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**Ensuring Reproductive Rights and Implementing  
Sexual and Reproductive Health Programmes  
Including Women's Empowerment, Male  
Involvement and Human Rights**

**Expert Round Table Meeting**

*Kampala, Uganda*

*22-25 June 1998*

**Technical and Policy Division, UNFPA**

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Note: The views and opinions expressed in this report are those of experts who attended the Expert Round Table Meeting on Ensuring Reproductive Rights and Implementing Sexual and Reproductive Health Programmes, Including Women's Empowerment, Male Involvement and Human Rights and do not necessarily reflect those of the United Nations Population Fund (UNFPA).

## **Foreword**

The Round Table on Ensuring Reproductive Rights and Implementing Sexual and Reproductive Health Programmes, including women's empowerment, male involvement and human rights, is the second in a series of meetings and consultations on major issues being organized by UNFPA to assess progress since the ICPD and to identify priorities for further action.

Each session in the meeting was expected to recommend further actions needed to achieve the goals of the ICPD. The conclusions will be consolidated in a background report to be reviewed by more than 100 countries meeting at the ICPD+5 International Forum scheduled for February 1999 in the Hague and as inputs to the Secretary-General's report for the Special Session of the General Assembly in June 1999.

Some fifty international experts on reproductive health and rights from all regions of the world representing regional and international non-governmental organizations, government and the United Nations system, participated in the Round Table. The meeting was held in Kampala, Uganda, from 22 to 25 June 1998.

This Round Table was hosted by the Government of Uganda, and was organized by the Technical and Policy Division of the United Nations Population Fund, in collaboration with the United Nations Population Division.

I would like to thank Dr. Laura Laski, who was responsible for organizing the meeting and preparing this report, as well as her colleague, Ms. Mette Ostergaard, for helping in developing the background paper prepared for the meeting and this report. I would also like to thank Ms. Sunetra Puri, general rapporteur; Mr. Peter McCormick, who edited this report; and Ms. Victoria Rector, who helped in the organization of the meeting.

Mohammad Nizamuddin  
Director  
Technical and Policy Division  
UNFPA  
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## **Acronyms**

AIDS	Acquired immunodeficiency syndrome
CEDAW	Committee on the Elimination of Discrimination Against Women
FGM	Female genital mutilation
FP	Family planning
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
MCH	Maternal Child Health
MIS	Management information system
MOH	Ministry of Health
NGOs	Non-governmental organizations
QOC	Quality of care
REACH	Reproductive, Education and Community Health programme
RH	Reproductive health
RTIs	Reproductive tract infections
SH	Sexual health
STDs	Sexually transmitted diseases
TBA	Traditional birth attendant
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

## ***Executive Summary***

The aims of the Kampala Round Table were to identify strategies that have emerged since the International Conference on Population and Development (ICPD) in ensuring reproductive rights and in making sexual and reproductive health programmes operational; to identify successes and constraints in policy, legal, administrative, managerial, strategic and financial aspects; and to agree on actions needed to accelerate progress towards achieving the goals of the ICPD.

The Round Table recognized that sector-wide progress in policy formulation has occurred in several countries, while work to improve specific aspects of policies and of implementation has started in others. Where there is political commitment to the principles of sexual and reproductive health and rights and gender equality and empowerment of women, progress is occurring in collaboration between governments and civil society. Effective and empowered women's movements, other mass movements and non-governmental organization (NGOs) are proving vital to ensuring progress in policy development and implementation in areas such as the establishment of greater understanding and will for developing rights-based policies.

While various elements of reproductive health care are available in many countries, the implementation of comprehensive integrated services has advanced slowly. Traditionally vertical administrative structures, compartmentalized budgets and personnel prevent intersectoral collaboration and coordination among ministries in numerous countries.

Within integrated and comprehensive reproductive health, three central issues have emerged as global concerns that have not received universal and balanced investment: meeting the need for family planning; ensuring maternal health (including the reduction of unsafe abortion); and reducing infant mortality and morbidity; and preventing and treating sexually-transmitted diseases (STDs), including HIV/AIDS. Although much remains to be done in these areas, the central commitment is to reduce verticality of programmes and integrate all aspects of reproductive health in the context of primary health care and health sector reform.

Technologies are seriously inadequate in STDs, including HIV/AIDS. Few women can protect themselves and their partners. Although the female condom exists and is beginning to be made available, simpler diagnostic tests and single dose treatments remain unavailable.

The challenge of Cairo continues to be the integration of or better collaboration between different institutional structures, transformation of existing facilities, improvement of logistic systems and training to ensure appropriate and effective care. The means to meet the challenge involve the structural and strategic reorientation of health systems and

financing. Integration is not just a matter of adding services to family planning programmes. Another challenge is to overcome social barriers to access, including men's understanding of their roles and responsibilities of women's health.

The Round Table experts reached consensus on the following actions needed:

- In health sector reform, emphasis must be given to ensuring sexual and reproductive health for all people at the highest achievable standard of care, and to mobilizing the necessary resources. Equity is a necessary prerequisite to achieving the right to health.

- Continue and promote the reorientation of the health system to ensure that sexual and reproductive health policies, strategic plans and all aspects of implementation are rights-based, cover the life cycle and serve all. This requires that the public health system be open to inputs from civil society in the content and delivery of services and information. The public health system should make partnerships with civil society in the spirit of collaboration with equals.

- Continue and promote health system structural reform involving infrastructure, human resource development, financing, to achieve both coverage and quality. Changes in systems will have to be incremental and phased according to resource availability. They should also be determined by a participatory consultative process and designed on the basis of the longer term strategic plan.

- Increased investments should be made in management of service provision including:

C Structural integration of reproductive health services or functional integration, including effective referral systems and training in supervision.

C Maximized use of existing resources to provide high quality services, increase resources to upgrade standards of care and perform continuing evaluation. Governments should establish regulations and quality assurance mechanisms that ensure standards for high quality health services for the public and private sectors.

C Training service providers to improve their technical skills, interpersonal communications and supportive supervision. Training should also prepare providers to communicate clearly with empathy and with respect for human rights, gender equality (including violence against women) and dignity and to provide dignified care.

- Provide more resources for groups to network: build alliances, involve the media, undertake advocacy, promote public education to create a favorable environment for the ICPD Programme of Action policy development and implementation; develop the capacity

of groups to participate in policy development and implementation; and ensure that groups can help in monitoring policy implementation.

- Empower people to uphold their sexual and reproductive rights and health. Information provided should be relevant and easily understandable. Content must include common human experience such as sexuality and power relations between men and women, including violence.

- Create an enabling environment through participatory processes at all levels of society for women's empowerment and male involvement in promoting sexual and reproductive rights in a human rights framework. This requires the adoption of a gender perspective that accounts for the different realities and constraints which women and men face in their lives. Programmes for women are an initial and essential means through which gender inequalities and inequities can be addressed.

## ***Introduction***

From 22 to 25 June 1998, 50 international experts on reproductive health (RH) and rights met in Kampala, Uganda to examine ways to hasten progress towards the goals set by the ICPD in Cairo in 1994.

The gathering, hosted by the Government of Uganda and organized by UNFPA, was the Expert Round Table Meeting on Ensuring Reproductive Rights and Implementing Sexual and Reproductive Health Programmes, Including Women's Empowerment, Male Involvement and Human Rights. The Kampala Round Table was one of a series of Round Tables, Technical Meetings and Regional Consultations which UNFPA organized during the year as part of a review of progress achieved in the implementation of the ICPD Programme of Action since 1994.

The outcome of the Kampala Round Table will be used in the preparation of reports on the status of ICPD implementation to be presented at the International Forum, to be held in The Hague in February of 1999 and the Special Session of the General Assembly that will meet to review and appraise progress in the implementation of the Programme of Action in June-July 1999.

Drawing from Chapters VII (Reproductive Rights and Reproductive Health) and VIII (Health, Morbidity and Mortality) in the ICPD Programme of Action, the Kampala Round Table set out to identify strategies since Cairo that ensure reproductive rights and the implementation of sexual and RH programmes. The meeting also sought to identify successes and constraints in policy, law, administration, management, strategy and finance. Last, the Round Table participants were asked to devise actions needed that would accelerate progress at the national level to achieve the goals of ICPD.

The Round Table addressed four issues: progress and constraints achieved after ICPD in the development of policies for ensuring reproductive rights and implementing RH; the integration of sexual and RH services, the improvement of care and access; and the achievement of gender equity and equality, women's empowerment, and male responsibility in the context of human rights.

The Round Table had four sessions which treated these themes. Speakers among the participants gave presentations, followed by question-and-answer periods. All participants were invited to join working groups which discussed progress since ICPD, constraints and actions needed. The subjects of the four working groups were:

- C Policies for Sexual and Reproductive Health
- C Designing High Quality Sexual and Reproductive Health Programmes
- C Access to Reproductive Health, Sexual Health and Family Planning Services
  
- C Creating the Necessary Conditions for the Implementation of Sexual and Reproductive Health and Rights.

This report is divided into three chapters: (I) Opening; (II) Background; and (III) Proceedings of Plenary Sessions and Working Groups, which includes working group reports on progress, constraints and actions needed.

## ***Chapter I: Opening***

### **Remarks by Dr. Nafis Sadik, Executive Director of UNFPA**

At the opening of the Round Table, Dr. Nafis Sadik, the UNFPA Executive Director, addressed participants and noted that the intention of ICPD was to shift emphasis from family planning to a broader approach, based on reproductive health and rights. Parallel moves towards gender equality and the empowerment of women in other areas of social and economic development were also essential features of the approach. The ICPD adopted the position that reproductive rights were human rights, which was endorsed by the Social Summit in Copenhagen and further endorsed and strengthened by the Fourth World Conference for Women in Beijing in 1995.

Real progress in attaining RH lies in the enactment of reproductive rights as part of law and policy, and their realization as part of health services, Dr. Sadik noted. The process of making and carrying out RH policy must reach beyond government ministries directly responsible for health, and must also involve a broad spectrum of NGOs. Each country has to make a frank assessment of its strengths, weaknesses and areas of greatest need, and make policy accordingly, she said.

Among countries with comprehensive family planning services, some have focused on linking or integrating structures, or on expanding the range of services. Dr. Sadik suggested that family planning services with limited resources would find that incremental implementation was appropriate. In any case, policy should maintain comprehensive RH care as the ultimate goal: RH is not a choice but a necessity for countries wishing to set a firm foundation for economic and social development.

Dr. Sadik emphasized five issues for the Round Table: women's empowerment; the need for change in male behavior; gender-based violence; RH care in emergency situations; and the need to reverse the tide of HIV and STDs. Dr. Sadik also noted the April 1998 Round Table on adolescent sexual and RH. She reminded her audience to keep in mind the findings of that meeting and to remember that youth made up one-fifth of humanity.

Alluding to these points, Dr. Sadik declared that free choice in the size and spacing of the family represented the cornerstone of empowerment. Despite progress, more than four in ten women in developing countries still lack access to good RH services. Many women also remain unaware of the range of family planning methods, just as not all family planning service providers are aware of the need to stress choice.

Education is a key to empowerment, Dr. Sadik stated. Women remain less educated than men. Fewer than half of all women in Sub-Saharan Africa discuss family size with their spouses, compared to 60 per cent of couples in Asia, North Africa and Latin America/Caribbean. The low figure for Sub-Saharan Africa is consistent with the low level

of awareness and use of contraceptive methods. Dr. Sadik added that the correlation between a woman's place in society and her access to RH services is a direct one. Sri Lanka, for example, although poor, is nevertheless a country where women enjoy high social status, and the maternal mortality rate there is among the lowest in the developing world.

Change in male behavior is a key to the empowerment of women. Behavioral change for men means their adoption of responsible sexual and reproductive behavior, and their supporting not only women's right to make their own reproductive choices but their right to the information and means to do so, Dr. Sadik explained. She added that people should be careful of regarding men as part of the problem; many would like to be part of the solution, and they should be encouraged to communicate better, to take responsibility and to make changes in favour of women's empowerment.

Noting that people in too many countries accept domestic violence as a fact of life, Dr. Sadik noted in contrast that since the ICPD, many countries have taken up the issue of female genital mutilation (FGM) at the highest levels. Uganda has shown the way to success in making major progress in the elimination of FGM, through high-level leadership followed by community action.

In emergency situations, in which women are at their most vulnerable, UNFPA is working to bring essential RH care, including the means to avoid pregnancy. Besides facing the task of changing male attitudes in regard to women as sexual targets, Dr. Sadik said colleagues working in refugee camps and similar situations needed to be persuaded that RH and preventive care for women were as essential as dealing with trauma and infection.

STDs, including HIV/AIDS, is a policy issue extending beyond any particular age group and beyond the health sector, Dr. Sadik said. It is a subject that demands behavioral change among men, and it also demands that policy makers give it priority in the allocation of development resources.

The four years since the ICPD is a relatively short time in which to see substantial change in reproductive health and reproductive rights, Dr. Sadik acknowledged. She added that people had to confront putting ideas into action in a context of severely limited national budgets and an international climate that demanded proof of the effectiveness of overseas assistance. Although much progress has been made, the hardest part lies ahead. RH must be institutionalized in the health sector, and operational links have to be established between RH and other aspects of development.

**Remarks of the Vice-President of Uganda,  
Dr. Specioza Wandira-Kazibwe**

*Delivered by Mr. Sam Kuteesa, Minister of State,  
Ministry of Finance and Economic Planning*

On behalf of Dr. Wandira-Kazibwe and the Government of Uganda, Mr. Sam Kuteesa welcomed participants of the Round Table. Dr. Wandira-Kazibwe recognized that Uganda wanted to be associated with the post-ICPD paradigm shift. The post-ICPD era has witnessed unprecedented support by developing countries for population policies and a greater involvement of civil society. She recognized that NGOs are playing a crucial role in Uganda and saluted their Government partnership with NGOs. The role of the private sector and the participation of the community after the implementation of a decentralization policy in Uganda was also noted. The fact that decisions can now be taken at lower level, close to the people so that they can decide on matters that affect their daily lives and prioritize them is a great opportunity.

She expected that the meeting could help learn from participants' experiences and evaluate progress since 1994. In Uganda for example, maternal mortality rates continue to be very high. Mothers are dying so needlessly from preventable conditions and the Government made a call for action to decrease maternal mortality now. Health statistics in Uganda show a maternal mortality level of 506 per 100,000 live births and an infant mortality rate at 97 deaths per 1,000 live births and fertility rates are as high as 6.9.

However, even national statistics do not tell the full story, for they are merely averages. Women still continue to be put at a disadvantage. Population and development programmes need to put women's strategic concerns at the center of their plans or are bound to produce negative results. Although Uganda has made some modest attempts to emancipate women, she recognized that they need to do much more. Women's education is of strategic importance and has a multiplier effect. Finally, Dr. Wandira-Kazibwe thanked the organizers of the meeting and declared the meeting officially open.

**The ICPD+5 Process**

*Mr. Mohammad Nizamuddin, Director, Technical and Policy Division, UNFPA*

Mr. Nizamuddin outlined how the present round table meeting is a component of the ICPD+5 process. It was initiated in response to the decision of the General Assembly to hold a special session in 1999 to mark the progress made in the implementation of the ICPD Programme of Action. In explaining the different activities, actors and expected outcomes of the ICPD+5 process, Mr. Nizamuddin put special emphasis on the importance of this particular Round Table, because RH constitutes the cornerstone of the ICPD Programme of Action.

## **Chapter II: Background**

### **ICPD Four Years Later: Recent Trends and Challenges in Meeting ICPD Goals in Reproductive Rights and Health**

*This section is based on the presentation made by Dr. Nicholas Dodd, Chief, Technical Branch, Technical and Policy Division, UNFPA and on the Background paper prepared for the Round Table by the Technical and Policy Division of UNFPA.*

The consensus reached at Cairo raised expectations towards establishing truly comprehensive sexual and RH services throughout the world. Four years later, there is growing recognition that progress has indeed occurred.

Examples of changes in policies have occurred, and many countries are building consensus on the need to revise policy and redesign programmes. Although the full implementation of this concept requires more than policy development, consensus-building represents a first step in the road to universal access to comprehensive RH services. Countries that defined priority areas for implementation, allocated resources and involved stakeholders in the decision-making process, and invested time and resources in the process, show signs of advancing the implementation of the Cairo agenda.

Many national policies since 1994 reaffirm the reproductive rights principle of the Programme of Action, namely, the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. Most policies also recognize the equal rights of women and men and that the status of women must be improved to reach this goal. Adolescent needs, including sexual and RH, have also gained recognition. Policies and practices that limit access to family planning services are being changing, particularly spousal authorization, marital status and age limitations. In the past, restrictive policies often denied services to unmarried women, adolescents, the divorced and widowed, and women who wanted to delay or space pregnancies.

Much remains to be done beyond policy formulation, however. While various elements of RH care are available in many countries, progress has yet to be made in implementing comprehensive, integrated services. Whether countries in their overall programme design have pursued the integration of services, broadened the scope of available services, or focussed only on providing a few components of RH, a more comprehensive RH approach can be distinguished by looking briefly at its key components.

*Meeting the need for family planning*

Family planning remains the central focus of most programmes. A RH approach to family planning has been the first step taken in the majority of countries where implementation has begun. This means that efforts are now more focussed on meeting the broader needs of clients. The efforts include reviewing the range of contraceptive methods available, and strengthening information and counselling services to enable more informed and appropriate contraceptive choices.

While about 56 per cent of couples in the world are using a method of family planning, contraceptives remain inaccessible to 120 to 150 million couples who want them. New contraceptives have appeared in the market since 1994, mainly once-a-month injectables, female condoms and revitalization of emergency contraception. However, high cost and quality of care continue to pose serious constraints in the provision of family planning.

*Improving maternal health*

Maternal health has improved in selected countries. For example, in Sri Lanka the maternal mortality rate, which declined from 500 deaths per 100,000 live births in the 1950s to about 50 per 100,000 in 1994, is one of the lowest in the developing world. Sri Lanka focused on the expansion of midwifery skills and now 95 per cent of all births occur in institutions. Factors behind such progress include the relatively high status that women enjoy, the existence of a general health infrastructure and a good road network to facilitate access to health services. In Uganda, a country with limited resources, a system has been developed to identify and transport pregnant women with complications to district hospitals. As a result, Caesarean section rates are increasing in some district hospitals and this could be taken as a proxy index of reduced maternal mortality.

In contrast, the experience of pregnancy and delivery for millions of women worldwide remains one of pain and suffering. WHO estimated that around 600,000 women continue to die each year from complications arising from pregnancy and 99 per cent of these deaths occur in developing countries. Little overall progress appears to have occurred since the Safe Motherhood initiative in Nairobi in 1987. The lifetime risk of maternal death is 1 per 48 of women living in developing countries, in contrast to 1 per 1,800 for women in the developed world.

In 1997, a review of the Safe Motherhood Initiative concluded that the training of traditional birth attendants (TBAs), antenatal screening for high risk pregnant women and the provision of simple birth kits, was insufficient. Women must have access to skilled personnel at delivery, postpartum care and effective referral and transport to well staffed and equipped first referral level hospitals and waiting homes. A challenge to maternal-health services, as in other aspects of sexual and RH care, is how to alter existing facilities, and training, to ensure effective care. Another challenge is to overcome social barriers to access. This includes the ensuring of education, nutrition, health care, employment opportunities for girls and women, and the changing of men's understanding

of their roles and responsibilities in women's health. The international health and development community need to continue to help countries ensure that reproductive services are available, affordable and acceptable to all women.

*Preventing unsafe abortion*

With twenty five million legal abortions taking place each year in the world and 1 out of 6 births ending in abortion, this issue cannot be ignored. WHO estimates that about 20 million unsafe abortions occur every year worldwide and between 60,000 and 80,000 women die of unsafe abortions. Since 1994, four countries have passed new laws regulating abortion.

*Preventing and treating STDs (Including HIV/AIDS)*

There is widespread agreement that the prevention and control of STDs, including HIV/AIDS, should be an integral component of RH programmes. Since ICPD, programmes have tried to develop and test strategies. While the immediate success of initiatives has varied widely, such approaches have generally confirmed the feasibility and desirability of integration.

Approximately 330 million new STDs occur every year. UNAIDS estimates that ten million people were living with HIV/AIDS in 1991. The number reached 31 million in 1997 and it is expected to increase to 40 million in 2000. Although some technologies are available, methods that women can use to protect themselves and their partners, such as the female condom are expensive and not yet widely available.

Progress has nevertheless occurred in some countries. The success of Thailand in reducing reported STD cases from 400,000 in 1989 to fewer than 50,000 in 1995 came from a firm political commitment, sufficient resources, and strong programme leadership. Uganda has also reduced HIV infection as evidenced by data from sentinel surveillance sites between 1996 and 1997, particularly among young adults.

The reduction of STDs and the consequences in health and social well-being requires not only services but major changes in the most intimate aspects of human relationships, in values and norms regarding gender roles and power imbalances between the sexes, and in mass media and other information sources. These changes in turn will require political will, information and education for people of all ages.

It is clear by now that ideas are changing favorably in support of RH in almost all regions in the world. The challenge is now how to put these ideas into action so that the ICPD becomes meaningful to all, even to women and men in the most remote areas of the world.

## Challenges for Further Progress

*Adrienne Germain, International Women's Health Coalition*

Ms. Germain discussed three major issues to be resolved for further progress in the implementation of the Cairo agenda. They are specific limitations and constraints; sensitive issues and political opposition. She called for consultations, partnerships, broad alliances, and investments in advocacy skills in order to build the strategic capacity of interested actors.

Ms. Germain identified limitations and constraints, which include (1) *Human resources*, particularly skilled and properly equipped health providers at all levels of care and committed policy makers, including the people who decide on the allocation of budgets and the content of programmes; (2) *Institutional capacity* from the primary health care level to the parliament and the cabinet; (3) *Financial resources*; (4) *Gaps in Technologies*, specifically, in STDs, including HIV/AIDS. The gaps include barrier methods that women can control, simple and better diagnostic therapies for the primary health care level and affordable single dose therapies for those with curable infections; and (5) *Lack of consumer knowledge*, which limits people's ability to protect their own health, particularly those people who lack the status to exercise their own rights in their communities, families or with their partners.

Ms. Germain recognized three important sensitive issues in the Cairo agreement. First, *the health, safety and lives of pregnant women* require political will and commitment by governments to invest in services and technologies needed by women wishing to become pregnant, and to the political dynamic and arguments concerning access to safe abortion for women with unwanted pregnancies. This is a quintessential women's health issue resulting from sex discrimination and male dominance. Second, *sexuality and gender power relationships* underlie concerns about sexual and RH and are reflected in inadequate services and information. It is important for all women and men but is particularly pertinent to young people. Third, she noted that *equality and equity of women and men* remains a fundamental issue in most societies.

The third challenge is how to organize and mobilize to confront well-organized and well-funded political opposition to ICPD goals. Political opposition also arises in the form of bureaucratic lethargy or lack of interest by politicians for the Cairo agreements. For politicians concerned with re-election in a short period, undertaking new activities involves more risks than by doing little.

Ms. Germain pointed out that these challenges can be met by creating the political will to make human and financial resources available and overcome sensitivities. She suggested a basic set of organizing principles which includes: (1) Consultation of stakeholders at all levels of society; (2) Equal partnerships between NGOs and governments; governments-

donors and NGOs that ensures their autonomy and accountability, particularly of NGOs; and (3) Building alliances, which requires developing consensus and reaching compromises among interest groups.

Underlying all this is the need to develop advocacy skills for building a strategic capacity of various interest groups to interact with those who control budgets and policies and focus on legislation that needs to change, monitoring and accountability. Finally, Ms. Germain called for the development of co-ordination to work across all ministries and sectors including not only the ministry of health but education, finance, labor, the cabinet level and civil society itself.

## **Chapter III: Proceedings of Plenary Sessions and Working Groups**

### **Session 1: Policies for Sexual and Reproductive Health**

**Chair:** Monique Essed Fernandes

**Presenter:** Dr. Dean Phiri, Director, Reproductive Health Unit, Zambia

#### **Developing a Sexual and Reproductive Health Policy: the Case of Zambia**

*Presenter: Dr. Dean Phiri, Director, Reproductive Health Unit, Zambia*

Zambia undertook a multi-sectoral and decentralized approach involving civil society in formulating a new RH policy which addressed gender issues, including male involvement, and the allocation of resources for implementation.

The ICPD and the Beijing Conference made the government aware of the need to broaden family planning to include RH. An inter-agency Technical Committee on Population was formed to integrate population issues in the planning and implementation across all government ministries, agencies and NGOs. This period coincided with health care reform initiated by the Government, which included RH as one of its major components of primary health care.

The development of the national RH programme was based on an extensive needs assessment. Surveys were used to determine priorities. These included the demographic and health surveys of 1992 and 1996, assessments of contraceptive needs assessment and traditional birth attendants, a situation analysis of RH services and a male involvement study. With the information provided by the needs assessment, the Ministry of Health developed a RH policy which included standards for the provision of services to be utilized by the districts in planning and implementing their own health strategies. To gain national consensus, the Ministry of Health hosted two workshops which involved health districts, NGOs, donor agencies, private and industrial institutions and traditional practitioners.

Teams that worked on specific issues such as safe motherhood, adolescents and STDs, including HIV/AIDS, provided inputs to a multi-disciplinary group from the Ministry of Health, NGOs and the private sector, which were responsible for formulating the Zambian RH policy. The law school in collaboration with a gender division in the Government was involved in developing the human rights framework of the RH policy.

The success of Zambia in formulating an RH policy emerged from the Government's identification of needs and the involvement of stakeholders in a multi sectoral approach, making the public aware, including managers, political, and local religious leaders at the district level, and placing RH at the center of health care reform.

## **Discussion**

The discussion centered on the constraints faced when developing RH policies, the type of NGOs that should be involved in the process and the nature of the participatory process.

### *Constraints in the development of policies*

Participants agreed that some of the constraints in the development of RH policies were the often rigid structures of ministries and the lack of interest and commitment of politicians who were interested in implementing policies with only temporary effectiveness.

### *Ensuring a long term participatory process*

The question was raised on whether a participatory policy-making process has served as a foundation for continued participation and cooperation. The answer was affirmative. It was noted that the consultative process resulted in an expanded partnership with groups that were not previously involved in RH. Through this partnership the division of labour for implementing the policy was established. The government continues, furthermore, to call on the various partners and stakeholders as their expertise and input is needed.

### *Which NGOs should be involved?*

It was pointed out that governments tend to involve only those NGOs which toe the line or involve NGOs as a token gesture. Thus organizations without power tend to be uninvolved. The challenge remains to involve those NGOs which really represent community interests and needs.

## **Findings of the Working Group on Policies for Sexual and Reproductive Health**

### **A. *Progress toward implementation of the ICPD Programme of Action***

Sector-wide progress in policy formulation has occurred in countries such as Zambia, Bangladesh and South Africa. Other countries have begun work on specific aspects of policies and implementation.

In many countries, civil society organizations exert considerable influence on policy development. An effective women's movement, other mass movements, and NGOs are proving fundamental to progress in policy development and implementation in places such as Brazil and Bangladesh.

**B. Major constraints in the development of sexual and reproductive health policies**

Policies for RH and rights are evolving amid increasing global poverty and inequality, weak and underfinanced social sectors (health and education), persistent gender inequality, and limited progress in the involvement of civil society in policy development. Constraints include:

- C Inadequate knowledge and understanding of reproductive rights and health as described in the ICPD Programme of Action. The Programme and the concepts it describes have not been disseminated widely and publicly. Consequently, aspects of the RH and rights have received only hesitant support.
- C Fundamentalist opposition to aspects of the ICPD persists.
- C In many countries, laws such as the prohibition of sex education in schools or of adolescents' access to contraceptives hamper implementation of the Programme of Action.

Where general support for the ICPD Programme of Action exists, policies often lack a human rights approach and commitment. Full support is still lacking for legislation to ensure reproductive rights and RH and gender equity and equality.

Policy development and implementation are limited by inadequate understanding of the structural and strategic implications of a shift from vertical maternal and child health/family planning structures to a rights-based sexual and RH strategy.

RH policy has tended to be shaped primarily by health sector organizations and professionals, to the exclusion of other sectors and disciplines. This means not enough attention is given to the social, economic and political dimensions of sexual health and reproductive rights. Similarly, little attention is paid to the psycho-social, gender and emotional aspects of the health and well-being of individuals.

Governments restrictions on NGOs and other civil society organizations limit their full participation in policy development and implementation.

Political instability and the frequent turnover of civil servants undermine the continuity of policy development, implementation and monitoring.

### **C. Actions needed**

#### *Political/Legislative level*

- In health sector reform, sexual and RH for all at the highest achievable standard of care must be ensured, and the necessary resources should be mobilized.
- Enact and implement legislation required to meet the commitments made in Cairo, using all necessary and appropriate means, such as removing restrictive laws.
- Finance groups that translate the Programme of Action into legislative terms, that lobby for Programme of Action implementation and build political will.
- Invest in training parliamentarians, legislators, and media in the importance of the Programme of Action.

#### *Ministry/Executive Level*

- Continue and promote re-orientation of the health system to ensure that policies, strategic plans, and all aspects of implementation are rights-based, cover the life cycle and serve everyone. This requires changing the attitudes of policy makers, health care providers, and users/clients so that the public health system is open to contributions on the content and delivery of public health services and information from civil society. The health system must be open to innovations from other sectors including civil society organizations and NGOs, enabling the system to establish partnerships with civil society organizations as a meeting of equals.
- Promote systemic structural reform in health -- infrastructure, human resource development, financing -- to achieve both coverage and quality. Realistically, changes in systems will have to be incremental and phased according to resource availability (organizational capacity, personnel, finances). Priorities for incremental changes and projects to test new approaches, must be determined by a consultative process and be designed on the basis of the longer term strategic plan. A key element needed is investment in developing managerial capacity at all levels to implement right-based RH policies. This requires not only technical training but also sensitization to gender issues, human rights, and reduction of hierarchical barriers.
- Involve middle level managers at all stages, to ensure continuity in the implementation of planning and policy.
- Engage all relevant sectors, not only health, in policy development and implementation.

*Civil Society Organizations*

- Provide more resources for groups, build alliances, involve the media, undertake advocacy, promote public education to create a favorable environment for the ICPD Programme of Action policy development and implementation. Promote the development and dissemination of materials to increase understanding of the concepts and develop strategies to implement the Programme.
- Provide resources to initiate innovative activities that demonstrate to government what can be done to implement the Programme of Action.
- Invest in developing the capacity of groups to participate in policy development and implementation. Ease their access to information.
- Ensure that groups participate in monitoring policy implementation.

*Donors and international agencies*

- Donors and international agencies should make their policies and budget allocations consistent with the ICPD Programme of Action.
- Donors and agencies should support a nationally driven policy development process and implementation, keeping in mind the importance of specific national conditions and the ultimate objective of sustainable nationally financed health services.
- Encourage governments to consult with civil society in policy development and implementation.

## **Session 2: Designing High Quality Sexual and Reproductive Health Services**

**Chair:** Dr. Adepeju Olukoya

**Presenters:** Dr. Saumya RamaRao, Population Council  
Dr. Sharad Iyengar, Action Research and Training for Health, India  
Dr. Khama Rogo, University of Nairobi, Kenya

**Panel:** Mr. Mohammad Nizamuddin, Director, Technical and Policy Division, UNFPA  
Ms. Adrienne Germain, International Women's Health Coalition, USA

## **Implementing and Monitoring Feasible Standards of Care**

*Dr. Saumya RamaRao, Population Council*

Dr. RamaRao defined Quality of Care (QOC) as “the way clients are treated by the service delivery system.” The definition focuses on the process of service delivery, including communication and information sharing; criteria for minimal standards for procedures and examinations; and whether clients receive the service appropriate to their needs.

With findings from situation analyses, Dr. RamaRao showed that even where a range of contraceptive methods, water, information material, and time were available, QOC does not necessarily result. Clients often receive only limited information on contraceptive methods, and often, service providers do not wash their hands before undertaking exams. Her findings also illustrated that where QOC is provided, the outcome is positive. Greater user acceptance, satisfaction and continuation of contraceptive use are achieved when clients receive comprehensive information on methods, their use and side effects.

These findings indicate that improvements in quality and greater user satisfaction and empowerment can be achieved with existing resources. The information is particularly important because much of the post-Cairo debate has centered, directly or indirectly, on the feasibility of offering sexual and RH services amid diminishing resources.

Dr. RamaRao identified the main constraints to good QOC as perceptions of irrelevance and expense; scepticism regarding outcomes; and lack of specified processes. While the presented studies contradict the validity of some of these perceptions Dr. RamaRao identified the following actions to overcome the remaining constraints: develop clear protocols for and training in high quality service provision; institutionalize supportive supervision and performance evaluation, which would also include the performance of supervisors; and conduct studies for assessment and training development.

## **Sexual and Reproductive Health and Rights in India Since ICPD**

*Dr. Sharad Iyengar, Action Research and Training for Health, India*

ICPD gave an impetus to India’s target-ridden family planning programme to move away from the predominantly clinic-based pick and choose approach, which in the late nineteen sixties saw the introduction of demographic targets for contraception.

Following ICPD, the “Target-Free Approach” was introduced in 1995. It discarded demographic contraceptive goals and instead, the 1998 “Community Needs Assessment” approach was instituted. It provides for annual primary health care plans based on needs assessment and encompasses contraception, maternal care, immunization, to be prepared locally with the involvement of the community. Identified constraints include the work culture

of health staff not traditionally involved in planning or calculating local needs. The staff found working without targets difficult and therefore lost touch with clients. Key experiences from the process include:

*Indicators:* The Community Needs Assessment approach introduced a modified management information system (MIS) that reflects concern for QOC and management by the service providers. Due to the work culture mentioned above, the key future action is to develop middle level management, leadership, and supervisory capabilities within the administration and to continue to underscore commitment to the new set of indicators.

*Private sector involvement:* The RH program collaborates with service providers of the NGO, private, and traditional sectors.

*Quality Assurance Measures:* Institutional quality assurance in the health system, including the private sector, should be pursued, according to the guidelines disseminated by the central government. For this purpose a self-regulation mechanism needs to be developed. Simultaneously, community groups should be equipped with simple indicators of QOC to allow them to undertake surveillance.

*Involvement of state legislatures and parliament:* Elected representatives have been sensitized to demographic concerns and now need to be sensitized to the rights and gender dimensions of RH. A key action is to advocate among legislators for recent policy changes to be translated into action.

## **Reducing Maternal Mortality**

*Dr. Khama Rogo, University of Nairobi, Kenya*

Dr. Rogo stated that in light of the low Government spending on health, poor general infrastructure and poor health infrastructure in Africa, maternal mortality is closely related to poverty. Delays occur in obtaining the essential obstetric services for complications of pregnancy. However, Dr. Rogo also pointed out a lack of initiative in addressing the root causes of maternal mortality. For instance, consequences of unsafe abortion are managed but the underlying reasons for unwanted pregnancies are not. Key activities in reversing this trend were identified as:

*Participation:* Community involvement to make maternal mortality a common issue should be achieved through advocacy, service and information provision (including access to emergency obstetric care), and community-level funding. Private and NGO sector involvement should include the majority of nurses, midwives and doctors who do not work in the public system and to enhance competition. Providers should be geared to provide relevant services through networking referral systems. Governments should formulate appropriate policies and laws, undertake real health sector reform, provide sufficient funding, and encourage intersectoral collaboration.

*Programming.* Process indicators should be reviewed. Dr. Rogo recommended the UNICEF indicators, which describe the minimum acceptable number of facilities and services per population, and emergency obstetric and birth facilities available to women. Marginalized groups like adolescents should be urgently addressed. This group represents 30 per cent of the population and suffers from three to four times higher than average maternal mortality. In many cases they are denied services. Dialogue with providers is also an important issue and it should be improved. Providers are well trained but the environment is not conducive for providing QOC. Providers have to be involved in decisions to provide quality services.

### **Broadening Constellation of Services within Existing Systems: The Case of Bangladesh**

*Mr. Mohammad Nizamuddin, Director, Technical and Policy Division, UNFPA*  
*Ms. Adrienne Germain, International Women's Health Coalition, USA*

Immediately following the ICPD, the Government of Bangladesh, together with a donor consortium and UN agencies, decided to develop for the first time a national health and population sector strategy. It was agreed that the ICPD Programme of Action would be used as the core substantive framework and that the design process would include the participation of representatives of all stakeholders at every stage. A great deal has been learned from this experience on such matters as the following:

- How to design an approach to RH services reflective of the ICPD commitment, while taking into account the human and institutional constraints the country faces. In the case of Bangladesh, the national (vertical) family planning programme has a 25-year history of investment and political support, and the Ministry of Health and Family Welfare is itself divided into two wings. Thus, developing RH policy and programmes requires not simply integration of health and family planning services, but also reorganization of bureaucratic structures at all levels. What is the best process for achieving this?
- Which of the many elements of sexual and RH care can the current human resources and institutions deliver? What exact steps need to be taken, in what order, to build the necessary human and institutional capacity to provide sexual and RH services, monitor progress, educate the public, develop partnership with NGOs and civil society, and ensure accountability?
- Which services should have priority in the allocation of scarce resources? How can all stakeholders participate in the decision-making process? What are appropriate means to use existing resources more efficiently, and to generate increased resources, including collaboration with the private sector, cost recovery through fees for services, and partnerships with NGOs? How can a social safety net be maintained to ensure access to services for the very poor, keeping in mind, especially, the fact that women have less

access to cash than men and their health care is often less valued than men's in Bangladesh and other countries.

- What are feasible and effective means to improve both access to services and the quality of services, especially technical quality and client-provider interaction?
- Once those sorts of questions have been addressed, what are feasible means, through a participatory process to design, implement and monitor detailed implementation plans?

The Bangladesh experience makes clear that "stakeholder participation" requires investment of both time and money by all actors. This investment pays off in a strategy firmly rooted in reality and "owned" by all those who participate.

## **Discussion**

### *Client perspective and empowerment*

The Round Table pointed out that the QOC provided often depends on the socioeconomic status and literacy of clients. Groups such as commercial sex workers, unmarried women, youth, and women seeking abortion (where it is not against the law) are vulnerable to hostile treatment from prejudiced health care providers.

The importance of empowering clients to demand QOC by raising awareness of their rights and on QOC was stressed. Information to create such awareness and demand should be provided outside the service delivery system, for instance, through the media. It was noted that clients are willing to pay for services they have demanded. In fact, the first stop for many clients is the traditional healer, whom they willingly pay.

Competition should be considered as a means to improve QOC. If there is a choice of service delivery points, clients can use the services that best live up to the clients' demand for QOC.

### *Provider perspective*

The need to assess the reasons for service providers' under use of resources illustrated in Dr. RamaRao's presentation was stressed. Providers are often demoralized by their working environment and by structurally flawed public health systems. In fact, the same person in the private sector performs much better. Providers should therefore not be considered the enemy but essential to improving QOC.

### *Training*

The Population Council is implementing a programme in which family planning providers and supervisors are being trained to improve QOC. Such training creates the commitment to solve problems as they arise. In South Africa, a pilot scheme is underway in which

training health workers in hospitals are instructed to provide greater understanding in post-abortion care. The curriculum was drawn up by an NGO.

South Africa has also effectively used the training methodology of Health Workers for Change, a programme that enables health workers to self-identify problems in the care they provide. This has helped to build morale which was mentioned several times as being at the core of improving QOC.

#### *Minimum standards in QOC*

The Round Table participants agreed that the family planning QOC framework is generally applicable to RH. Many techniques and skills needed are the same. Issues of quality such as confidentiality, privacy, counselling and interpersonal relations, remain.

The key question is, how to define minimum standards for QOC, and how to improve QOC continuously as more resources become available. The debate centered on the need to interpret international QOC standards according to local needs and perceptions. It was underlined that minimum standards should also apply to the private sector just as special attention should be given to setting minimum standards for unfamiliar or new services, and for services provided in emergency situations.

The Round Table underscored that QOC is human rights in action. If clients are not provided with sufficient information to make fully informed choices their human rights are violated. This is the case, for instance, with sterilization clients are not made aware of the permanence of the procedure.

## **Findings of the Working Group on Designing High Quality Reproductive Health Programmes**

### ***A. Progress toward implementation of the ICPD Programme of Action***

Some progress since ICPD has occurred in integration, such as the provision of more services at the first point of contact and in the establishment of referral systems. This has been achieved in projects conducted by NGOs. Countries have also made progress with initiatives, often begun before 1994, for integrating MCH and FP services. Since ICPD, the focus has been to further integrate these services with STD/HIV/AIDS prevention, screening and treatment. Integration may, however, only involve that services are offered at the same service delivery place while different providers continue to address individual aspects of RH.

Many countries have adopted the quality of care language and have focused on providing the determining factors for quality of care. Some progress has been made in expanding contraceptive choice, and many countries (Bangladesh, some states of India and Mexico) are concerned with providing information and counselling and ensuring informed consent

and confidentiality. NGOs are increasingly involved in defining and implementing QOC and quality assurance systems are in place in many countries.

Taking note of the health sector reform in many countries, the group pointed out that this process can both be a facilitator and an impediment to comprehensive and integrated sexual and reproductive health QOC. The process may facilitate integration, collaboration between sectors, and decentralization but there are the risks that sexual and RH does not receive enough priority in the process and that the capacity to manage the new system is not present at the decentralized level.

In integrated and comprehensive RH, three issues have emerged as global concerns: meeting the need for family planning, ensuring maternal health (including reducing unsafe abortion) and reducing infant mortality; and preventing and treating STDs, including HIV/AIDS.

### ***B. Constraints in designing quality RH programmes***

The vertical organization structure of health care systems constitutes the main institutional barrier to a more integrated approach. Separate budget allocations, administrative structures and personnel prevent the coordination and integration services.

Lack of political commitment to improve QOC endures because change is seen as too costly. The group found that improving the quality of services requires not only expanded choices but also information and counselling to take advantages of expanded choices and strict adherence to at least minimum technical standards of care. Studies reveal that improvements in service provision can be made at reasonable cost.

Technologies are seriously inadequate in STDs, including HIV/AIDS. The female condom is expensive. Few women have a method that they can use to protect themselves and their partners; simpler diagnostic tests and single dose treatments are not available.

### ***C. Actions needed***

#### *Ministry Level / Service Delivery*

- Increase investment in the management of service provision, including:

- C Structural integration of RH services or at least functional integration, including effective referral systems and training in supervision is required to move vertical services and management systems to integrated comprehensive care.
- C Make the most of existing resources to provide good services, improve resources to upgrade standards of care and perform continuing evaluations. Governments should establish regulations that ensure standards for high quality health services.

- C Training service providers to improve their technical skills, communications and supervision. Training should also prepare providers to communicate clearly with empathy and with respect for human rights, gender equality (including violence against women) and the provision of dignified care.
- C Develop indicators to monitor QOC provision and train managers and supervisors in using MIS for QOC improvement.
- C Institutionalize quality assurance measures, to which both the public and private sector should be held accountable. There is also a need to develop and apply community-driven quality assurance by applying a simple QOC framework.

*Donors and international agencies*

- In STD and HIV/AIDS, increased subsidies are needed to broaden access to female condoms. Investments are urgently required for research and development of microbicides, simple diagnostic tests and single dose treatments.
- Develop a system for monitoring the implementation of the paragraph 8.25 of the ICPD Programme of Action regarding safe abortion.

### **Session 3: Access to RH/SH/FP Services**

**Chair:** Dr. Mawaheb El-Mouehly

**Presenter:** Ms. Maria Isabel Plata, Executive Director, PROFAMILIA, Colombia

#### **Diversifying Service Providers: The Participation of the Private Sector Including NGOs in the Provision of Services**

*Ms. Maria Isabel Plata, Executive Director, PROFAMILIA, Colombia*

PROFAMILIA, a financially self-sufficient NGO in Colombia, provides more than 60 per cent of national family planning and legal services specializing in family law. Ms. Plata charted the progress of PROFAMILIA, which started distributing condoms 30 years ago, to the current organization, which has a \$28 million annual budget and more than 1,000 staff members. Mindful of women's autonomy, PROFAMILIA launched a legal service in 1986 which expanded into an office for Sexual and Reproductive Rights and Gender in 1995.

When PROFAMILIA started operations it met opposition from the medical profession and the Catholic Church, but the government let PROFAMILIA conduct its work. The programme grew by meeting public demand with high quality services and a growing number of Colombians now accept family planning. Today, family planning is a constitutional right and is a part of new public and private health plans.

Initially donor support was critical for increasing outreach, but through its cost recovery programme, PROFAMILIA can now subsidize services in poor and remote communities and for teenagers. Cost recovery has helped ensure voluntary and informed choice as well as maintain high quality of care. Reliance on cost recovery prevents abuse: “We sleep better knowing people have to pay for a tubal ligation or vasectomy,” Ms. Plata said. “No one is going to pay for something they do not want.”

Ms. Plata underscored the importance of NGOs being politically independent and constantly correcting mistakes. While governments never supported PROFAMILIA the political independence was important for governments nevertheless to allow it to conduct its work. She also stressed the importance of MIS to improve QOC to meet the needs of the community is essential, especially in a program that depends on cost recovery.

## **Discussion**

The discussion focused on the relation between PROFAMILIA and the government, and the sustainability of PROFAMILIA.

### *NGOs and government*

The lesson of the PROFAMILIA shows that the flexibility of NGOs enables them to promote RH through their own services without absolving governments of their responsibility to provide a full package of services. PROFAMILIA showed how an NGO can collaborate closely with a government. PROFAMILIA provides a unique example of how public funds can be used for paying for private sector services. Its applicability in all poor countries is questionable, however, because of the absence of national health insurance.

### *Sustainability*

Ms. Plata notes that levels of self-sufficiency can be duplicated by NGOs that have support of the international community. Self-sufficiency requires the efficient management of finances and planning. In Colombia, user fees are found to empower clients to demand better services. This effect was noted by conference participants with experience from other regions.

Health reform can create healthy competition between the public, private and NGO sectors. Once fees are standardized clients will be attracted to the clinic which offers the best QOC.

## **Findings of the Working Group on Access to RH/SH/FP Services**

### **A. Progress toward implementation of the ICPD Programme of Action**

#### *Education*

Information and the confidence to take action in personal and institutional relationships are a precondition for sexual and RH. NGOs have been successful in building the knowledge base and confidence of women, men and adolescents to claim their sexual and reproductive rights and promote their sexual and RH including the effective use of health services.

Innovative methodologies and materials have been developed to help people realize their sexual and RH and rights. These include drama, mass media and peer education.

#### *Service Delivery*

The diversification of service provision for selected RH services such as family planning has improved access in some countries. Community-based distribution programmes and social marketing are proven to be effective and cost-effective.

### **B. Constraints in improving access to RH/SH/FP Services**

Prevailing economic conditions and the resulting poor health care infrastructure continue to obstruct access to services. Barriers to service include distance, cost, ignorance and the poor attitude of providers.

The separation of basic primary health care services places an exceptional burden on women to meet their diverse needs and those of their children. It also leads to duplication of infrastructural, management, information and other systems. Men often can prevent women's access to sexual and RH care and endanger their health and lives.

### **C. Actions needed**

#### *Government/Legislative*

- Equity is a precondition to achieving the right to health. Health sector reforms must be designed to ease people's access to services. Investments must be made to health financing systems to safeguard equity of access, while facilitating the use of diverse providers including NGOs, the private and the public sectors.

*Ministry/Executive*

- Because health services cannot function without infrastructure, governments must make a priority of developing and maintaining services such as water supply, power, sanitation, roads, transport, and communications. Health services should give priority to women's health needs.

*Service providers*

- Empowering people to uphold their sexual and reproductive rights and health requires that information be available and that it be relevant and easily understandable. Governments and NGOs should increase efforts to evaluate the effectiveness of communication techniques and materials and share them widely. Content must include common human experience such as sexuality and power relations between men and women, including violence.

### **Session 4: Creating Necessary Conditions for Implementing Sexual and Reproductive Health and Rights(Part I)**

**Chair:** Dr. Mawaheb El-Mouehly

**Presenters:** Mr. Jackson Chekweko, Reproductive, Education and Community Health Programme (REACH), Uganda

Ms. Wanda Nowicka, Federation for Women and Family Planning, Poland

**Discussants:** Ms. Ylva Sorman Nath, Women's Forum, Sweden

Ms. Anika Rahman, Center for Reproductive Law and Policy, USA

### **Female Genital Mutilation in Uganda**

*Mr. Jackson Chekweko, Reproductive, Education and Community Health Programme (REACH), Uganda*

Mr. Chekweko set the scene for the discussion on violence by describing the REACH programme, a unique UNFPA-funded project which has greatly reduced FGM in the Kapchorwa area of Uganda, one of 30 African countries where the practice takes place.

FGM poses severe physical and psychological risks. Nonetheless, the district resisted efforts by government and NGOs to eradicate the practice because resented what it saw as outside interference. At one point, Kapchorwa District had passed a law requiring the circumcision of all women.

The REACH project began in 1995. It involved allowing people to determine and bring about change on their own. REACH succeeded by separating FGM from the cultural values it was supposed to save, proposing alternative activities to sustain those ideals, and by consulting the custodians of community ethics. The process of acceptance involved

awareness workshops and seminars held at all levels in the district for all sectors of the community; peer education both at school and rural areas; extension of RH services integrated with FGM; sensitization through the training of health workers; participation in all events and functions; training of circumcisers to be TBAs; and undertaking operational research. The project found opportunities to enable free discussion of FGM especially among young males, empowering women through education, and establishing a NGO link. In 1996 FGM dropped by 36 per cent.

According to Mr. Chekweko, local communities should occupy a central position in the implementation of the programme, and governments in consultation with communities should design laws to protect women from all forms of violence. Discussions of FGM should be included in school curricula, girl child education should be encouraged and research that is sensitive to culture be undertaken. Those who earn their income by performing the practice must be shown alternative ways to support themselves. Interagency collaboration is needed at all levels to deliver the same message to the community.

### **Violence Against Women: the Role of the Health and Education Sectors**

*Wanda Nowicka, Federation for Women and Family Planning, Poland*

Ms. Nowicka described acts of gender-based violence during the woman's life. Before giving birth, women suffer gender-based violence, including sex-selective abortion, battering during pregnancy and coerced pregnancy. During infancy, violence includes female infanticide, emotional and physical abuse, and the relegation of inferior food and medicine to females. Gender-based violence among children includes child marriage, FGM, sexual abuse and child prostitution. In adolescence, girls face sexual abuse and harassment, forced prostitution and trafficking. During women's reproductive span, they face marital rape, dowry deaths, psychological and sexual abuse. In addition, the abuse of elderly widows is increasing.

To prevent violence towards women, Ms. Nowicka recommended sex education that promotes gender equality, human rights and training for the police and other law enforcement institutions such as the judiciary. Health care systems should recognize the consequences of violence and address both the prevention and the consequences of violence. Most of all, provide full information to women and facilitate their access to reproductive health services including abortion (where it is not against the law) and family planning. It is important to include communication skills and education on violence in the curricula of medical and nursing schools. Counseling and referral systems should be developed in the health care system and health care services should be improved to identify and treat casualties of violence. The issue of violence, including the identification of child abuse, should also be included in teachers' training. All this should be supplemented by the provision of shelters for victims of gender based violence. Finally, Ms Nowicka urged energetic efforts to persuade the media to end their indifference to gender-based violence.

## **Discussion**

Ms. Ylva Sorman Nath discussed her work in trying to eliminate FGM in Sweden, where it is practiced among some Somali migrants. Sweden developed guidelines about FGM for health workers and incorporated these into women's rights work and into education and maternal and child health programs. The media was educated on FGM and carried responsible stories that raised awareness among Swedes and Somalis.

The FGM project in Gothenburg involves Somali doctors, men and religious leaders, nurses and schools in discouraging FGM. These efforts have succeeded in curbing the practice, although some Somali women still feel it is necessary to keep their daughters eligible for marriage by making them undergo FGM. Ms. Nath recommends using Somali professionals, encouraging religious leaders to emphasize that the practice is not required by any faith, involving Somali men to see the disadvantages of FGM and educating the media on the issue.

### *Human rights*

Gender based violence should be seen as a human rights issue. Education and training of the health, education and law enforcement sectors is essential. Strategies to prevent gender-based violence should encourage male participation.

### *Community approach*

It was suggested that any project initially reflect gender-based violence as a global problem and then focus on the problems in the community.

### *Interagency collaboration*

It was recommended that the success of the WHO/UNICEF/UNFPA effort in FGM should be broadened to gender-based violence. Successful programmes need to be analyzed and best practice results disseminated widely.

## **Session 5: Creating Necessary Conditions for Implementing Sexual and Reproductive Health and Rights (Part II)**

**Chair:** Dr. Isaiah Ndong

**Presenters:** Ms. Anika Rahman, Center for Reproductive Law and Policy, USA  
Ms. Barbara Klugman, Women's Health Project, South Africa

### **Reproductive Health as a Human Right: Gender Equality and Women's Empowerment**

*Ms. Anika Rahman, Center for Reproductive Law and Policy, USA*

Ms. Rahman reviewed the legal foundation for reproductive rights in the Universal Declaration on Human Rights and other human rights instruments adopted by the international community since 1945. The right to the highest attainable standard of health, and sexual and reproductive rights are based on UN conventions, signed by governments, which include the International Covenant on Economic, Social and Civil Rights, The Convention on Elimination of All Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child and the International Convention against Racial Discrimination. They can be used as instruments of advocacy and as frameworks for activism. The realizations of reproductive rights calls for the dissemination of information about those rights, establishing a culture of rights in each country, and developing indicators for monitoring their implementation.

Reproductive rights include reproductive self-determination, which in turn include rights explicitly guaranteed in international conventions: the right to decide the number and spacing of children, the right to marry and to have a family, the right to freedom from torture or other cruel or degrading forms of treatment or punishment; the right to modify customs that discriminate against women, and the right to freedom from sexual assault and exploitation. Advocacy methods useful in advancing reproductive rights include lobbying for legal and or policy reforms, instituting legal proceedings; educating policy makers and the public, building coalitions and global networks; and negotiating with public institutions, including donors.

Advocates, before embarking on lobbying or court actions, must first examine existing laws, especially those dealing with sterilization and abortion, and how they are interpreted or enforced, and consider whether the public is aware of them. When further action is required, it is often easier to push for changes in policy rather than laws, because efforts to alter laws involve more time.

## **Legislating and Implementing Reproductive Rights in South Africa**

*Ms. Barbara Klugman, Women's Health Project, South Africa*

Ms. Klugman reported on the gains made in legislating and implementing reproductive rights in South Africa since the end of apartheid. The new constitution provides for health care and sexual and reproductive rights. South Africa recently adopted a population policy and its parliament passed the Termination of Pregnancy Act in 1997.

South Africa is unique among countries dealing with reproductive rights issues because the African National Congress won the national election on a human rights platform. There is also a powerful moral imperative to end discrimination, including that against women, and to end family planning for population control reasons. The minister and government leadership are committed to sexual and reproductive health. They favor the involvement of civil society in policy, through the use of green papers and draft white papers for public scrutiny and public hearings. There also exist soft boundaries between politicians, government and policy activity, which can create opportunities for discussion.

The Women's Health Project identified abortion as a public health issue during the numerous seminars and meetings at all levels. It developed a strategic advocacy plan which included alliances, influencing politicians and educating the media. The Project formed an alliance with all groups interested in RH. It then promoted a public discussion on the population policy, encouraged NGOs and members of the civil society to respond to the government's draft White Paper on the population policy, thus strengthening the democratic process.

To bring politicians to support the Termination of Pregnancy Act, the Project collaborated with the renowned Medical Research Council to conduct research and disseminate its findings on numbers and cost of unsafe abortions. Two public hearings were organized on abortion: on the issue itself and on legislation. The Project invited a male black doctor who worked in the rural area and knew first-hand the results of botched illegal abortions. Young girls who had undergone illegal abortions also testified. The news media, uncommitted at first, was galvanized into supporting legal abortion when a girl who was made pregnant by a Catholic priest testified that the priest had encouraged her to have an abortion.

The example of South Africa offers valuable lessons. It is important to understand politicians' concerns and to convince them that their support for the desired change will help their careers and constituents. For this purpose research and data underscore the validity of the problem and the potential solution. The strategic use of the news media to create public awareness and political support is also recommended. In addition, it is useful to find research to answer the perspectives put by opponents, whether civil society lobbyists or politicians.

The mobilization of mass organizations and the inclusion of important members of the public who speak on the issue strengthen advocates' campaigns. It is also useful to prepare potential legislation, and to publicize individual testimonies, reminding politicians that the questions at hand affect their constituents. Because the civil service is influenced by concerns about the costs of new legislation, and advocates can win their support by showing the cost effectiveness of intervention, including social costs. It is also important to assess the capacity and willingness of bureaucracy to implement a consultative process.

## **Discussion**

### *Opposition*

In dealing with religious opposition without confrontation, it was noted that an alliance was formed of pro-choice religious leaders who were used as spokes-people with the media.

### *Alliances*

The South African example showed that while the consultative process was democratic, a division of labour was established: urban NGOs undertook practical campaigning and lobbying while rural NGOs offered first-hand testimony to public opinion. The Alliance of NGOs for RH and RR now runs a sexual rights campaign at all levels to ensure that the policy is implemented.

### *Male involvement*

The need for male involvement in empowering women is crucial in South Africa. During peer education programmes, couples are not only given contraceptives but are drawn into discussions on power relationships. To involve men, the leadership must be committed. No minister in South Africa can make a speech without mentioning HIV/AIDS, and most Ministers are men. Human rights and sex education in schools should address both men and women.

The issue of male reproductive rights provoked a great deal of discussion during this session, with some participants arguing that men and women should have equal rights. It was pointed out by others, however, that one of the points is that women must obtain and be able to exercise the reproductive rights due to them which have traditionally been denied them. Only when women can freely exercise these rights can both sexes say that they are enjoying equal rights. Gender equity and not only gender equality should be achieved.

## **Findings of the Working Group on Creating Necessary Conditions**

### ***A. Progress toward implementing the ICPD Programme of Action***

Several countries have developed policies banning FGM, have followed up with programmes and have developed laws or policies on sexual and gender violence, which

have received far more attention since the ICPD. Some countries have abolished spousal consent for the provision of contraceptive services.

Pioneering projects are being developed by NGOs working with young people, with the police and health care providers in training the judiciary to deal with violence against women.

### **B. Constraints in creating necessary conditions**

Due to lack of political will at the national level, gender concerns in the formulation and implementation of policies and programmes are not articulated. This is further complicated by poor funding for national women's organizations. Also, there is relatively little operational and qualitative research on these issues. This fact contributes to inconsistencies between policy frameworks and implementation strategies. Appropriate indicators for monitoring are largely absent.

Many social, cultural and religious attitudes and beliefs still put women's childbearing functions before other roles, restrict women's decision making in the private and the public domain. Restrictive attitudes also limit women's economic, political and educational, restrict their access to and control of land and credit as well as information and knowledge, and exclude their views as important stakeholders in policy formulation, planning and implementation. The restrictions perpetuate gender gaps, hinder efforts to empower women, thwart strategies to integrate a human rights perspective and nullify legal and related interventions to promote gender equality.

One of the most pernicious obstacles to gender equality and equity is gender based violence. Little headway has been made in addressing violence against girls and women as a human rights and public health issue. Sexual coercion, abuse and violence remains pervasive in the lives of many girls and women.

### **C. Actions needed**

#### *Political/Legislative/Ministry level*

- Create an enabling environment through participatory processes at all levels of society for women's empowerment, male involvement in promoting sexual and reproductive rights in a human rights framework. This requires the adoption of a gender perspective that accounts for the different realities and constraints that confront men and women. Programmes specifically for women are essential means for addressing gender inequalities and inequities.

- Revise and ensure the repeal of restrictive and punitive laws and policies to advance the sexual and reproductive health and rights of girls and women.

- Introduce mechanisms to provide human rights-based implementation of the ICPD Programme of Action by all actors (UNFPA and other UN agencies, Governments, NGOs, civil society partners and human rights treaty bodies) which are accountable, transparent, and evaluated on regular basis, by: (a) increasing NGO involvement in state parties implementation to human rights treaty bodies; (b) establishing human rights commissions in countries which address sexual and reproductive rights; and (c) promoting involvement of civil society in preparation of shadow reports to human rights treaty bodies.
- Investments are needed to support men's contribution to the sexual and reproductive health of their partners, such as partners' access to reproductive health care and men's involvement in child care. Information and services for boys and men themselves need to be increased to enable them to take responsibility for their own reproductive and sexual behaviour (such as information on and access to contraceptive methods that provide protection against STDs/HIV), taking responsibility for avoiding unwanted pregnancy. These investments, however, must not detract programmes and services for women.

### ***Concluding Remarks by Mr. Mohammad Nizamuddin***

Mr. Nizamuddin, after thanking the Government of Uganda for hosting the meeting and the participants for their varied contributions, noted several issues that were debated during the Round Table. Some attention needed to be given to men's roles and responsibility in reproductive health including support for partner's access to reproductive health care as well as information on and access to services. Concerning resources, Mr. Nizamuddin added that more attention needed to be addressed to resource shortages, and that concrete suggestions for both developing and developed countries were needed. He hoped that the resource situation would become clearer, as would data about resources, by next year, enabling UNFPA to establish to where it stood five years after Cairo.

### ***Closing Remarks by Mr. Jotham Musinguzi***

Mr. Jotham Musinguzi, Director of the Population Secretariat of the Government of Uganda, stated that since ICPD in 1994, the Ugandan Government had attempted innovative ways of implementing the Programme of Action by identifying areas of priority, which previously had not been adequately addressed: adolescent needs; women's empowerment, reproductive health and rights.

Mr. Musinguzi concluded that the Government could point to some success in its efforts, and could point to achievements in the empowerment of women, the involvement of men, and respect for human rights. Although the Government had taken action, Mr. Musinguzi added that "our best is not enough", and he assured the chairman of the final session that Uganda would take the Report on the Round Table with great seriousness.

## **Regional Perspectives on Progress Achieved in Ensuring Reproductive Rights and in Implementing Reproductive Health Since ICPD**

Among Asian countries, the Bangladeshi national family planning programme had for decades made great progress in the promotion of contraception. But by the mid-1990s, the status of women's health remained low. Half the population was younger than 15, which underscored the need to ensure opportunities for adolescents to delay marriage and reproduction. Furthermore, the risk of HIV/AIDS and STD epidemics loomed. The broader RH framework therefore had immediate relevance and the ICPD recommendations were widely discussed among the government, NGOs and donors. The post-ICPD consultations resulted from government interest, vibrant NGOs and an unusually positive atmosphere of donor cooperation.

Bangladesh also offers a unique example of NGOs engaged in consortium and of donors working together towards a common goal. The intention of moving toward RH in the health sector is reflected in the 1997 "Health and Population Sector Strategy", which affirms the principles of ICPD and recognizes the need for a client-centered approach and for good service delivery. In 1997, a National Reproductive Health Strategy was formulated with the involvement of NGOs, professional groups and consultants. Four service areas have priority: safe motherhood, family planning, menstrual regulation and care of post abortion complications and the management of RTIs/STDs. It is based on a life cycle approach, in which women are the objects of specific services and people are treated holistically.

In Africa since the adoption of the ICPD Programme of Action, heads of states in Ghana, Kenya, Uganda and Senegal have made public statements of support especially for reproductive health in general or for specific aspects such as birth spacing, AIDS, or FGM and other harmful traditional practices, such as expected early childbearing and female religious bondage. Although these statements have not been followed by further legislative provisions or other means of enforcement, they have provided a *de facto* visa for action especially for sexual and reproductive health and reproductive rights. In some countries, population policies adopted before 1994 have been or are in the process of being revised in accordance with the Programme of Action.

Post-ICPD population policies have been developed in line with the Programme of Action in Ghana, Mauritania, Uganda, Chad and the Central African Republic. Other countries are in the process of moving towards a reproductive health approach.

Latin American and the Caribbean is noteworthy for the relationship established in many policies between reproductive health and primary health care and the broader context of sustainable development. The Government of Peru, for example, approved in 1996 the new RH and Family Planning Programme, which recognizes abortion as a public health problem,

proposes an emergency plan to reduce maternal mortality and considers FP as a strategy to reduce poverty. In Brazil, a Commission on Population and Development was created after ICPD with a broad participation of the civil society. Reproductive health is central to its agenda among other development issues and in 1997, the Congress approved a National Family Planning Law. All temporary contraceptive methods are covered by the law, that also recognizes sterilization as an acceptable procedure for reimbursement by the Unified Health System.

Among Arab States, a Ministry of Population has been established in Morocco. In the MOH, the MCH division has been changed to the Division on Reproductive Health, where reproductive health is defined as taking an integrated approach to women's health. Consequently, MCH and FP are now under the same roof, while linkages are being strengthened to the division responsible for STD/AIDS. Population commissions have been reactivated at national and regional levels. They involve various ministries and their regional administrations in the planning and implementation of RH services and related issues such as girls education.

In Eastern Europe, countries offer different experiences. The RH approach is well received in Latvia, while in Russia, there is wariness based on the belief that RH services will further decrease the already negative natural population rate. It is interesting to note that this concern differs from that in Asia, where people fear that the RH approach will increase the fertility rate due to target-free FP provision. Poland is the only country in the world which has enacted a more restrictive abortion law in recent years.

**ICPD+5:  
EXPERT ROUND TABLE MEETING ON ENSURING REPRODUCTIVE  
RIGHTS, AND IMPLEMENTING SEXUAL AND REPRODUCTIVE HEALTH  
PROGRAMMES, INCLUDING WOMEN'S EMPOWERMENT, MALE  
INVOLVEMENT AND HUMAN RIGHTS**

*Kampala, Uganda  
22-25 June 1998*

## ***Agenda***

### ***Sunday, 21 June 1998***

17:00 - 19:00                      Registration. *Lobby of Nile International Hotel*

### ***Day 1: Monday, 22 June***

*Nile Hotel International Conference Centre  
Committee Room B*

9:00 - 9:15

#### ***Welcome Remarks***

Mr. Emmanuel Tumusiime-Mutebile Permanent Secretary,  
Ministry of Finance, Planning and Economic Development  
(delivered by Ms. Naomi Kibajju, Principal Assistant  
Secretary/Finance and Administration, Ministry of Finance and  
Economic Planning)

#### ***Purpose and Organization of the Round Table***

Mohammad Nizamuddin, Director,  
Technical and Policy Division, UNFPA

**Chair: Monique Essed-Fernandes**

**Background**

9:15 - 10:30

**ICPD: Four Years Later. Recent Trends and Challenges in Meeting ICPD Goals in Reproductive Rights and Reproductive Health**

Dr. Nicholas Dodd, Chief, Technical Branch  
Technical and Policy Division, UNFPA

**Discussants:**

Ms. Adrienne Germaine, International Women's Health Coalition, and Ms. Karen Newman, IPPF

Discussion

10:30 - 11:00

Coffee Break

**Session 1. Policies for Sexual and Reproductive Health**

11:00 - 12:00

**Developing a Sexual and Reproductive Health Policy**

Dr. Dean Phiri, Director, Reproductive Health Unit, Republic of Zambia

Discussion

**Opening**

12:00 - 1:00 **Welcome Address:**

**Dr. Nafis Sadik, Executive Director, UNFPA**  
**Vice-President of Uganda, Dr. Specioza Wandira-Kazibwe**  
(delivered by Honourable Mr. Sam Kuteesa, Minister of State, Ministry  
of Finance and Economic Planning)

1:00 - 2:00

Lunch

2:00 - 2:15

Plenary Session. Briefing on the Working Groups

2:00 - 3:30

Working Groups

3:30 - 4:00

Coffee Break

4:00 - 5:30

Working Groups, continued

6:30

Reception

**Day 2: Tuesday, 23 June**

Chair: Dr. Adepeju Olukoya, Women's Health Organization

**Session 2. Designing High Quality Sexual and Reproductive Health  
Services**

9:00 - 10:30 Quality of health services

***Implementing and monitoring feasible standards of care  
(experiences from India, the Philippines and Zambia)***

Ms. Saumya RamaRao, The Population Council

Discussion

***Broadening constellation of services within existing systems.***

Panel: Mr. M. Nizamuddin, and Ms. Adrienne Germain

Discussion

10:30 - 11:00 Coffee break

11:00 - 1:30 Scope of health services

***Experiences from Improving Quality of Care in India***

Dr. Sharad Iyengar, Executive Director, Action Research and Training for Health

***Reducing maternal mortality***

Dr. Khama Rogo, University of Nairobi

Discussion

1:30 - 2:30 Lunch

2:30 - 4:00 Working Groups

4:00 - 4:30 Coffee Break

4:30 - 5:30 Working Groups, continued

***Day 3: Wednesday, 24 June***

***Chair: Dr. Mawaheb El-Mouelhy, AVSC International***

9:00 - 10:30 Gender-based violence

***Female genital mutilation***

Mr. Jackson Chekwoko, Reproductive, Education and Community Health Programme, Uganda

***Violence against women: the role of the health and education sectors.***

Ms. Wanda Nowicka, Federation for Women and Family Planning, Poland

Discussion

10:30 - 11:00                      Coffee Break

**Session 3. Accessibility to RH/SH/FP Service**

11:00 - 1:00    **Key Issues in improving access to sexual and reproductive health services:**

- <    **Linking reproductive health information and services**
- <    **Diversifying health providers: the participation of the private sector including NGOs and the expansion of social marketing**

Ms. Maria Isabel Plata, Executive Director, PROFAMILIA ,  
Colombia

Discussion

1:00 - 2:00                      Lunch -- *Conference Center Dining Room*

Video presentation on **Reproductive Health in Refugee Situations in Emergency Plan -- the IFRC/UNFPA/UNHCR project**

Dr. Daniel Pierotti, Emergency Relief Operations, UNFPA/ERO

2:00 - 4:00                      Working Groups

4:00 - 4:30                      Coffee break

**Chair: Karen Newman, IPPF**

4:30 - 6:30                      Report from Working Groups

**Day 4: Thursday, 25 June**

**Chair: Karen Newman**

**Session 4. Creating Necessary Conditions for Implementing Sexual and Reproductive Health and Rights**

8:30 - 10:30 Legislation and regulations

**Reproductive health as a human right; gender equality and women's empowerment**

Ms. Anika Rahman, Center for Reproductive Law and Policy, USA

**Legislating and implementing reproductive rights**

Ms. Barbara Klugman, Women's Health Project, South Africa

Discussion

10:30 - 11:00 Coffee Break

11:00 - 1:00 Presentation of Working Groups 1 and 4

1:00 - 2:00 Lunch

2:00 - 4:00 Working Groups

4:00 - 4:30 Coffee Break

5:00 **Final Plenary Session: Actions Needed**

Chair: Karen Newman

Presentation of Reports of 4 Working Groups

Closing Remarks

Mr. Jotham Musinguzi, Director, Population Secretariat  
Government of Uganda

Mr. James Kuriah, UNFPA Representative, Uganda

Mr. M. Nizamuddin, Director, Technical and Policy Division  
UNFPA, New York

**Round Table on Reproductive Rights and Implementation of  
Reproductive Health Programmes, including women's empowerment,  
male involvement and human rights**

*Kampala, Uganda, June 22-25, 1998*

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