdeen).

18 See: Meda et al. (2008).

implementation of a health centre intrapartum-care strategy.[19] As Campbell forecasts, 'it is expected that without this approach, substantial declines in maternal mortality are unlikely to occur in the next 10 to 20 years'. The central element in this strategy is to ensure that all women have the *choice* to deliver in a health centre – referred to as 'skilled care at the first level' – an understanding which is rooted in a human rights focus, and accelerated by the Cairo Conference.[20]

In reality, many developing countries are far from having this strategy in place. Furthermore, ensuring there is a package of intrapartum care in health facilities does not by itself guarantee an effect on maternal mortality. The actual impact depends upon uptake of services, the quality of the implementation and the preclusion of harm. In the absence of a well implemented intrapartum-care strategy, or in the period of transition towards it, many countries have to rely on home-based strategies. When rethinking primary health care, it is increasingly being recognised that interventions at the household and community levels are crucial elements in the chain of 'continuum of care' for maternal and newborn health, and as potential agents in linking communities to the local health system.[21]

Pfizer (in: JHIEGO, 2004) describes the results of a community-based intervention in Indonesia. The aim of the study was to document the effect of community-based distribution of misoprostol to address two issues: the potential of expanding the active management of third stage of labour (including the administration of oxytocin by a midwife) and the effect of self-administration of misoprostol if a midwife is not available. Women in the intervention area were less likely to experience excessive bleeding, less likely to need an emergency referral, and less likely to need an emergency referral for post-partum haemorrhage. Campbell et al. (2006), however, caution against relying on technologies that yet have to prove their effect on maternal health and moreover still have to prove their safety, taking into consideration the potential misuse of misoprostol in the home and the relatively uncontrolled over-the-counter sale of misoprostol and ocytocin.

For many years, the role of traditional birth attendants (TBAs) was contested because of the limited evidence of their contribution to reducing maternal mortality. After much debate and operational research the general consensus is that trained TBAs have a limited effect on maternal outcomes, most often because skilled back-up services and referral systems are not in place. Two large-scale randomised controlled trials, one in

19 A health centre intrapartum care strategy targets all intrapartum women and aims to maintain the normality of the birthing process, with an emphasis on non-intervention and timely watchfulness, and on the preservation of psychosocial benefits of a positive birthing experience. Underlying this strategy are principles of safety, primary prevention where possible, and early detection and management of problems. The treatment component of the strategy includes all basic emergency functions, apart from blood transfusion or surgery available at the referral levels (comprehensive emergency care). In: Campbell et al. 2006.

20 See: WHO, 2005 World Health Report.

21 See: the Lancet Series of eight papers about Alma-Ata: rebirth and revision (September 2008).

Pakistan (Jokhio et al., 2005) and one in Nepal (Manandhar et al., 2004) support this conclusion.

However, as White (in: World Bank, 2005a) describes, evidence from Bangladesh suggests a positive effect of trained TBAs on infant lives saved.[22] A similar effect on perinatal mortality was found in an impact study in Pakistan. Jokhio et al. (2005) report that while training of TBAs and support to health facilities did not have a significant effect on the percentage of women who delivered at a public or a private health facility, it did positively influence a reduction of perinatal mortality – provided the TBAs were sufficiently trained and linked to the health system.

The study by Manandhar et al. (2004) specifically addresses the effect of an intervention (participation of women's groups) on a reduction of neonatal mortality. The intervention resulted in changes in home-care practices and health-care seeking for both neonatal and maternal morbidity. The study is one of the few controlled investigations addressing the effect of participation as a key element in primary health care. Both studies (Jokhio and Manandhar) substantiate the possibility of achieving major improvements through interventions at the community level in terms of perinatal health and, to some extent, of maternal health.

Bhutta et al. (2008) conducted a systematic review of new evidence on potentially useful interventions and strategies for enhancing delivery at the primary health care level. Some of the strategies proved especially suitable, such as the community support groups and interventions to link communities with first-level referral facilities. The authors underline the need to ensure universal access to skilled care at delivery; however, from a pragmatic perspective – and taking into consideration the shortages of trained staff – other alternative strategies need to be considered. The most prominent option is to make use of community health workers to deliver specific services. Although there is credible evidence from cluster and randomised trials[23] on the difference they can make – especially in the management of newborn and childhood illnesses – this does not necessarily result in such approaches being upscaled. According to Bhutta et al. (2008), countries must carefully weigh up whether to invest in developing a new cadre of health workers, especially when the primary care health system is reasonably functional and care-seeking is the norm.[24] However, in countries with a low coverage and limited care-seeking behaviour, the training of community health workers may prove the best intermediate effective way to reach those in greatest need – provided these efforts do

22 The World Bank financed the training of approximately 14,000 traditional birth attendants through the late 1990s. When training of TBAs was abandoned, a shift in international opinion was observed towards a policy of all births being attended by skilled birth attendants. The evidence in the report on Bangladesh does show the effect of training TBAs on saved infant lives, at a cost of USD 220–USD 800 per life saved.

23 See Bhutta et al. (2008), referring to among others to the studies in Pakistan (Jokhio et al., 2005) and in Nepal (Manadhar et al., 2004).

24 Bhutta et al. (2008) referring to experiences with the phasing out of 'Barefoot doctors' in China, as soon as the health system strengthened.

not sidetrack from implementing longer-term interventions to strengthen the health system.

3
Promoting family planning

3.1 Introduction

Despite the long history of family planning programmes, since the early 1960s the high fertility rates and huge unmet need for family planning in some countries have been staggering. It is estimated that over 120 million couples do not use contraceptives, even though they want to space or limit their childbearing. In some sub-Saharan countries the total unmet need exceeds 30% of all married women.[25] In part this shortcoming in addressing the reproductive health needs of millions of couples worldwide is explained by a shift in focus induced by the International Conference on Population and Development in 1994, to incorporate family planning into a broader agenda of women's empowerment and reproductive health and rights. In addition, new priorities arose, including HIV/AIDS, population ageing, and international migration. This in turn influenced funding channels and the overall family planning agenda.

As in other areas, there is no blueprint for the most (cost) effective ways of promoting family planning. On the biomedical side, the safety and effectiveness of methods themselves are well established. The key issues therefore remain the promotion of methods, increasing knowledge and ensuring equitable access to service delivery. Furthermore, contextual elements will largely determine whether an intervention will work. As Cleland et al. (2006) argue the best family planning programmes have drawn widely on indigenous knowledge and creativity to promote family planning; this underlines the need to adapt standard approaches to local circumstances.

The principles underlying effective ways of promoting family planning are straightforward and uncontroversial (Cleland et al., 2006): a climate of opinion needs to be created that is supportive of modern contraceptive use and the idea of smaller family sizes; knowledge about methods should be disseminated; a range of family planning services and products should be made accessible and affordable; and health concerns related to family planning must be adequately addressed. The available evidence on the impact of interventions in the areas of knowledge and changing behaviour (section 3.2), quality aspects (section 3.3) and strategies to increase access (section 3.4) is discussed below.

3.2 Increasing knowledge and changing behaviour

Traditionally many family planning campaigns are based on 'knowledge, attitude and behaviour' approaches[26], all of which place an emphasis on knowledge and attitude as

25 Estimates of unmet need are available for 57 developing countries that have undertaken a DHS inquiry since 1995. In 13 nations, 9 of which are in SSA, total unmet need exceeds 30% of all married women. In an additional 18 countries, 15 of which are in SSA, the estimates lie between 20% and 30%. Cleland et al., 2006.

26 This approach implies a sequence of knowledge preceding attitude, preceding behaviour/positioning behavioural change as the ultimate outcome of a cognitive and affective dimensions.

precursors to or main determinants in behaviour change. This notion has been contested by some, who have argued that environmental or resource constraints may impede immediate uptake of services or intentions to alter certain behaviour. In addition, the role of communication (with partner, health professionals and friends) as expressed in the ideation model[27] is considered essential in changing individual thoughts and community norms about family planning (Snyder, 2003).

In a meta-analysis of the effectiveness of family planning campaigns in developing countries, Snyder et al. (2003) collated evidence on the effect of a variety of outreach methods from 39 campaigns implemented between 1986 and 2001.[28] Their analysis examined the ability of family planning campaigns to impact on different types of outcomes. The 'bottom line' behaviour examined was the use of modern contraceptives and family planning in general. Because of the difficulty in bringing about behaviour change, the study aimed to map progress of *moving towards* behaviour change.

The meta-analysis succeeded in collating evidence on a number of issues. Not surprisingly, most campaigns succeeded in increasing knowledge – even when actual knowledge levels were already high – and, to some extent, spousal communication. More illustrative were the average results on the effect of the campaigns on actual use among those who – prior to the campaigns – had high intentions of using contraceptives. This may illustrate the potential of targeting campaigns (or tailoring interventions) to those who have decided to adopt a modern family planning method, but have not yet taken any action. Though much has been written about the effect of multimedia behaviour change communication (BCC) campaigns on family planning attitudes and behaviour, evidence from rigorous impact evaluations is harder to find, or is cannot be used to establish causal relationships because of design[29] or methodological limitations.

3.3 Quality of family planning programmes

The aspect of quality in reproductive health care may refer to the readiness (or preparedness) of facilities to offer services, but also to the manner in which clients are cared for. RamaRao and Mohanam (2003) reviewed major research and interventions regarding 'quality of care' in family planning programmes. They commented on the relatively limited number of rigorous experimental studies in this area. Though quality

27 Ideation change, defined as a change in a person's way of thinking brought about by the diffusion of new ideas and practices (Cleland and Wilson, 1987).

28 Implemented by a wide variety of organisations receiving US federal funding.

29 An appreciable number of evaluations identified by the initial search for impact studies were excluded from the synthesis because they did not meet the inclusion criteria, usually because of the lack of a control group.

aspects are recognised as important, this has not inspired many either to document the efforts made to ensure quality, or to assess the effect of good quality.

The authors looked at a variety of interventions, ranging from system-wide improvements (a series of interventions to improve the readiness of facilities), to specifically targeted interventions (training of providers, job aids). Interventions that improve client-provider interactions appeared to show the greatest promise. Good quality of care results in positive outcomes such as client satisfaction, increased knowledge, and more effective and longer use of contraceptives. The review also indicated that some aspects of quality of care – for example, interpersonal communication – can be improved without large investments in staff, equipment, or supplies. Overall, RamaRao and Mohanam (2003) conclude that based on the studies reviewed it was not possible to draw firm conclusions about which interventions have a significantly positive effect on continued contraceptive use. They advocated doing more rigorous research to answer some of the remaining questions, including the effect of healthcare sector reforms on interventions to improve quality; the readiness and quality of care delivered by the private sector; and insights into whether (and how) perceptions of quality influence a person's choice of family planning facilities.

3.4 Increasing access

Interventions to increase access to family planning services can be located at the level of health facilities, commercial outlets or community. Community-based distribution has proven its benefit in countries where women's access to services is limited, whether by social, cultural or geographical barriers.[30] Douthwaite and Ward (2005) provide compelling evidence on the effectiveness of doorstep delivery of family planning services on contraceptive prevalence in rural Pakistan. Results from this study, including an increased use of reversible modern contraceptive methods, are noted to be similar to the findings of a study on a doorstep programme of 'welfare assistants'[31] in Bangladesh; a country which has seen a steep decline in the total fertility rate over the past two decades.

30 See for example the report on the evaluation of the project on essential health services delivery at the community level (The World Bank, 2004). The study raised the issue of sustainability of the intervention, and stressed the crucial element of discussing this aspect with communities from the outset of the intervention, accompanied by government support to the communities to sustain interventions. A study in Ghana (described in: Debpuur, 2002; Phillips, 2003 and 2005) also addressed the impact on reproductive change of introducing health and family planning services in a traditional African setting. The main findings indicate that reproductive change can be achieved through supply-side approaches; however, the impact cannot be attributed solely to improving access. The most important factor appears to be the incremental effect of combined approaches (community mobilisation and nurse-outreach) on fertility.

31 Trained married women providing family planning counseling and services to couples in rural households.

Bangladesh's success in fertility decline is interesting for a number of reasons. Much debated is the question whether decline in fertility is attributable to reduced poverty and increased women's empowerment, or to the family planning programme in the country. In an analysis of interventions to improve maternal and child health and nutrition outcomes in Bangladesh, White (in: World Bank, 2005a) argues that although socioeconomic changes have played their part in the changes, a substantial part is plausibly explained by the presence of a successful family planning programme. Evidence that supported this explanation is the fact that the fertility decline exceeded expectations given the country's income growth over this period. Furthermore, by the early 1980s contraceptive knowledge was almost universal – again a much better outcome than expected, given the levels of income and female education. Bangladesh's low fertility is also exceptional given the young age at which women marry. These aberrations are best explained by the presence of a family planning programme. Less directly, the analysis shows the importance of access to media in reducing family size and improving knowledge on contraception.

The studies in Bangladesh and Pakistan furthermore deal with the advantages of doorstep delivery of family planning, as compared to integrating these services in family planning or reproductive health services (fixed services).[32] While some claim that female outreach workers can act as agents of change, others argue that these services maintain social barriers restricting women's mobility. In addition, in terms of cost-effectiveness the doorstep approach has been opposed because of the high cost of maintaining a network of outreach workers. As Douthwaite and Ward conclude, improved understanding is needed of the processes that lead to uptake of modern methods, combined with research to establish the best cost-effective way of ensuring such uptake.

Another study in Pakistan addressed the impact of franchised family planning clinics – in poor urban areas – on knowledge, contraceptive use, and the unmet need for family planning (Hennink and Clements, 2005). The new clinics appeared to have had little impact on the overall contraceptive prevalence rate of the population, though distinct effects were seen on the adoption of individual methods, including a decline in condom usage rate and a rise in female sterilisation. The patterns of effect on unmet need for family planning varied geographically. At two locations there was a decline in the unmet need to limit births (as compared to spaced births). In other intervention areas the new clinics did generate a demand, though this did not lead to method adoption. The findings of the research suggest the importance of location. Furthermore, the study provided useful information on effective channels of communication for increasing knowledge. An interesting result was the finding that the franchise clinics attracted populations other than those originally foreseen. Despite being located within poor urban communities and offering services at subsidised rates, the clinics drew quite a

32 See also chapter 8 (integrated services).

number of clients from outside the catchment areas, and did not seem to attract the poorest groups.

Chin-Quee et al. (2007) assessed a provider-oriented intervention: the WHO decision-making tool on method continuation and counselling experiences with family planning providers.[33] A field test of the tool in Nicaragua[34] did not yield evidence of a positive outcome in terms of higher overall or method-specific contraceptive rates. On the contrary, women in the control group reported even higher rates of contraceptive use than those in the intervention group. According to the authors, this finding is in line with other research indicating that quality improvements are not necessarily associated with a woman's decision to continue with a particular method but tend to manifest in other aspects, such as side-effects or support from the partner.[35]

33 The DMT tool (or WHO flipchart) functions as a prompt by supplying providers with directions, technical information, sample questions and statements and counselling tips. Unlike other family planning flipcharts the WHO flipchart uses a decision-making algorithm to systematically guide clients and providers through the counselling process.

34 The tool was also field tested in Indonesia and Mexico, using different study designs (Kim et al., 2005).

35 Among others, a study in Peru on targeted counselling (Population Council, 2004).

4
Combating sexually transmitted infections

4.1 Introduction

Efforts to advance treatment and the control of the human immunodeficiency virus (HIV) infection continue to overshadow the attention paid to other sexually transmitted infections, especially in the light of the financial and human resources made available to interventions in HIV/AIDS over the past decades. Worldwide, nearly one million people a day acquire a sexually transmitted infection (STI), HIV being the most well known.[36] Despite the fact that controlling infections – other than HIV – is not specifically addressed in the MDGs, more attention to this neglected area would considerably contribute to their attainment, not least because of the potent interaction between the very early stages of HIV infection and other STIs (Wasserheit in: Low, 2006 and WHO, 2007a).

Low et al. (2006) observe that in terms of treating STIs/RTIs, the most important intervention is the availability of cheap and accurate diagnostic tests, antibiotics, and suppressive antiviral therapies. Unfortunately, many of these are either not available or not accessible in resource-poor settings. The development of rapid diagnostic tests was a relatively slow process, and where available, they are generally still too expensive for governments to incorporate into national health care programmes (WHO, 2007a).

This chapter reviews evidence on STI prevention and control strategies intended to prevent people from contracting the infection, or, as in the case of secondary prevention, to break the chain of onward transmission. A wide array of interventions is available. Research into their effectiveness is discussed in section 4.2.

4.2 Prevention

The effect of community-based interventions to control sexually transmitted infections has been tested in a number of randomised controlled trials. The findings of a trial in Mwanza, Tanzania indicated HIV infection was reduced by about 40% in rural communities as a result of STD treatment interventions. (Grosskurth et al., 1995 in: Sangani et al., 2004) The results inspired many to be hopeful about the effectiveness of syndromic management measures on HIV infections. Unlike the Mwanza study, however, a second trial in Rakai district, Uganda[37] (Wawer et al., 1999 in: Sangani et al., 2004) did not report a striking significant effect of the intervention on HIV incidence (the reduction was only 3%). The results of a third trial with similar interventions in the Masaka district, Uganda (Kamali et al., 2003 in: Sangani et al., 2004), confirmed the findings of the earlier trial in Uganda. The discrepancies in results sparked intense debate on the

36 Each year there are an estimated 340 million new cases of curable STIs as well as many millions of incurable viral STIs, including some 5 million new HIV infections (WHO, 2006).

37 Testing the effect of STD control on HIV infection through periodic mass treatment.

implications of the findings.[38] It was recognised that contextual factors, i.e. the particularities of the environments (including the phase of the HIV epidemic) may have contributed to the different outcomes. The general consensus was that STI treatment interventions may prove beneficial in an environment with an emerging HIV epidemic, combined with high-risk sexual behaviour, high STI rates and a generally poor state of STI treatment services (Mwanza-like settings). In other environments – a more mature HIV epidemic and lower risk behaviour, as in Uganda – the effect of STI treatment on HIV incidence is limited.

Despite the limited effect on HIV prevention there are other compelling reasons why STI treatment services should be strengthened. A review of randomised trials in Peru and South Africa (Sangani et al., 2004)[39] underlines the importance of local acceptance of an intervention and the beneficial impact of interventions on the quality of STI treatment. The studies in Peru and South Africa demonstrated how improved STD case management was achieved through a simple and affordable health service intervention (training, supervision) that could be applicable in similar resource-poor settings. Based on the findings of the trials the authors recommend investing in community-based randomised controlled trials in a variety of settings, to test a range of alternative STI control strategies. Such trials should aim to measure a range of factors that include health-seeking behaviour and quality of treatment, as well as HIV, STI and other biological endpoints.

A systematic review (Bertrand et al., 2006) looked into the effectiveness of 24 mass communication programmes – implemented between 1990 and 2004 – on changing HIV-related knowledge, attitudes and behaviour. None of the campaigns reviewed was based on a comprehensive behaviour change programme (mass media and community level activities). Overall, the review yielded mixed results regarding the effectiveness of the mass media on changed HIV-related behaviours. The effectiveness of the campaign on knowledge improvements was seen in about half of the studies, and ranged from 2% to 100%. Eight studies reported the campaign had a positive effect, reducing high-risk sexual behaviour. In most of the studies it was not possible to assess the distinctive features of an effective campaign. Overall, as the authors conclude, an appreciable number of the studies they examined suffered from a weak design.

38 See also: Korenromp et al., 2005; Cochrane review of Sangani et al., 2004; Kovsted and Schleimann, 2008.

39 The studies were part of Cochrane review of population-based interventions for reducing sexually transmitted infections, including HIV infection (five trials including the Tanzania and Uganda trials). Unlike the studies in Tanzania and Uganda, the focus of the evaluations in Peru and South Africa was on the effect of quality improvements (training of primary care clinic nurses and pharmacists) on the provision of contraceptives, counselling, treatment-seeking behaviour, utilisation of services, sexual behaviour.

5
Preventing unsafe abortion

5.1 Introduction

Of the 210 million pregnancies that occur each year worldwide, about one in five (46 million) is terminated by induced abortion. Of these, around half (20 million) are estimated to be unsafe.[40] Almost all unsafe abortions take place in developing countries; they cause the death of approximately 68,000 women per year. The WHO estimates that an additional 5 million women per year become temporarily or permanently disabled because of the procedure. Abortions are of all times. Even in circumstances where effective contraceptive methods are easily available and widely used, nowhere has the abortion rate has been reduced to zero. Sometimes the decision to terminate a pregnancy by abortion is made for reasons other than birth control, for example because an unwanted pregnancy is a result of rape.

The precise impact of unsafe abortion on maternal morbidity and mortality is difficult to assess, mostly because of incomplete vital registration statistics on abortion-related complications, coupled with a general tendency to underreport, especially in countries where the procedure is illegal. It is even more difficult to link specific programmatic interventions at the population level that are intended to prevent or treat complications from unsafe abortion. The general trend appears to be a decline in abortion-related morbidity and hospitalisation (Grimes et al. 2006), in part because of successful primary prevention[41] and advocacy for access to safe abortion. Progress in declining mortality and morbidity is further attributable to the rise in safe and effective abortion services[42] that are widely promoted as alternatives to dilatation and curettage (sharp curettage), and which are undoubtedly preferable to 'back-street' methods of abortion.

Below, evidence on interventions (e.g. safer techniques) to prevent unsafe abortion is discussed (section 5.2), followed by an overview of studies addressing the effect of post-abortion care programmes (section 5.3). The chapter concludes by discussing human resource issues in countries where abortion is legal (section 5.4).

5.2 Safer techniques

The WHO recommends vacuum aspiration as the preferred method for uterine evacuation before 12 weeks of pregnancy, and a combined use of mifepristone and misoprostol for early medical abortion.[43] However, as mifepristone is not widely available and can be expensive, impact studies were set up to test the effectiveness of

40 Unsafe abortion is defined as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills, or in an environment lacking minimal medical standards, or both.

41 An approach focusing on access to contraception, legalisation of abortion on request, safer techniques and improved provider skills.

42 Noted as secondary prevention interventions, including post-abortion care programmes and tertiary prevention intervention measures such as access to EmOC and repair of fistulas in bowel and bladder.

43 WHO (2003). Safe abortion: technical and policy guidance for health systems.

misoprostol as an abortificiant. Weeks et al. (2005) report on the findings of a trial in a low-income setting in Uganda, comparing the safety, efficacy and acceptability of misoprostol and manual vacuum aspiration (MVA) for treatment of incomplete abortion. Both methods presented similarly high successful abortion completion rates and were perceived satisfactory, though complications were less frequent in those receiving misoprostol.

Unfortunately, nearly one-third of participants did not return for follow-up, making it impossible to provide outcome data on a relatively large proportion of the participants. Therefore a similar study was carried out in Burkina Faso, designed to validate the efficacy results reported in Uganda (Dao et al., 2007). This second study confirmed the earlier results on the efficacy of the treatment methods: high abortion completion rate (both methods) and high acceptability and satisfaction rates for both MVA and misoprostol. In addition, the majority of women reported they were 'satisfied' or 'very satisfied' with the method received and expressed a desire to choose that method again, or recommend it to a friend.

Though the study in Burkina Faso provides support for inclusion of misoprostol in PAC programmes – by demonstrating the safety, effectiveness of non-surgical methods – the study design (open-label controlled setting) and the inability to distinguish between induced or spontaneous abortions may have skewed the results. Some providers believe that misoprostol works differently for induced and spontaneous abortions. As yet there is no scientific evidence to support this presumption. In addition, the counselling, care and follow-up in a controlled setting may not be replicable in day-to-day clinical care. Despite its limitations, the authors are upbeat about the option misoprostol offers in combating maternal morbidity and mortality.[44]

The above results inspire one to be hopeful regarding the potential use of misoprostol as a safe and effective alternative to unsafe abortion practices, provided the introduction becomes part of a wider (national) context of post-abortion care programmes and is supported by information and counselling interventions. The latter proviso is important because, as Grimes et al. (2006) argue, the use of misoprostol often takes place out of sight of the health system and may be administered at home, with no control, as occurred in Brazil where the drug became a common home-based used abortificant after widespread over-the-counter sales. Alarmed by the subsequent rapid increase in hospitalisation rates increased, policy makers reacted by restricting the sale of misoprostol, but this led to clandestine use and even higher rates of abortion-related hospitalisation and higher death rates in some areas of the country. Nevertheless, as Grimes et al. (2006) conclude, women's use of misoprostol in Brazil reduced the severity of unsafe abortion complications, and to some extent also reduced the number of women admitted to hospital.

44 As well as in demonstrating the ability to conduct high quality randomised clinical studies in resource-poor settings, such as Burkina Faso.

5.3 Post-abortion care programmes

Several impact studies have addressed the effectiveness of improvement of post-abortion care (PAC) services (Huntington, 1999). Billings (2005) reviewed 10 post-abortion care projects in Latin America, implemented between 1991 and 2002. Despite methodological limitations[45] the review presents useful evidence on the impact of changed clinical practices on quality and costs. For example, the mere existence of high quality alternatives to effective pain management other than heavy sedation is no guarantee that women will receive them.

Willingness to interact with women before and after the procedure is crucial in this matter. Modifications in the organisation of services – the reorganisation of PAC as an ambulatory service – have great potential to reduce costs, especially considering the high burden of in-hospital care of patients with incomplete abortion. However, the evidence is not conclusive, because of design limitations and actual differences in outcomes on this issue. Lastly, the findings of the review illustrate the need to link post-abortion treatment with counselling on contraceptives: in almost all the studies, post-abortion patients accepted contraception at higher rates than when such services were not offered. Patient counselling remained weak in the various studies, suggesting the need for more provider training and supervision to strengthen this care component. Billings (2005) sees this as one of the main reasons for the expansion of the original PAC model to one that explicitly includes the counselling component.[46]

Johnson et al. (2002) assessed the potential reduction in unwanted pregnancy and abortion through post-abortion contraception in Zimbabwe. Women who received ward-based post-abortion family planning reported higher levels of contraceptive use and fewer unplanned pregnancies. The differences in repeated abortion were not considered significant. Furthermore the provision of free contraceptives, and possibly other reasons underlying the women's decision to participate in the study, may have influenced the women's behaviour, and subsequently the study findings.

An impact study in Ethiopia assessed the availability and quality of PAC, after a scaling-up of services in three regions (Tesfaye et al., 2006). Overall, the intervention appeared effective in terms of increased provision of services and post-abortion contraceptives, improved performance of MVA and providers trained in MVA clinical skills. Interestingly, progress was also reported at the comparison sites. This outcome may have resulted from a nation-wide effort to improve PAC services across the health system in Ethiopia. A matter of concern is the fact that only one in three health centres

45 The review is based on a combination of randomised trials, quasi-experimental and non-experimental designs.

46 Two additional elements: general counselling to identify and responds to women's emotional and physical health needs and other concerns; and community and service provider partnerships to help mobilise resources for PAC and prevention of unsafe abortion and that help services reflect and meet community expectations and needs (Corbett and Turner, 2003, in: Billings et al., 2005).

appeared to be able to provide emergency transportation for patients with severe complications.

5.4 Human resources

In most countries where abortion is legal, only doctors are authorised to provide first-trimester abortions, consequently restricting access to safe induced abortion because of a limited availability of trained health-care providers. Initiatives to broaden access are currently being tested: they include programmes to train nurses, midwives and mid-level health-care workers to provide first-trimester abortions. A randomised controlled trial in South Africa and Vietnam (Warriner et al., 2006) compared the performances of mid-level providers and doctors in first-trimester MVA abortion, in terms of the incidence of abortions with complications. The findings in South Africa and Vietnam indicate that first-trimester manual vacuum aspiration abortions performed by mid-level providers were comparable in terms of safety and acceptability to those performed by doctors. The authors urge caution regarding the validity and applicability of the findings, noting among other things that the study took place in private clinics and there might have been a loss of follow-up. In addition, because of the low number of complications, it was not possible to ascertain how much of the variation in complications was due to variation between providers and between clinics rather than to variation between women.

6
Reproductive rights, sexual health, gender issues and gender-based violence

6.1 Introduction

Agencies throughout the United Nations system have adopted a rights-based approach which has replaced the former *basic needs* approach and places the emphasis on legally binding international treaties that rest on principles of ethics and social justice – many of which are directly relevant to population issues and reproductive health.[47] The International Conference on Population and Development underlined the need to recognise reproductive health as *the basic right* of all couples and individuals.

Another major achievement of the Cairo Conference was the recognition of *sexual health*[48] as being fundamental and relevant throughout a person's lifespan, not just during their reproductive years. In addition, participation became a key element to achieving sexual and reproductive health, requiring people to be empowered to exercise control over their sexual and reproductive lives.

UNFPA supports the integration of human rights standards into their programming framework and guides others in applying a rights-based approach. One of the ways to do so is by recognising that a rights-based approach should rest on an analysis of gender and vulnerability to ensure that programmes reach segments of the population that are marginal, especially disadvantaged women and young people.[49] This section deals with promising approaches reflecting such efforts (section 6.2), followed by a discussion of interventions aiming to address gender equality (section 6.3) and gender-based violence (section 6.4).

6.2 Human rights-based approach

As indicated above, the human rights-based approach provides governments with a framework for taking action and promoting mechanisms by which those assigned responsible can be held accountable. One tool that could be helpful when examining government actions in the light of government commitments is the *Human Rights for Maternal and Neonatal Health*, developed by the WHO and the Harvard School of Public Health (WHO, 2006a) and field tested in Brazil, Mozambique and Indonesia. Though not designed as an impact analysis, the study in Indonesia underlines the need to acknowledge maternal and neonatal health as human rights, and also discusses the implications of this acknowledgement.

47 UNFPA/Angarita A (2005). Rights into Action. UNFPA implements Human Rights-Based Approach.

48 Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (www.who.int/reproductive-health/gender/sexualhealth.html#32002).

49 UNFPA/Angarita A (2005). Rights into Action. UNFPA implements Human Rights-Based Approach.

6.3 Gender equality

In recent decades, attitudes towards the role of men in reproductive health have evolved towards recognising their useful or even 'crucial' role in the promotion of sexual and reproductive health. Sternberg and Hubley (2004) conducted a meta-analysis of strategies regarding men's involvement in sexual and reproductive health promotion. Based on an analysis of 24 studies, they conclude that despite the rhetoric around men's involvement in sexual and reproductive health, in reality there are few published evaluations of interventions. They were unable to determine whether such interventions had had a trickle-down effect on women's empowerment. Some evidence was found on the use of media approaches, though they raised doubts about the application of certain cognitive behaviour change approaches. Sternberg and Hubley suggest that the overall lack of evidence may reflect the fact that the majority of programme interventions are still targeted at women's and children's health.

A study conducted in Bangladesh (Al-Sabir et al., 2004) discussed the results of integrating reproductive health services for men into Health and Family Welfare Centres in the country. The intervention did result in a substantial increase of male clients in the intervention sites; however, most of these consultations were on general health problems. It was encouraging that male attendance at the clinic did not adversely affect women's care-seeking behaviour: on the contrary, the number of female visits to the intervention sites also increased – a result that was sustained after project implementation. Though small in numbers, consultations of RTI and STI clients did increase, among both males and females. This result confirms the hypothesis that if RTI and STI services are introduced in Health and Family Welfare Centres and people are informed about them, they will use the services. The researchers were cautious about the sustainability and scaling-up of the programme. Pre-testing revealed that the providers had limited knowledge on STIs, so therefore follow-up and practical – on-the-job – training will be needed to sustain the improved management of STIs and RTIs.

A study in India (Varkey et al., 2004) reached similar conclusions. The study looked into the involvement of men in maternity care in India. The findings indicated that counselling and involvement of men did increase family planning use – postpartum and among non-users – as well as an increase in joint decision-making on health and family planning issues. Overall, the feasibility and acceptability of male participation was demonstrated. In addition, because of the marginal cost of implementing the intervention it was considered affordable by the management.

6.4 Gender-based violence

Generally, the number of studies into gender-based and sexual violence is rather limited. Only one impact study was found which specifically looked into the impact of a community programme to prevent female genital cutting (FGC) in eastern Nigeria (Babalola et al., 2006). The intervention was successful in terms of increasing intentions not to perform FGC. However, because of the considerable variations in FGC prevalence within the country, it was not possible to extrapolate the findings. Overall, community interventions to eradicate FGC – especially a blend of approaches such as mass media campaigns combined with community activities – have the potential to positively influence the abandonment of FGC. The results of operations research on community-based interventions to abandon of FGC in Burkina Faso and Sudan are expected in 2009.[50]

50 www.who.int/reproductive-health/fgm/eliminating.htm.

7
Promoting the sexual and reproductive health of adolescents

7.1 Introduction

A growing understanding of how behaviour patterns originating in childhood and adolescence influence adult health and longevity has stimulated policy makers and health planners to pay more attention to the period of adolescence. While most young people grow up to become healthy and productive adults, quite a number do not. Social changes, such as rapid urbanisation and a rapid spread of mass media communications, have influenced the sexual behaviour and relationships of young people. In addition, in recent decades important demographic changes have taken place, including earlier puberty, rising mean age of marriage and a steady decline in the extended family. Increasingly, young people are having sexual relations at an earlier age; this coupled with the 'traditional' problems of unwanted or early pregnancy has intensified other sexual and reproductive health problems, such as a rise in infertility because of STIs and unsafe abortions, infection with HIV, and the likelihood of subsequent death from AIDS.

Over the past decade there has been a huge increase in the number of programmatic interventions in adolescent sexual and reproductive health, most notably the primary prevention interventions such as mass media campaigns, social marketing of condoms, peer education, life skills programmes and curriculum-based prevention programmes. Also, more attention is being done to create supportive environments within the communities and within health care facilities. Below is an overview of approaches that have proved successful in reaching adolescents and informing them about their sexual and health rights. The first two sections of this chapter (sections 7.2 and 7.3) deal with prevention programmes for adolescents, then follows a description of promising approaches to increase adolescents' access to SRH services (section 7.4). The final section 7.5 discusses how participation programmes may impact on adolescents' sexual and reproductive health.

7.2 Prevention programmes

There is growing evidence that prevention programmes such as curriculum-based health education and life skills programmes[51] can contribute to young people's mental well-being and influence their health and social behaviour, provided they are focused on specific risk-taking behaviours, such as unprotected sex. The key question in many studies into the impact of such interventions is whether such programmes are capable

51 Life skills programmes aim to foster positive behaviour across a range of psycho-social skills, and to change behaviours learned early, which may translate into inappropriate behaviour at a later stage of life (in: Tiendrebéogo et al., 2003). Life skills programmes typically consist of basic psycho-social life skills (creative, critical thinking), situation-specific life skills (negotiation, assertiveness and self-esteem) and applied life skills (influencing young people's ability to avoid a range of high-risk behaviours) (UNICEF, 1997).

of equipping young people with the information and skills they need in order to be able to resist pressure from peers and other societal influences.

Over the years various such studies have been published. Many are studies on the effectiveness of the promotion of low-risk behaviour in the context of protection from HIV and other STIs and unwanted pregnancy. In their systematic literature review, Kirby et al. (2005) analysed 83 evaluations of curriculum-based education programmes on sex and HIV, of which 18 were deployed in developing countries.[52] The vast majority of the programmes focused on pregnancy or HIV/STI prevention behaviour and did not include broader issues of sexuality (such as gender roles, or romantic relationships). Though the studies in the review successfully demonstrated that sex and HIV education programmes can increase the target group's *knowledge* about how to avoid HIV/STIs and unintended pregnancy, their ability to influence behaviour in such a way that the incidence of HIV/STIs and unintended pregnancy was actually reduced was less clear cut.[53]

Tiendrebéogo et al. (2003) also note that for many years, responses to the problem of high HIV prevalence among young people have focused on information, education and communication materials. However, as the authors conclude, 'the hoped-for changes in behaviour and attitudes in response to this flood of information have not materialised. Study after study has shown little correlation between information and behaviour change'.

Kirby et al. (2005) note that half of the studies they examined lacked sufficient statistical soundness to enable any meaningful conclusions to be drawn about a programme's effect on behaviour. The statistical unsoundness was aggravated by the fact that the studies had to divide their samples into various sub-samples. Despite this, it was possible to draw conclusions about the content of successful programmes, and the implementation requirements. For example, it was concluded that the participation and involvement of the target group in design issues was found

52 Schaalma et al. (2002) comment on the fact that rigorously evaluated interventions that have been found to be effective, predominantly are from the United States. However, a randomised controlled trial in the Netherlands reported on the effectiveness of a theory- and evidence-based programme for secondary schools (Long Live Love) that has been widely implemented within the Dutch education system. The trial demonstrated the favourable effects of the programme on social-cognitive mediators of consistent condom use, and a differential effect on sexual risk behaviour: the higher young peoples' sexual risk at baseline assessment, the more they benefited from the intervention programme. In addition, as Schaalma et al. argue, cultural, social and economic differences make it unlikely that interventions found to be effective in developed countries will transfer easily to developing countries. Such technology transfer should be accompanied with expertise in how to develop and evaluate culturally embedded interventions.

53 However, Jemmott and Jemmott (in: Schaalma et al., 2002) note that carefully designed and theory-based interventions that take account of the population characteristics and cultural context can generate positive behavioural changes in adolescents' HIV-risk behaviour. But they stress 'that the boundary conditions for such effectiveness need to be clarified, and questioned whether interventions found to be effective will remain effective when implemented on a wider scale by people who were not involved in their design and evaluation'.

important. Furthermore, effective curricula had in common that they created a safe environment for youth and focused on clear goals. A curriculum was also more successful when it addressed *risks* as well as *protective* factors affecting sexual behaviour, and included activities to change these factors. A consistent finding was that skill-based programmes were more effective at changing behaviour than were knowledge-based programmes.[54]

Complementary to Kirby's review, which dealt mainly with studies in developed countries, is the review of school-based HIV education programmes for African youth. (Gallant and Maticka-Tyndale, 2004) This review is notable for its critical comments on methodological issues and the interpretation of results. Firstly, the reviewers found no evidence to support the assumption that basing a programme on theory contributes to its effectiveness.[55] An important point was that almost all programmes attempting to promote condom use, except one in South Africa and one in Nigeria, encountered resistance from communities and teachers.[56] The findings indicate that the introduction of condoms as a preventive measure may work best among older youth, when teachers are not the primary programme implementers and when there is clear community support. (Gallant and Maticka-Tyndale, 2004).
Three school-based HIV/AIDS interventions (teacher training, encouraging student debate on HIV/AIDS protection and reducing the cost of education) were assessed on their effectiveness regarding teenage childbearing. Teenage pregnancy is seen as a proxy for risky sexual behaviour, and although imperfect, is generally considered to be a more reliable statistic than self-reported behaviour data. Overall, programme interventions, especially teacher training, appeared to have limited impact on the actual teenage pregnancy rates. However, reducing the cost of education for students appeared to decrease dropout rates, marriages and childbearing among teenagers. The authors conclude that it is necessary to use biomarker tests[57] in order to properly assess

54 Teaching young people to resist social pressure is central to many health promotion programmes, as demonstrated in the Long Live Love programme in the Netherlands (see: Schaalma, 2004).

55 Based on the evidence collated in Schaalma et al. (2002) on the effectiveness of a theory base for HIV prevention interventions, it was noted that it was the early efforts (in the 1990s) in particular that reported few effective interventions, primarily because 'AIDS reduction efforts that have been based on formal conceptualisations of any kind are extremely rare'. Most evaluations showed methodological weakness and a lack of clarity regarding the theoretical basis and the precise nature of the interventions.

56 Compare Schaalma et al. (2004a), who report that despite evidence of the capability of designing programmes that do bring about change, there are many obstacles to the widespread diffusion and adequate implementation of school-based sexual health promotion programmes. They include the acceptability of these programmes to teachers and school administrators (who may perceive a programme as being too sensitive or controversial for children). AIDS education may also conflict with the teacher's own personal sexual morals and values. Other obstacles include lack of self-efficacy, perceived complexity, or incapacity to discuss sexual issues except as biomedical phenomena. In addition, to succeed, education on AIDS and sex must be given in a 'safe' classroom environment.

57 The school bases survey before and after implementation of the MEMA kwa Vijana Project in rural Tanzania (Ross et al., 2003 and Todd et al., 2004) used biomarkers to test for HIV, Chlamydia trachomatis, Neisseria gonorrhoeae and, among female participants, for pregnancy. The study was the first reported school-based survey of the prevalence of HIV and STI in primary school children in SSA.

whether self-reported use of condoms corresponds with an actual reduction in the incidence of HIV/AIDS.[58]

The African Youth Alliance (AYA) programme implemented in Ghana, Tanzania and Uganda[59] aimed to improve the adolescent sexual and reproductive health of male and female youth and prevent HIV transmission. In each country, AYA focused on the simultaneous implementation of six key programme components[60] that formed the integrated package of interventions to address ASRH needs. The evaluation (JSI, 2007 and Williams, 2007) produced positive results in terms of outreach of the programme and young people's ability to recall ASRH messages. The degree of exposure, however, varied by country and by type of intervention. The results further demonstrated a significant positive impact, most notably on condom use, contraceptive use, reduction in the numbers of sexual partners, self-efficacy and knowledge. Overall, the impact of AYA on ASRH behaviours and their antecedents was greater for young women than for young men, especially in Ghana and Uganda. The researchers conclude that a comprehensive, multi-component approach such as AYA's can be effective in improving some key aspects of ASRH.

A culturally consistent reproductive health programme for young people in Kenya (the community-based and locally designed 'Nyeri Youth Health Project') was unique in a number of ways (Erulkar et al., 2004). Firstly, the intervention (counselling and life skills curriculum) was accepted by the community. Also, the period of intervention was presumed to be long enough to affect young people's behaviour. Some of the indices of ARH behaviour in the control area did worsen, perhaps partly because of increased campaigning against family planning clinics by religious sects in Kenya. The project illustrated that the incorporation of indigenous systems in programming can be instrumental in improving the reproductive health status of young people in SSA.

7.3 Social marketing

Social marketing programmes aim to increase knowledge on HIV/AIDS and STI prevention, generally through mass media campaigns to promote condom use. In many countries these programmes are being implemented by PSI, a non-profit social marketing organisation selling products and services at subsidised prices in order to motivate commercial sector involvement. Quite a number of the evaluations of such

58 In a systematic review of evaluations of HIV/AIDS assistance Kovsted and Schleimann (2008) arrive at a similar conclusion regarding the limited evidence base on the impact of prevention programmes on behaviour change.

59 A partnership between UNFPA, Pathfinder International and the Program for Appropriate Technology on Health. The programme interventions included a comprehensive set of interventions of BCC, youth-friendly services and outreach services (peer education and other community activities).

60 Policy and advocacy coordination, capacity building, coordination and dissemination, BCC, YFS, and the integration of ASRH with livelihood skills training.

programmes have methodological flaws, because they were designed as programme evaluations and not necessarily to measure the impact of the intervention on behavioural outcome. Overall, social marketing programmes appear to be effective in terms of improving awareness and increasing knowledge, but have less impact on young people's perceptions about their susceptibility to reproductive health problems, or on bringing about actual changes in their behaviour (sexual activity and condom use).[61] These findings are in line with the conclusions of Kovsted and Schleimann (2008) regarding the effect of condom marketing in the context of HIV/AIDS prevention programmes. The effectiveness of knowledge and awareness campaigns is often hampered because condoms are used infrequently and because of the misconception that condoms are only to be used for family planning purposes. The authors state that the precise extent and nature of these problems are not known, as evaluations of these types of programmes generally record progress in terms of programme output only.

7.4 Increasing access

A study in Nicaragua (Meuwissen, 2006) looked into the impact of a voucher programme on improved access and quality of primary care, including SRH care, among poor adolescent girls in Managua. The study demonstrated how a simple intervention successfully increased access to SRH care for poor and underserved girls and increased their knowledge and use of modern contraceptives. Many adolescents appeared willing to protect themselves against the risks inherent in sexual intercourse. The future will reveal whether the impact will be sustained beyond the voucher programme, after the withdrawal of financial support and technical guidance. The researchers further stress that knowledge and access alone are not sufficient to change adolescent behaviour. Other factors such as the social (parental) and legal acceptability of providing condoms to adolescents may have an impact on the contraceptive use among adolescents. The study did prove, however, that even without changes in the social context of the girls, it is possible to increase access to quality care for a considerable proportion of the target population.

Dickson et al. (2007) evaluated whether the implementation of adolescent-friendly standards contributes to the improvement of quality clinical SRH services for adolescents. In a number of public health clinics in South Africa, a quality improvement intervention was implemented through the National Adolescent Friendly Clinic Initiative. The findings of the study suggest that the programme did improve the quality of adolescent services in clinics. For instance, intervention clinics were more inclined to conduct a community assessment and develop a service plan based on that assessment. Interestingly, a number of control clinics were able to meet some of the standards too. This may be attributed to the fact that some of the 'quality of care' criteria

61 See also (Agha, 2002 and PSI, 2000) for an evaluation of social marketing programmes in Botswana, South Africa, Cameroon, Guinea (Agha, 2002 and PSI, 2000).

(for example, infection control or the availability of medical supplies and drugs) are not restricted to adolescent-friendly services. It is increasingly being recognised that these programmes need to include actions to enhance community support and the acceptance of the intervention – by the providers as well as by the target group. Very few services are designed to meet the specific needs of adolescents. Young people tend to stay away from these services or come too late for effective help, because they often feel unwelcome or misunderstood.[62]

Other studies confirm that merely having adolescent-friendly services in place does not guarantee increased access. A study in Brazil (Magnani et al., 2001) revealed that the programme interventions appeared to have lower impact than expected.
The implementation of a referral system through the schools was not effective because young people tended to use clinics at convenient locations and of perceived better quality. In addition, the evidence found by the study is in line with other studies indicating that the use of SRH services is related not so much to the youth-friendliness of the clinic, but rather to the level of community acceptance of such services for young people.

7.5 Participation

A number of studies looked into participatory approaches that in some way pave the way for increased community understanding and support for interventions in adolescent SRH. In Nepal, an impact study was undertaken to ascertain the impact of a participatory approach and its effectiveness to address the reproductive health concerns of adolescents in Nepal (described in Mathur, 2004 and Malhotra in: World Bank, 2005b). The researchers conclude that overall the intervention had a positive outcome: although the effect was only marginal in terms of basic indicators of youth reproductive health (YRH), it was substantially more positive in terms of the broader, more contextual factors that influence YRH, such as age at marriage, prenatal care, institutional delivery and increased male awareness of reproductive health needs of women. Moreover, the project results indicated that at the study sites there had been improvements in the enabling environment for good reproductive health, resulting in benefits such as the generation of a new mindset in the community, and a deeper understanding of young people's reproductive health and its implications.
The researchers point out that despite the fact that participatory processes are time- and resource-intensive, in the long run the results may prove to be much more cost-effective than other approaches.

Another programme designed to build the capacity and vocational skills of adolescents is the Better Life Options Programme in India, which specifically targeted young girls

62 See also: Mishra and Levitt-Dayal (2003) for results of an intervention in India to improve adolescents' reproductive health knowledge and outcomes through NGO Youth-Friendly Services.

in peri-urban slums. The intervention appeared successful in terms of increased education and vocational skills levels, economic empowerment, autonomy and mobility, self-confidence, and health-seeking behaviour patterns. A potential selection bias may have occurred, however, because participation in the programme was voluntary; this makes it difficult to attribute behavioural changes to the programme (Mensch, 2004).

8
Integrated services

8.1 Introduction

After the Cairo Conference on Population and Development, many countries started reviewing their national responses to reproductive health, and made an effort to align programmes and services to the 'new' approach which was widely agreed upon: integrating SRH services within the public health system. Though the need to integrate services was uncontested by a wide variety of stakeholders, there are examples of initial resistance to integrating STI services into family planning programmes, often because of concerns of stigmatisation.[63] Furthermore, a debate commenced on the meaning of integration and which services to integrate at what level in the health system (WHO, 2005).[64]

A useful contribution to the discussion on entry points for integration of services is the 'integration continuum approach' proposed by Mayhew (in: WHO, 2005). Achieving such a continuum of care requires taking steps at each level of the health system, and carefully analysing the local conditions in order to identify which services need to be integrated and which are best left vertical.[65] In addition, the exact position of integrated services within the health system is often context- and country-specific. For example, whereas STI services in Western Europe are provided at the primary level and usually free of charge, such services in other countries – e.g. the newly independent states – are allocated at the secondary (specialist) level (WHO, 2005). These differences clearly illustrate the need to carefully assess the specific conditions and health system requirements in order to achieve effective integration of services and create opportunities for 'a continuum of care'.

The first part of this chapter (section 8.2) deals with integrating services. In section 8.3 a review is given of integration of sexuality counselling into SRH and HIV/AIDS counselling. The chapter concludes (section 8.4) with some observations on health system challenges.

8.2 Integration

The 2006-2015 Global Strategy for prevention and control of STIs (WHO, 2007a) makes a strong case for expanding the provision of good quality STI care more widely into

63 See: www.rho.org/html/rtis_progexamples.htm#indonesia.

64 Integration of services can be defined as 'the availability of two or more services at the same facility during the same operating hours, with the aim of making those services more convenient and efficient'; furthermore, integration may range from incorporation into a vertical programme of additional activities, to a full merging of two or more programmes into a comprehensive and horizontal primary health care structure (WHO, 2005).

65 A continuum of care services refers to a continuum of services, meeting all the client's needs in a convenient and affordable way, as well as to a continuum over time, meaning that SRH services must be linked over time, from one visit to the next, to ensure continuity and provision of appropriate advice and services (UN Millennium Project, 2006).

primary health care, sexual and reproductive health services and services that provide HIV management, and urges the construction of appropriate models of service provisions that address the needs of men and women equally.

A collation of programme experience on the integration of sexual health interventions into public health services from developing countries provides a comprehensive overview of the latest state of the art and evidence on different aspects of integrated services for men and women (WHO, 2005).[66] As this review illustrates, research on the 'technical' aspects (clinical management) outnumbers operational research on a wider integration agenda. Most notable is the absence of impact studies on the health system requirements for a continuum of care throughout a person's life cycle.

In South Africa, a 'mothers2mothers' programme has demonstrated positive results in terms of increasing the use of prevention of mother to child transmission (PMTCT) services for HIV-positive women (Baek et al., 2007). The programme was designed to serve women throughout the entire PMTCT process, from the beginning of pregnancy through the first year of motherhood. Despite some limitations in terms of study design, the evaluation shows how the service model succeeded in linking community activities to a clinic-based PMTCT programme of delivery of ANC, HIV testing and counselling, and treatment services. The evaluation also provides valuable insights into the role of peer support and counselling activities.

8.3 The 'S' in SRH

Despite a consensus on the need to apply a life-span approach to sexual health and to offer *integrated* sexual and reproductive health services, the evidence on programmes that succeed in doing so is scarce. According to Khanna (2008) many programmes are still struggling with the 'S' in SRH and in general there is still insufficient evidence to be able to draw conclusions on how programmes should deal with sexuality and sexual health.

The systematic review of integration of sexuality into SRH and HIV/AIDS counselling interventions (KIT, WHO, LRIG, 2006) in developing countries provides an overview of the evidence in this area, and identifies promising approaches in improving people's sexual health. The authors conclude that actual insight into the content of sexuality counselling is limited. None of the 27 studies included in the review explicitly assessed the outcome of sexuality issues related to the counselling. Most studies only measured the effect on service delivery. Counselling offered in several SRH and HIV/AIDS related settings contributed to increased uptake of services, increased contraceptive use, increased partner notification, increased condom use, and decreased risky sexual

66 The review compiles programme experience from developing countries with integrating sexual health interventions into reproductive health services, including services for women, men, adolescents. Experiences with violence related to gender, and sexuality and health system issues and challenges are also presented.

behaviour. Based on the available literature, the researchers identified the need for consensus about what the integration of sexuality into SRH and HIV/AIDS counselling interventions entails. Furthermore, good-quality empirical research on the integration is needed, as well as evaluations of programmes designed for specific marginalised groups.

A recent undertaking to fill this gap, though not designed as an impact study, is the documentation of promising approaches in a series of four case studies of sexuality counselling programmes in Uganda, Kenya, Brazil and India. The first study has recently been published (Khanna, 2008).

8.4 Health system challenges

Few rigorous impact studies have been published that systematically evaluate the effectiveness of interventions to strengthen health systems. To date, there are still shortcomings in documenting experiences with the successful integration of sexual health into reproductive health services. The scarcity of evidence is not limited to the field of sexual and reproductive health, and may be attributed to a lack of health systems research in general. As the Alliance for Health Policy and Health Systems Research[67] points out, besides a lack of technical capacity to conduct rigorous – and complex[68] – evaluations, other factors such as little interest from governments, donors and aid agencies, and political and financial constraints may have contributed to this gap. However, despite limited evidence on effective intervention in health systems strengthening, considerable funding is still earmarked for interventions that have yet to prove their effectiveness. A striking example of such is the continued support for training programmes. Implementation of such programmes appears to be based on *assumption* (that training is effective), rather than on evidence.[69]

In addition, examples of successful integration programmes tend to be small-scale; problems are often faced in replication and scaling up. Integration efforts appear to be hampered by problems related to shortcomings of the health system, as concluded by the authors of the synthesis of programme experiences with integrating sexual health interventions (WHO, 2005). In many resource-poor settings, underfunding and poor management of public sector services have an impact on the implementation interventions. For example, shortcomings in personnel and medical supplies may influence the quality of the services, or hamper the delivery of integrated services in the first place. As Mayhew points out (in: WHO, 2005), even where integration is a priority

67 See: WHO/Alliance for Health Policy and Health Systems Research (2007). Health system strengthening interventions: Making the case for impact evaluations.

68 It is difficult enough to map the cause and effect between an activity and a health outcome; it is even more difficult to do this for health reform interventions such as decentralisation or community-based health insurance.

69 Described in: WHO/Alliance for Health Policy and Health Systems Research (2007). Health system strengthening interventions: Making the case for impact evaluations.

and the resources are made available, supply channels are often not well organised, and drugs and materials – made available through international funding – do not reach the services.

The evaluation of the 'mothers2mothers' programme in South Africa described earlier is one of the few documented interventions addressing health systems challenges in sexual and reproductive health: in this particular case, linking communities to their health system. Despite the fact that in recent years the support for health systems research has grown, there are still numerous options for research testing the impact of interventions in strengthening health systems.

9
Conclusions

9.1 Monitoring and evaluation issues

- Overall, the number of impact evaluations in SRHR is limited; an extensive search for relevant (quasi-)experimental studies yielded some 40 studies which met the inclusion criteria. This is no surprise, given the costs and technical requirements of such studies. As Baker (in: World Bank, 2000) notes, many governments and development partners 'are reluctant to carry out impact evaluations because they are deemed to be expensive, time consuming, and technically complex'. In addition, implementing organisations or governments may be reluctant to commission impact evaluations, for fear of the political and or economic (ceased funding) repercussions if the outcome is negative. Duflo and Kremer (in: Pitman et al., 2005) also note the possible interference with genuine interest in evaluating impact. However, it is difficult to assess whether or not critical evaluations have influenced funding for specific programmes.[70]
- Because of the variations in projects, evaluation questions, available data and country circumstances, each impact evaluation is different. In addition, not all project interventions are suitable candidates for an empirical or quasi-empirical evaluation. Hence, the decision to conduct an impact study tends to be based on a balance between the relevance of the subject matter, and its ability to fill a gap in knowledge or to provide evidence to justify scaling-up the intervention. The most robust studies are those with an experimental design, but only a few studies in this synthesis meet this criterion: most of the evaluations in this synthesis were of studies based on quasi-experimental designs. Ideally, a study design includes both qualitative and quantitative methods, allowing for a quantifiable proof of the efficacy of the intervention, as well as an explanation of the processes and interventions that yielded a certain outcome. Reviewing the evidence, it is fair to say that a number of studies would have benefitted from an approach that considers the comprehensiveness of sexual and reproductive health, and the social determinants of health – including education, gender equity, social status, health-related behaviour.
- When it comes to measuring equity, defined as achieving *universal access to reproductive health*, the methodological challenges are numerous. Firstly, the concept of equity is broad and includes a wide range of aspects. Not only is equity a comprehensive concept; measuring progress towards attaining it involves other determinants too that either promote or impede a person's sexual and reproductive health status. Secondly, *access* can refer not only to physical access to services, but also to access to less tangible aspects, such as information, and affordable or good quality services. Ideally, all such demand- and supply-side factors should be considered when *use* of services is used as a proxy measure of access to health care. Finally, whereas universal access is often defined as an objective of health systems, it appears to be more

70 Kovsted and Schleimann (2008) also refer to this aspect in the context of HIV/AIDS evaluations.

practical to 'translate' this as equitable *access* – that is, equal access for people with equal need.[71]

- Only a few of the studies included a cost-effectiveness analysis of the intervention (see for example Barbey et al., 2001, and World Bank, 2005). Despite its difficulties[72] a cost-effectiveness analysis may guide governments in priority-setting processes, by providing information on the relative costs of achieving the programme outcomes.
- Not all aspects of sexual and reproductive health have attracted similar interest from researchers and policy makers. A relatively large number of studies described in this synthesis deal with aspects of improving maternal and perinatal health, family planning and sexual and reproductive health of adolescents, whereas other areas have received less attention (for example, interventions in abortion care, or counteracting sexual violence). This disparity may in part be due to methodological issues or ethical implications. On the other hand, it suggests that programmes and planners have neglected to address less tangible aspects of sexual and reproductive health: for example, how gender inequities and power imbalances may interfere with women's health.
- This synthesis of impact studies falls short in providing convincing examples of interventions able to alter behaviour: for example, in contraceptive use and in prevention of HIV or unwanted sex. In part this is a result of the methodological difficulties of measuring events that *did not* occur because of a programme intervention. As Adamchak et al. (2000) explain, measuring the *absence* of certain behaviour is complex. In addition, it may take years before changes in the health status can be observed. For example, measuring the impact of programmes for young adolescents aimed at delaying their first sexual activity may not yield results until years later.
- Impact evaluations in SRHR are conducted in a wider context, often of poor health information systems, a lack of local capacity to undertake rigorous impact studies, or with other local conditions hampering the research. A number of evaluations reported the need to adapt the initial research methodology for reasons to do with security, participant attrition during the course of the study period, or difficulty in accessing hard-to-reach target populations. In spite of these limitations, as Baker (in: World Bank, 2000) points out, it is possible to conduct rigorous evaluations provided the study is planned properly (ideally prospectively), is supported by policy makers and authorities, and there is a willingness to invest in impact research.[73]

71 WHO/UNFPA (2008b). National-level monitoring of the achievement of universal access to reproductive health. Conceptual and practical considerations and related indicators.

72 First of all, it is difficult, if not impossible, to aggregate all benefits in the analysis. In addition, some benefits may be hard to quantify monetarily, and those that lack adequate measurement methodologies may be omitted. Also, predicting future benefits may appear difficult. See also: The Alan Guttmacher Institute/ Vlassoff M, et al. (2004).

73 Generally a relatively small amount, compared to the overall programme costs.

9.2 Evidence gaps

By and large there is consensus among policy makers and scholars alike on the need for more evidence on best practices, cost-effective and innovative interventions and approaches in the domain of sexual and reproductive health and rights. The Conference 'Making the link', organised on the eve of the tenth anniversary of the ICPD[74], reflected the widespread belief among academics, programme staff, donors and policymakers that there is a need to create an evidence base linking sexual and reproductive health and health systems. See Mayhew et al. (2004) for an overview of the conference contributions.[75]

The WHO Reproductive Health Strategy also calls for action to be taken, noting that 'analysis of epidemiological and social science data is needed to understand the type, severity and distribution of reproductive and sexual risk exposure and ill-health in the population, to interpret the dynamics that drive poor reproductive and sexual health, and to elucidate the links between such ill-health and poverty, gender and social vulnerability'. In order to do so it recognises that 'improved data collection and analysis, including information about costs and cost-effectiveness, are essential bases for selecting among competing priorities for action and for aiming health-system interventions at targets that are most likely to make a difference within the limits of available resources'.[76] An overview of the foremost gaps found in the five core aspects of sexual and reproductive health is presented below.

Maternal and perinatal health

Key areas in maternal health are: care during pregnancy, care during delivery and its aftermath, and support for the newborn. In these areas, research gaps remain, the most notable being the measurement of factors impeding the use of existing emergency services. Furthermore there is a need to investigate the best approaches to enhance access to skilled attendance at delivery (addressing supply and demand-side constraints).

Family planning

The research issues relating to addressing the unmet need, are the scaling-up of proven effective approaches in family planning (such as community-based approaches). More

74 Mayhew S, Gerein N, Green A, Cleland J (2004). Improving health systems and enhancing reproductive health: linkages and lessons for action. *Health Policy And Planning* (2004); 19 (Suppl. 1): 11-14.

75 Most of the contributions are not based on impact studies, though offering valuable insights into community-based health insurance and access to maternal health (in Ghana, Mali, Senegal); reproductive health as the missing component in health sector reform in China; an epidemiological tool as an instrument in increasing access (in Mali); interventions in HIV/AIDS and SRH and their implications for national programmes; and priority setting in SWAp (in Ghana).

76 World Health Organisation (2004). Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets, adopted by the 57th World Health Assembly, May 2004, paragraphs 52-54.

evidence is needed on male involvement in family planning, and on individual and social dimensions underlying choices in family planning. Additional research should look into the effect of mass communication and social marketing programmes on actual and long-term family planning behaviour changes and fertility.

STIs

The challenge for researchers is to undertake investigations that identify, adapt and scale up interventions for preventing and controlling STIs, in particular in resource-poor and high risk settings. This includes studies into the efficacy of rapid low-cost diagnostic and treatment technologies, and also into the interplay between social and behavioural determinants of condom use and treatment adherence. Furthermore, in light of the surge of female condom promotion interventions, more information is needed on factors associated with intentions to use and sustained use. Anecdotal evidence suggesting the effect of novel approaches (e.g. through private sector outlets) needs to be substantiated by more rigorous evaluations.

Unsafe abortion

Research into this area has been difficult, for obvious reasons, including ethical considerations, privacy of clients and the taboo that surrounds abortion. Operational research has shown the effectiveness of using simple technologies administered by trained practitioners. Clinical trials have shown the potential of medical methods in low and medium resource settings. Additional research could provide valuable information on barriers (legal or within the health system) which hamper women's access to safe abortion services.

Reproductive rights, sexual health, gender issues and gender-based violence

Approaches in strategising reproductive health as a human right should be reflected in all aspects pertaining to SRH. Consequently, all evidence on interventions which improve equity, participation and accountability in sexual and reproductive health will add to the evidence base of successes in human rights programming. Despite their complexity, it is possible to establish causal relationships between interventions addressing broader social determinants and their effect on sexual and reproductive health. Overall, the evidence base on successful approaches in reducing gender inequity and their effect on sexual and reproductive health is meagre. More research is also necessary into the impact of male involvement on health outcomes, to substantiate the current view that men play a crucial role in sexual and reproductive health promotion.

Adolescent sexual and reproductive health

The vast majority of the evaluations on interventions to induce behaviour change among adolescents have generally only been able to assess increases in *knowledge* and *intentions* to alter behaviour. Despite the generous funding of such interventions, this area appears to be not sufficiently researched. More research is also needed on effective programmes for reaching out-of-school youth. In addition, it would be useful to

examine more closely which instruments, strategies, and messages work best. Similarly, there is a need for evidence on how life skills programmes influence the sexual and reproductive health outcome of adolescents. In terms of increased access of adolescents to SRH services, some promising examples are documented in this synthesis, such as the voucher scheme in Nicaragua. Improving access to SRH services is also sought through the establishment of youth-friendly services. More evidence is required on the effectiveness of such services. Lastly, there is a need to address the effect of community and participatory approaches on improved adolescent SRH. An area virtually unexplored is adolescent SRHR in conflict settings.

Integrated services

Overall, more impact studies are needed on interventions regarding integrated services: for example, the integration of vertical family planning services into the public health system, or on effective public-private partnerships in family planning. Because of the elusiveness of the concept of sexuality (and sexuality counselling) in relation to health, there is – not surprisingly – also a research gap in terms of identifying the successful approaches that aim to integrate these services into RH services. Finally, the search for impact studies in SRHR failed to find impact evaluations of interventions to strengthen health systems. Though it may be complex to map the causality between an activity and a health outcome; the complexity increases when mapping the causality of health reform interventions such as decentralisation or community-based health insurance. As the Alliance for Health Policy and Health Systems Research (2007) points out, besides a lack of technical capacity to conduct such rigorous evaluations, other factors including little interest from governments, donors and aid agencies plus political and financial constraints may have contributed to this gap. Areas for further research include: assessing the right conditions, dynamics, and possibilities of public-private mix in SRH service delivery; the effect of financing and payment reforms on SRH services; addressing new and innovative models for government contracting, and developing partnerships with the private sector; and human resource challenges.

Annexes

Annexe 1 About IOB

Objectives

The objective of the Policy and Operations Evaluation Department (IOB) is to increase insight into the implementation and effects of Dutch foreign policy. IOB meets the need for independent evaluation of policy and operations in all policy fields falling under the Homogenous Budget for International Cooperation (HGIS). IOB also advises on the planning and implementation of the evaluations for which policy departments and embassies are responsible. Its evaluations enable the Minister of Foreign Affairs and the Minister for Development Cooperation to account to parliament for policy and the allocation of resources. In addition, the evaluations aim to derive lessons for the future.

Efforts are accordingly made to incorporate the findings of evaluations into the Ministry of Foreign Affairs' policy cycle. Evaluation reports are used to provide targeted feedback, with a view to improving both policy intentions and implementation. Insight into the outcome of implemented policy allows policymakers to devise measures that are more effective and focused.

Approach and methodology

IOB has a staff of experienced evaluators and its own budget. When carrying out evaluations, it calls on the assistance of external experts with specialised knowledge of the topic under investigation. To monitor its own quality, it sets up a reference group for each evaluation, which includes not only external experts but also interested parties from within the Ministry.

Programme

The evaluation programme of IOB is part of the programmed evaluations annexe of the explanatory memorandum to the budget of the Ministry of Foreign Affairs.

An organisation in development

Since IOB's establishment in 1977, major shifts have taken place in its approach, areas of focus and responsibilities. In its early years, its activities took the form of separate project evaluations for the Minister for Development Cooperation. Around 1985, evaluations became more comprehensive, taking in sectors, themes and countries. Moreover, IOB's reports were submitted to parliament, thus entering the public domain.

1996 saw a review of foreign policy and a reorganisation of the Ministry of Foreign Affairs. As a result, IOB's mandate was extended to the Dutch government's entire foreign policy. In recent years, it has extended its partnerships with similar departments in other countries, for instance through joint evaluations.

Finally, IOB also aims to expand its methodological repertoire. This includes greater emphasis on statistical methods of impact evaluation. As of 2007 IOB undertakes policy reviews as a type of evaluation.

Annexe 2 References

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Annexe 3 Overview of the impact studies

Area [77]	Countries
Improving maternal and perinatal health	Argentina, Cuba, Saudi Arabia, Thailand (*Villar et al., 2001*) Bangladesh (Barbey et al., 2001) Burkina Faso, Kenya, Tanzania (*FCI, 2007*) Indonesia (*Pfizer, in: JHIEGO, 2004*) Nepal (*Manandhar et al., 2004*) Pakistan (*Jokhio et al., 2005*) Various (*Bhutta et al., 2008*)
Promotion of family planning	Bangladesh (*White in: The World Bank, 2005a*) Ghana (*Debpuur, 2002 and Phillips, 2003 and 2005*) Malawi (*The World Bank, 2004*) Nicaragua (*Chin-Quee, et al., 2007*) Pakistan (*Douthwaite and Ward, 2005*) Pakistan (*Hennink and Clements, 2005*) Various (*RamaRao and Mohanam, 2003*) Various (*Snyder et al., 2003*)
Combating STIs	Peru, South Africa, Tanzania, Uganda (*Sangani et al., 2004*) Various (*Bertrand et al., 2006*)
Preventing unsafe abortion	Ethiopia (*Tesfaye et al., 2006*) South Africa, Vietnam (*Warriner et al., 2006*) Uganda (*Weeks et al., 2005*) Uganda (*Dao et al., 2007*) Various countries in Latin America (*Billings, 2005*) Zimbabwe (*Johnson et al., 2002*)
Reproductive rights, sexual health, gender issues, gender-based violence	Bangladesh (*Al-Sabir et al., 2004*) India (*Varkey et al., 2004*) Nigeria (*Babalola, 2006*)

77 A separate document contains a summary of the studies included in the synthesis (published on the website: http://www.minbuza.nl/iob-en).

Area [77]	Countries
Promoting the sexual and reproductive health of adolescents	Botswana, Cameroon, Guinea, South Africa (*Agha, 2002, PSI, 2000*) Brazil (*Magnani, 2001*) Ghana, Tanzania, Uganda (*JSI, 2007 and Williams, 2007*) India (*Mensch, 2004*) India (*Mishra et al., 2003*) Kenya (*Erulkar et al., 2004*) Nicaragua (*Meuwissen, 2006*) Nepal (*Mathur, 2004 and Malhotra in: Worldbank , 2005b*) South Africa (*Dickson et al., 2007*) Various (*Gallant and Maticka-Tyndale, 2004*) Various developed and developing countries (*Kirby et al., 2005*)
Integrated services	South Africa (*Baek et al., 2007*) Various (*KIT/WHO/LRIG, 2006*) Various (*WHO, 2005*)

Evaluation studies published by the Policy and Operations Evaluation Department (IOB) 2004-2009

Evaluation studies published before 2004 can be found on the IOB-website: www.minbuza.nl/iob

297 2004 **Over solidariteit en professionalisering**
Evaluatie van Gemeentelijke Internationale Samenwerking (1997-2001)
isbn 90-5328-341-2

298 2004 **Onderzoek naar de kwaliteit van in 2002 afgeronde decentrale evaluaties**
Eindrapport.
isbn 90-5328-344-7

299 2005 **Een uitgebreid Europabeleid**
Evaluatie van het Nederlands beleid inzake de toetreding van Midden-Europese landen tot de Europese *Unie* 1997-2003
isbn 90-5328-347-1

300 2005 **Aid for Trade?**
An Evaluation of Trade-Related Technical Assistance
isbn 90-5328-349-8

301 2006 **Van Projecthulp naar Sectorsteun**
Evaluatie van de sectorale benadering 1998-2005
isbn 90-5328-351-x

301 2006 **From Project Aid towards Sector Support**
An evaluation of the sector-wide approach in Dutch bilateral aid 1998–2005
isbn 90-5146-000-7

302 2006 **Evaluatie van het Nederlandse mensenrechtenbeleid in de externe betrekkingen**
isbn 90-5328-350-1

303 2006 **Dutch Humanitarian Assistance**
An Evaluation
isbn 90-5328-352-8

304 2007 **Evaluatie van de vernieuwing van het Nederlandse onderzoeksbeleid** 1992-2005
isbn 978-90-5328-353-0

304 2007 **Evaluation of the Netherlands' Research Policy 1992-2005**
(Summary)
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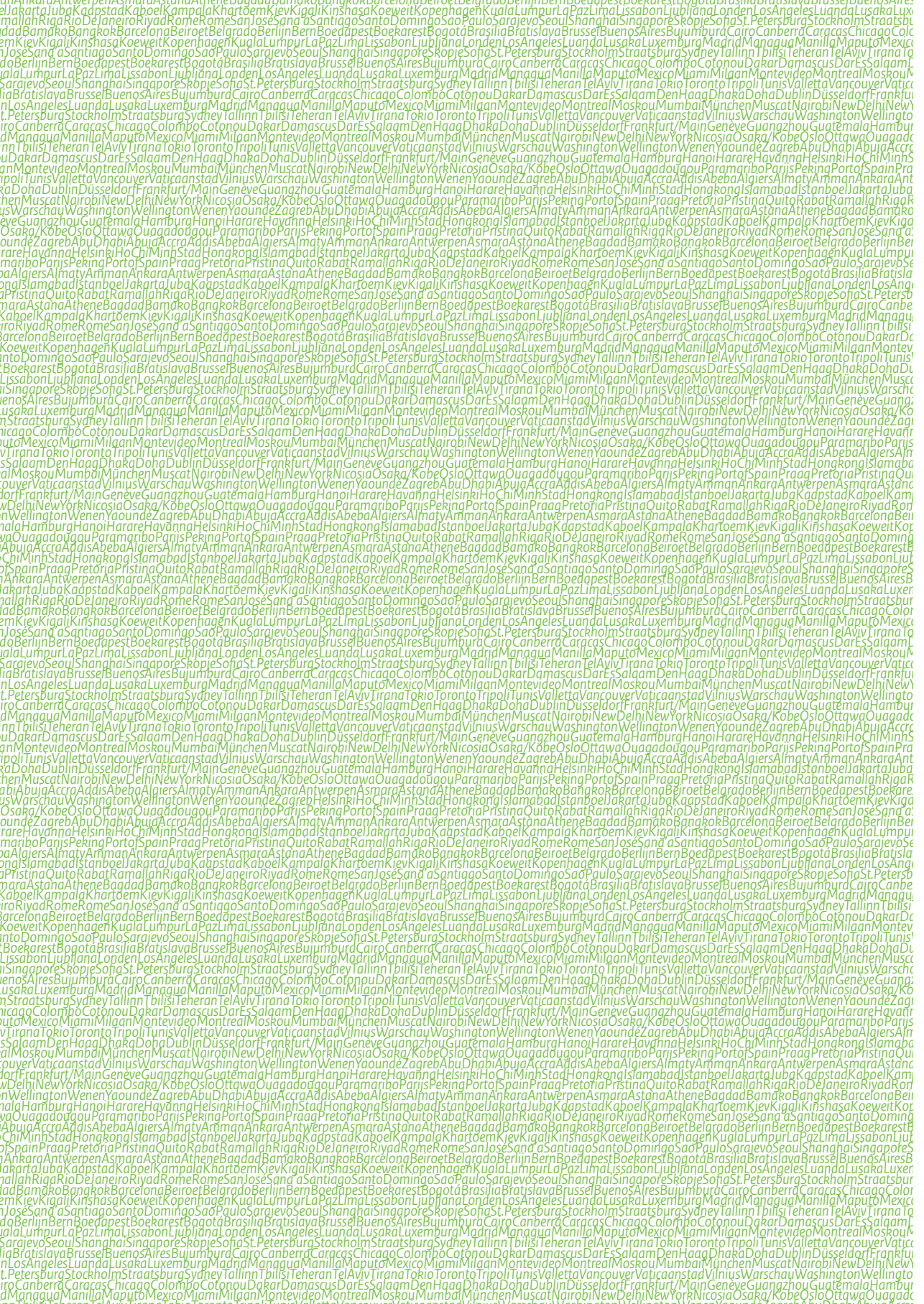

The right to self-determination in matters of sexuality and reproduction is at the core of the recently introduced new Dutch policy in the field of sexual and reproductive health and rights. The policy focuses on preventing human rights violations and increasing access to prevention against unwanted pregnancy, HIV-infection and unsafe abortion. This synthesis study is based on a review of relevant impact studies in the field of sexual and reproductive health and rights that applied an experimental or quasi-experimental design and were conducted in developing countries. Information on the effectiveness of interventions may contribute to the fine-tuning and adaptation of policies.

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