

ICPD: Four Years Later

Recent Trends and Challenges in Meeting ICPD Goals in Reproductive Rights and Reproductive Health

Table of Contents

1. Introduction	1
2. The Programme of Action on Reproductive Rights, Reproductive Health, Women Empowerment including Male Involvement and Human Rights	2
3. Policies for Sexual and Reproductive Health	3
Overview	3
Regional Perspectives	5
Policy Development Process	10
Financing Policies	13
Changes in Policies of Bi-Lateral and Multi-Lateral Donors	15
4. Designing Quality RH Services	17
Integrating and Broadening Service Delivery	17
Components of RH Programme Design	20
Training	21
Quality of Care - Implementing Reproductive Rights	23
Management Information Systems	25
Addressing Gender-Based Violence	26
5. Accessibility	27
IEC Needs and Services	

27 Service Provision

28

6. **Creating necessary Conditions for Implementing Sexual and Reproductive Health and Rights**

29

7. **Conclusion**

31

Bibliography

ICPD: Four Years Later

Recent Trends and Challenges in Meeting ICPD Goals in Reproductive Rights and Reproductive Health

1. Introduction

At the International Conference on Population and Development (ICPD) held in Cairo in 1994, 184 countries recognized the need to view population issues in a different light. Previously, discussions on population had centered around the degree to which population growth was a cause or a consequence of failures of development, of poverty and its role in environmental deterioration. International discussion often reflected the first view by suggesting demographic targets for limiting the world's population. In Cairo, however, the international community recognized that links between population and development were multidimensional, emphasized that human and social development was essential to establishing positive correlations between the two, and identified reproductive rights and sexual and reproductive health as the way to contribute to human and social development within the population context. The Programme of Action (POA) of the ICPD, focuses on the sexual and reproductive health needs of the most vulnerable members of society and of those who enjoy the least autonomy to protect their rights, including the poor, women and adolescents.

The ICPD POA defines reproductive health as a human right. Women have the right to access sexual and reproductive health services. This also means that women are entitled to demand from governments the provision of quality reproductive health services¹. The ICPD POA is unique by calling for the civil society, including NGOs, to take major responsibilities in designing and implementing reproductive health policies. The Programme also calls for national governments, bilateral and multilateral donors to make substantial budget reallocations.

This document reviews progress made in the implementation of the ICPD POA with respect to ensuring reproductive rights and implementing reproductive health four years after the Conference. It has been prepared as a background document for the Round Table meeting on Ensuring Reproductive Rights and Implementing Reproductive Health, including empowerment of women, involvement of males and human rights.

The paper builds on information gathered through a review of literature on the subject, interviews and on the expertise of UNFPA Country Support Team Advisers who work with the issues involved at country and regional level on a daily basis who kindly have provided their valuable inputs to this paper. This paper does not build on a systematic survey, and the main limitation of this methodology is that not all issues may be reflected in the paper and the examples provided may not all represent the most common developments in countries or regions. Furthermore, the important work of

¹Although the ICPD Programme of Action does not impose sanctions for non compliance

international non-governmental organization in advocacy and technical assistance is not included in its full dimension even though we recognize that this work in many places has been instrumental in bringing about the changes described in this paper.

The chapters of the document discuss the topics of the sessions of the Round Table meeting; a) "Policies for Sexual and Reproductive Health," addressing policy change since the ICPD, process and content; b) "Designing Quality Sexual and Reproductive Health Services," addressing management issues of broadening scope of and establishing linkages between services; c) "Accessibility," addressing links between IEC and services, and role of providers; and d) "Creating Necessary Conditions for Implementing Sexual and Reproductive Health and Rights," addressing gender equality, women's empowerment and reproductive rights.

2. The Programme of Action on Reproductive Rights, Reproductive Health, Women Empowerment including Male Involvement and Human Rights.

With respect to reproductive rights the ICPD POA states that:

"Everyone has the rights to the enjoyment of the highest attainable standard of physical and mental health...All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so." (UN, 1994, para 2.8)

"...[These] rights rest on recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion, and violence, as expressed in human rights documents" (UN, 1994a, para 7.3)

Reproductive Health Care includes:

"... counseling, information, education, communication, and services for family planning; all stages of pregnancy and delivery; prevention and treatment of infertility; prevention of abortion and the management of the consequences of unsafe abortion; prevention and treatment of reproductive tract infections, sexually transmitted diseases (STDs) and other reproductive health conditions, prevention and appropriate treatment of infertility, and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood..."

For Gender Equality, Equity and Empowerment of Women, the Programme of Action calls for:

"addressing the imbalanced relations between women and men, elaborates on the need to empower women, protect the girl child, and achieve gender equity in all spheres of life. Women should be protected from all forms of discrimination, violence, abuse, harassment, and exploitation. Men should take responsibility for

their sexual and reproductive behavior and their social and family roles.”

3. Policies for Sexual and Reproductive Health

Overview

Following the ICPD, the challenge for the 184 countries that endorsed the POA was to apply it in accordance with the circumstances prevalent in each country. For most, an important first step of this process was the formulation of reproductive health (RH) policies. This implies that a specific decision or set of decisions were made which selected the reproductive health approach from among alternatives and in the light of given conditions to be the future course of action.

Process: The overall picture of countries that have adopted RH policies is very encouraging but the process of policy formulation have by no means been uniform. In many countries in Latin America, the initial reaction to the ICPD was resistance towards the concept of reproductive health -- promoted by a strong Catholic Church -- which other national stakeholders, primarily NGOs, had to overcome before policy formulation could take place. The Arab States offer examples of countries which already had extensive service provision networks, which facilitated the process of moving towards the RH approach. In the newly independent states of Eastern Europe RH policy formulation is an ongoing process which in some instances have been overtaken by RH service provision by both state and NGOs. In several countries in Asia, the RH concept was readily accepted by many governments and often other stakeholders were involved in the process. In Sub-Saharan Africa, leaders made political statements in favour of the RH approach, and some countries have or are developing RH policies.

According to a UNFPA survey with 482 responding NGOs from all regions, NGOs have increasingly been involved in the development of policies and laws. NGOs typically participate as adviser to specially created commissions that review national plans, discuss and elaborate policy changes and organize national consultations. They are also actively involved in advocacy to influence the agenda of law- and policy-makers. (UN, Economic and Social Council, 1997).

Definitions and priorities: In analyzing policies it is critical to look at the definitions of RH in policies and the priority given to different RH components to establish how far the polices have gone in adopting the RH approach:

With regard to definitions, eight countries in four regions (Bangladesh, India, Nepal, Jordan, Ghana, Senegal, Jamaica and Peru) studied by “The Futures Group International” have all changed from a family planning (FP) to a RH focus in their policies and have all based the definition of reproductive health in their policies on that of the ICPD POA. Six of the countries have adopted a broad perspective as in the POA while Jordan and Peru have used more narrow definition. (Hardee *et al.*, 1998, p. 2-3).

The same study found, regarding priorities, that FP was the main priority of policies, followed by

maternal and child care (MCH), STDs/HIV/AIDS and RTIs. In addition, post-abortion care and programmes for adolescents are areas which have received increased emphasis in some countries. (Hardee *et al.*, 1998, p. 4). This is confirmed by the regional perspectives below which find that while some RH policies have taken a comprehensive approach to RH, others may not be all that different from previous MCH/FP policies.

The strategy chosen by countries has often depended on the FP/MCH/health care system which existed before the formulation of the RH policy. But also countries with similar baseline situations have designed very different RH policies. Some countries with limited service delivery systems have taken the opportunity to clear the board and have formulated comprehensive RH policies (Cambodia), while others kept to a narrow focus (Lao PDR). Among countries with already extensive FP/MCH service provision, some have focused on establishing linkages between or integrating previously vertical structures (Romania, Tunisia), while others have expanded the range of services (Brazil, Thailand).

Reproductive rights and gender: Most policies reaffirm the reproductive rights principle of the POA as quoted above, namely, the basic 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 the fact that women's status needs to be improved to reach this goal. These are encouraging developments, but critical issues arise in connection with what priorities should be established to enable couples and individuals to enjoy these rights.

For reproductive rights, most countries seem to give the highest priorities to aspects of service provision. Few specifically address the context in which reproductive decisions are made, i.e. gender and power relations. These issues will be further discussed in Chapter 7.

Strategies oriented towards gender issues and equality include policies on improving girls enrollment in schools, and laws and policies that address harmful traditional practices. Few countries seem to have policies that take a comprehensive approach to women's empowerment or call for the active involvement of men in reproductive health issues. There are however encouraging examples including Ethiopia, where the general objectives of the Population Policy include raising the economic and social status of women by freeing them from the restrictions of traditional life and making it possible for them to participate productively in the larger community (The Center for Reproductive Law and Policy, 1997, p. 160); Thailand where the Eighth Five Year Development Plan promote more equal male participation (UNFPA, 1998, p. 19); and Zambia, where the RH policy document includes a section on the rationale and strategies for male involvement.

For gender and women's issues and other cross-cutting issues, it is important that policies clearly define whether they will be managed by a specific institution, e.g. a ministry or a department or inter-ministerial body, or whether the strategy is to institutionalize cross-cutting issues in each concerned office. South Africa offers an example where the Department of Health has a dedicated gender / women's unit in one directorate but where other directorates also deal with women. The lack of clear

institutional set-ups can lead to confusion regarding further policy development, management and financial issues. (Stevens, 1997, p. 288)

Adolescent sexual and reproductive health: An area which seems to have gained comprehensive recognition in recent policies of many countries is the area of adolescents sexual and reproductive health needs. The POA calls upon countries to address adolescent sexual and reproductive health issues, such as unwanted pregnancy and STDs, including HIV/AIDS, by of responsible and healthy reproductive and sexual behaviour. While adolescent SH/RH was a controversial subject in a majority of countries just a decade ago, many countries have since realized that the only way to counteract the establishment of unhealthy behavioural patterns and early childbearing is to deal with adolescents' sexual and reproductive health concerns. This is reflected in a number of RH policies, and in policies pertaining to education, sport and leisure (Tunisia, Thailand). However, some policies do not provide access to adolescents for youth-friendly services. In other countries, the controversy remains strong enough to prevent the formulation of policies. Nevertheless, activities are often ongoing as carried out by NGOs with the silent endorsement of the government (Romania, Russia).

Access to family planning: In many countries, policies that limit access to family planning services are being lifted. Regulations and policies being reviewed concern spousal authorization, marital status and age limitations that have strong effects on denying services to unmarried women, adolescents, divorced and widowed, and women who want to delay or space pregnancies but are not able to negotiate this with their husbands. However, by 1997, fourteen countries still required spousal authorization for women to receive contraceptive services and 60 additional countries required spousal authorization for permanent methods.

Elimination of unsafe abortion: A recent study by the Alan Guttmacher Institute of abortion laws of 152 nations and dependent territories with population of one million or more found that 61% of the world population live in countries where induced abortion is permitted for a wide range of reasons or without any restrictions as to reason at all. Induced abortion is permitted for 14% of world population to protect the pregnant women's physical or mental health, and only 25% live where abortion is generally prohibited. Since 1985, 19 countries have liberalized their abortion laws, three of them since 1994, and only Poland has moved to a more restrictive category (in 1993, reaffirmed in 1997). The study therefore concludes that the global trend towards liberal abortion laws which began before 1985 has continued over the last dozen years. (Rahman, Katzive and Henshaw, 1998).

Regardless of national abortion policy, the paragraph 8.25 of the Programme of Action urge countries "...to deal with the health impact of unsafe abortion as a major public health concern and to reduce the course of abortion through expanded and improved family planning services..." Some countries such as Peru, Bangladesh and Ghana have recognized abortion as a public health problem.

Regional Perspectives

In Asia a number of countries with advanced FP programmes, some integrated with MCH, readily adapted the RH concept and formulated policies accordingly. Several countries with histories of

target-oriented, demographically driven policies also gradually shifted toward target free approaches. The scope of RH policies differs among countries but generally they tend to prioritize a few key areas, among them the provision of FP services.

Thailand, which for two decades has had a strong FP programme, has endorsed a broad 10 component RH policy which builds on the life cycle approach and which includes adolescents. The policy has abandoned demographic targets as a rationale for FP. The strategy on “appropriate family size” is proposed in the development context under the Eighth National Economic and Social Development Plan (1997-2001) which also includes a component on the promotion of a suitable geographical distribution of the population. This involves slowing down FP activities in the areas that have replacement fertility and to promote FP activities in the remaining high birth rate areas. (Thailand, 1998), (Warakamin, 1998).

In India, another country with a long history of target oriented FP programmes, the “target free approach” was announced in April 1996. The possible impact of a target free approach was demonstrated by an experimental pilot project in two districts, providing integrated FP and RH services without target or quota. At the end of two years, the pilot areas showed an increase in contraceptive prevalence by 50% (Singh, 1997). The new approach was, however, met with concern that target free approach would lead to contraceptive use declining when providers lack management incentives to promote FP. Consequently, some states continue to set targets. (Jones, 1998, making reference to Visaria, Jejeebhoy and Merrick, 1996).

In the Philippines, the Government decided to integrate the Ministry of Health (MOH) units responsible for RH services within an Office of Special Concern under an assistant secretary. A comprehensive RH programme has been implemented in Region II of the country.

Some countries, scarce in resources and lacking access to services and experience, have also adopted the RH concept. In Cambodia, the new policy supports the rights of couples and individuals “to decide freely and responsibly the number and spacing of their children”. The three central elements of the “National Reproductive Health Plan” are FP; maternal mortality and morbidity and infant mortality. The implementation of the policy involves the provision of a “minimum service package” which conforms to the broader principles of RH. The policy of Lao PDR has FP provision and the reduction of maternal and infant mortality as the two main goals. (UNFPA, 1998, p. 15).

These examples imply that Asia has moved cautiously toward broader RH without losing emphasis on FP. They also suggest that priorities among countries differ. Several countries in the region have made important advances in promoting a quality of care approach. Indonesia has developed strategies to broaden contraceptive choices. China has focussed its new programme (1995-2000) on needs of clients and “quality of care in FP.” Others, including the Philippines, have undertaken needs assessments to determine how quality of care can be improved. (Economic and Social Commission for Asia and the Pacific (a) and (b), 1998). The major implementation tasks will change from a target-oriented to a client-oriented and needs-based approach, with a focus on quality of service while reconciling target free management of FP with national demographic goals. Already important steps

have been taken in this direction in the Region (see box 4).

Box 1:

Bangladesh

In Bangladesh, the FP programme had achieved significant progress by promoting contraceptive prevalence to 45% and reducing total fertility by 50%. However, by the mid 1990's women's health status was still markedly low; half the population was younger than 15, which underscored the need to ensure opportunities, information and services for adolescents to delay marriage and reproduction. In addition, and a potential 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 reportedly resulted from government interest, vibrant NGOs and an unusually positive atmosphere of donor cooperation (Family Care International, 1998, p. 8) and they constituted the forum where new RH policy priorities were identified.

Bangladesh also offers a unique example of NGOs being 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 quality in service delivery. In addition, possible inter-sectoral programming options are being explored as the links between RH, poverty alleviation and economic development are recognized. In the latter half of 1997, a National Reproductive Health Strategy was formulated, also with the active involvement of NGOs, professional groups and consultants. In this strategy, 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, which is defined as women not to be seen as objectives of specific services but rather to be treated holistically. (Family Care International, 1998), (Government of Bangladesh, 1997), (Singha, 1997).

In Africa, since the adoption of the ICPD POA political leaders, notably heads of states have made public statements of support especially for reproductive health in general or for specific aspects such as birth spacing, AIDS, or female genital mutilation (FGM) and other harmful traditional practices such as expected early childbearing and female religious bondage (Ghana, Kenya, Uganda, and Senegal). 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 POA (Ghana, Kenya, South Africa), while post-ICPD population policies have been developed in line with the POA in other countries. (Mauritania, Uganda, Chad, Central African Republic). Other countries have not moved towards the RH approach. The objective of reducing fertility as a way of improving development is common in the region. Ethiopia, Ghana, Kenya and Zimbabwe have set numerical goals for the total fertility rate. (The Center for Reproductive Law and Policy, 1997).

The ICPD focus on gender has led some countries to develop new policies. Uganda, Eritrea, Mauritania and Tanzania are adopting specific policies on gender and development and women's empowerment. Elsewhere gender issues are being incorporated in pre-ICPD policies (Ethiopia, Chad,

Central African Republic, Tanzania, Mauritania, Rwanda). FGM is a criminal offence in Ghana and Togo. Ministries, secretariats or state commissions for gender have been created to provide the institutional framework for the achievement of gender main streaming and women's empowerment (Burundi, CAR, Chad, Mali, Mauritania, Rwanda, Tanzania).

Reproductive and ownership rights within marriage are covered in the marriage laws of many countries (Ghana, Kenya, Ethiopia, Tanzania and Rwanda). However, these laws co-exist with customary unwritten laws and religious marriage laws (Muslim and Hindu) which in some cases provide women with fewer rights and less protection than civil law. Only in Ethiopia is it explicitly stated that all marriages, whether contracted under civil, religious or customary law, are regulated by the civil code. Some countries, including Mali, have officially issued directives empowering women, irrespective of their matrimonial status or position of their spouse, to access services at their own will.

In Latin American and the Caribbean, many countries have formulated policies that follow the ICPD recommendations. In particular the region is worth noting 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 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.

In Bolivia, the Government in 1994 issued a declaration of principles on Population and Sustainable Development, which recognizes that sexual and reproductive health is an integral component of health. In Mexico, a programme on reproductive health and family planning was approved in 1995. It states that reproductive health should be a basic part of health services, along with nutrition and vaccination.

Among Arab States, some countries such as Tunisia and Morocco had comprehensive health policies covering the main components of RH before the ICPD. While the change towards an RH approach is therefore not primarily seen in national policy change, it is apparent in changing working arrangements.

In Tunisia, the National Family Planning and Population Office has adopted the life cycle approach, as opposed to previously targeting women of reproductive age only. With the new approach, RH issues pertaining to youth, menopause women, STD/AIDS, and cancers of the reproductive system are now being included in the scope of concerns of the office. (Personal communication with Helene Zoughlami, UNFPA Tunisia, May 1998)

In Morocco, a Ministry of Population has been established. 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. 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. (Personal communication with Vincent Fauveau, UNFPA, Morocco, May 1998).

In contrast, Jordan is a country where RH remains a vague idea and where there is no consensus definition of the concept. The Policy Project referred to above met, for example, with the perception among high-level officials in the Ministry of Health that FP is a broader concept than RH. At the same time, the National Population Council is in the process of revising the national population strategy to reflect the ICPD recommendation. (Hardee *et al.*, 1998, p. 4-5). This example illustrates the confusion that a new concept can provoke; a confusion which other examples show is best overcome through a participatory policy development process.

In Eastern Europe, countries have had different experiences. For example, the RH approach is well received in Latvia (see box 2), while in Russia, there is wariness based on the belief that RH services will further decrease the already negative natural population growth rate. It is interesting to note that this concern differs from that found in Asia, where people fear that the RH approach will increase the fertility rate due to target-free FP provision. As mentioned above, Poland is the only country in the world which has enacted a more restrictive abortion law in recent years (Rahman, Katzive and Henshaw, 1998).

In Romania, no primary health care (PHC) system existed under the Ceaucescu regime and people generally went directly to specialists. While no policy change as such has come about, a loan agreement between Romania and the World Bank provided that Romania will move towards a PHC approach, and the intention was to have FP integrated into this approach. FP is the main RH concern in Romania as use is very low and as both the public and practitioners were disinformed about the harm of modern contraceptive methods under the former regime. Today, women in Romania primarily use abortion to regulate their childbearing. Consequently, the maternal mortality ratio remains one of the highest in Europe despite a dramatic fall after abortion was legalized (i.e. performable under safe medical conditions) in December 1989. (Personal communication with Katy Schoff, CTA WHO Romania), (Ghetau, 1997).

Observations on the regional perspectives: Although the overall picture of policy change towards the RH approach is very encouraging, a note of caution should be born in mind as to whether these RH policies can be taken for face value. Some studies suggest that RH policies are not driven or backed-up by genuine government commitment to reproductive health, or that, in some instances, the main government concern may be to ensure continued donor contributions. (Family Care International, 1998), (Hardee *et al.*, 1998), (Economic and Social Commission for Asia and the Pacific (a), 1998, p. 6).

Box 2:**Latvia**

By the mid 1990's Latvia found itself in a paradox: Fertility rates were so low that the country had a negative natural population growth. At the same time contraceptive use was as low as about 20% among people aged 15-45. There are several explanations: High and increasing abortion rates and low information and awareness. Increasing STD rates are a consequence. In recent years, both state, NGOs, professional and community-based organizations have intensified their efforts to provide improved RH services and information. However, without a national policy and strategy RH efforts remain un-coordinated and scattered. In February 1997, Latvia's Ministry of Welfare (MOW) began developing a national RH policy for Latvia. This participatory process consists of the following steps:

C The MOW invited various state organizations and NGOs to nominate a representative for a national working group which is overseeing project implementation.

C The working group developed a questionnaire for a national survey on the population's opinions on, attitudes towards, awareness of and behaviour regarding various aspects of RH.

C The national survey was conducted through personal interviews with women and questionnaires to men, as most of interviewers were women.

C After a primary analysis of the data, in September 1997, the MOW organized a 3-day conference where the data was further analyzed and discussed by national experts and representatives from NGOs. The participants developed recommendations for further national action needed to develop and implement a national reproductive health policy.

C A national report was published this year by the working group. It includes both the survey findings and the recommendations of the conference for the government of Latvia.

C The general public has been kept informed of the process both through the media and through the distribution of informative materials.

The actual RH policy now remains to be developed: It is the main recommendation of the National Report that this is done. (Rudze et. al, 1998)

Another observation concerns the degree to which RH policies are integrated or linked to overall development policies. In both Asian and Africa some countries appear to continue to make demographic goals a greater policy priority higher than reproductive health as the demographic goal is linked to overall development issues while the RH approach is identified as the means to achieve this goal. Where a large unmet need exists there need not be any contradiction here, but the ICPD POA does recognize the attainment of RH as a goal in itself and not as a means to and end, and as such it is an integral part of the human right to the highest attainable standard of health. Some countries do adopt the ICPD perspective and recognize further in their development policies the fundamental linkages between health (including reproductive health), environment, women's empowerment, economic development and population. (Bangladesh)

Policy Development Processes

Policy formulation processes have differed among countries even if most countries, as a first step, arranged national workshops or conferences to come to a common understanding of the concept and to relate it to a national context. However, when analyzing the different processes, two particularly important aspects stand out: Needs assessment and the involvement of stakeholders.

Needs assessments: If a needs assessment of the RH situation in the country is carried out, the policy and its priorities can respond to prevalent problems. Needs assessments that focus on priorities and views of potential clients facilitate the design of a need-based, client-focused RH approach. Latvia offers one such example as evident from box 2 and Zambia another (see box 3). The regional perspective on Asia found that countries in this region also have undertaken needs assessment to improve quality of care. A key issue in conducting RH needs assessments is the issue of indicators which will be further discussed in the section on management information systems below.

Box 3:

Zambia

The overall goal of the National Population Policy of Zambia, adopted in 1989, was to improve the standard of living and quality of life of all Zambians. Among the objectives of this policy is to slow the population growth rate and the policy includes quantitative targets regarding this objective. As part of health sector reform FP has been included in the essential health package which is a basic package of cost-effective health care services that the government has committed itself to financing.

Post-ICPD: In March 1997, the MOH and the Central Board of Health Zambia published "Family Planning in Reproductive Health. Policy Framework. Strategies. Guidelines". This document resulted from a series of workshops with participants from all levels of the public sector, from government to service delivery points as well as from NGOs and other local stakeholders such as the University Teaching Hospital. International organizations provided technical support. The workshops were conducted from March 1994 to May 1995 - as the document states "the process of consensus building and technical inputs into a changing health scenario, of necessity, required time" (p. v).

The policy framework of this document states that it is in line with the goals of the above mention population policy but it also states that the rights of individuals to informed choices should be upheld and that Zambia "is moving toward a concept of reproductive health that offers a more comprehensive and integrated approach to meeting the current health needs of all" - i.e. a needs based approach. While a potential conflict can be identified between these two statements, the policy document includes the findings of an assessment of FP services (1995); a comprehensive literature review; a situation analysis of safe motherhood (1994); and a sensitization workshops on RH (1996). In other words, the policy document focuses on client's perceptions and needs as well as providers' attitudes and knowledge and the RH strategies of the document are formulated to respond to the needs of clients and to overcome barriers to informed and voluntary choice. (Zambia, 1997).

Involvement of stakeholders: The second aspect is the involvement of stakeholders, including NGOs and professional organizations, in the process of developing the policy. Their involvement is important for at least four reasons:

1) Such groups serve as advocates and "gatekeepers" to ensure that international conventions and agreements which the country has endorsed are reflected in policies and that national authorities, and NGOs themselves keep the promises made at ICPD. In India, NGOs, including the network Health Watch, work to ensure that women are given a strong role in planning, monitoring and evaluating the new target-free family planning services. In Mexico, the Reproductive Health Network of Mexico City organized a public tribunal to denounce cases of abuse in RH service. This resulted in the commitment of programme managers to improve the quality of services provided, including

amelioration of the way women are treated in those services. (UN, Economic and Social Commission, 1997, p. 10). In Honduras, 17 NGOs have formed a network to coordinate and promote implementation of ICPD recommendations. In Peru, the Government, NGOs and UNFPA have created a tripartite commission to follow up on the commitments made by the Government.

2) They serve as the voice of groups affected by the policies and work towards ensuring that the priorities of these groups are reflected in policies. In Senegal, NGOs find that while they are generally involved due to cultural traits which ensure openness and discussion for the purpose of reaching consensus, they are in particular involved in deliberations pertaining to health because they provide a lot of the health services of the country. (Hardee *et al.*, 1998, p. 8).

3) Their participation ensures that the process of developing policies is transparent and their networks serve to disseminate information on the process. In Ghana, the participation of NGOs, which exist at all levels, ensured that communities achieved a sense of ownership because the organizations took the draft policies back to their communities for discussion. (Hardee *et al.*, 1998, p. 7). In Brazil, women's NGOs and the civil society participate in the decentralization of the health system through the state and local health councils.

4) The participation of NGOs and other stakeholders reinforces the awareness of their political potential to contribute to improving the RH status of a population. In Bangladesh and Sri Lanka, NGOs have been involved in the process of formulating national strategies because the government recognized no comprehensive RH approach could be achieved without. The success of this approach is illustrated in the following comment made by a NGO representative cited in one study: "Now that government organization and NGO sectors are working together, the whole system has improved - health, family planning, and all sectors of development." (Hardee *et al.*, 1998, p. 6). In Pakistan and Nepal such recognition of NGOs has significantly increased their presence since the ICPD. (Family Care International, 1998, p. 6-7).

Constraints to the policy making process includes the selection of stakeholders to include in the process. In India, one NGO respondent has commented that "NGOs are invited to forums for decision making with Government, however,... the most vocal NGOs are not invited for policy discussions" (Hardee *et al.*, 1998, p. 6).

Another constraint occurs where NGOs feel that they while they are marginally involved, they lack decision-making power or are uninvolved in policy development. In Nepal, a NGO Coordinating Council was established in 1995, but NGOs continue to feel that the government does view them as their partner. (Hardee *et al.*, 1998, p. 7).

It is also worth mentioning that the collaboration with government has created a dilemma for some NGOs which fear that such relationships can compromise their role as a watchdog. Some NGOs find that if they had a greater degree of financial autonomy this tension could be overcome. (UN, Economic and Social Commission, 1997, p.17).

Despite these constraints the UNFPA NGO survey referred to above found that there is a widespread sense among NGOs that ICPD marked a turning point for them. Although many were already involved in the area of sexual and reproductive health long before ICPD, they find that the Cairo Conference served to legitimize them as genuine partners in the implementation of the POA. In many countries members of national NGOs have gained direct access to ministries and international agencies as never before, and they are now consulted widely on RH efforts. This success seems to be partly attributable to the ICPD POA, which serves as a common reference point governing interaction between Governments, NGOs and International Organizations. (UN, Economic and Social Council, 1997, p. 6-7)

Financing Policies

The Policy Project study mentioned above found no consistent trend regarding the financing of RH policies. In Bangladesh funding has increased; plans for the introduction of user fees are now being developed in order to increase sustainability. In India funding decreased over the 1991-1994 period. The study questioned whether the downward trend of public support will continue since structural adjustment measures are now being adopted and the commitment to RH is mixed within the government. In Nepal, most respondent to the survey found that resources were too limited to embark on a broader RH approach even with donors presently funding over half of the health sector. In Jordan respondents also found that the cost of a broader approach hindered its implementation. Answers in Ghana were mixed with some finding that government expenditure is both large and has been increasing for population activities, while other point out that NGOs, funded by donors, are also of great importance in serving underserved populations. In Senegal, government funding for health is increasing but donors are largely funding the area of RH. (Hardee *et al.*, 1998)

Cost recovery is on the increase reinforced by the policies in the Bamako Initiative of the Health for All Strategy. Cost-recovery has helped to sustain local expenses for RH clinic services in Iraq. In Jamaica, spending for health has decreased and it is uncertain what will happen under the health sector reform. While there has been a shift towards increased private sector provision of FP services the government is still committed to provide a safety net of free services of at least 40%. One NGO respondent to the policy project survey commented that “Since Cairo, we don’t have to fight with the government over the budget. We have the support of the highest levels of government” (Hardee *et al.*, 1998, p. 8, 13-15). In Peru the government has “dramatically increased” funding for RH meaning that the role of donors is decreasing. (Hardee *et al.*, 1998, p. 13-15)

Prioritizing RH: Other questions than actual spending and cost recovery are involved in the question of funding for reproductive health. One issue is the question of decentralization which is an important part of health sector reform in many countries. When health spending priorities are identified at the local level safeguarding spending for RH will be dependent either on an understanding of RH having trickled down to the regional or local level - or having “trickled up” from a demand from women, which would be dependent on their empowerment to recognize their needs. Often such an understanding has not yet occurred at regional and local levels which the example of India illustrates with some states continuing the target-oriented approach, despite the fact it has officially been

abandoned. In Zambia, where the health sector reform process has been on-going since 1992, a broad based understanding of reproductive health has been facilitated by the involvement of all levels of the public health system in the policy formulation process (see box 3). In Zimbabwe, a country devastated by the HIV epidemic, women NGOs were instrumental in organizing the demand for state subsidized female condoms that will allow women to take the control over protection against HIV infection.

Another question pertains to whether resources are available to offer the whole range of RH services and, if not, how they should be assigned priority. Many countries, including countries with broad RH formulations in their policies, have found it necessary to assign priorities and, as evident from the discussion of policies presented above, this has often resulted in strategies still focusing on the previously high priority areas of FP and MCH.

The cost of RH: An interesting observation is made in a forthcoming publication, namely that in discussions of resources for RH the assumptions are made that existing resources at service delivery points are used in an efficient and cost-effective manner and that service delivery points and staff are over stressed and operating at full capacity. To test these assumptions, a secondary analysis of five Situation Analysis studies in Africa has been conducted. This review found that 60-75% of clients are served by only 25% of the service delivery points. At service delivery points which according to policy *and* in stock have at least four contraceptive methods available (which was the case at 81% of the studied sites) only 34% of new spacing clients are actually informed about three or more methods. The Situation Analysis studies also show that while available clinical technologies such as blood pressure machines and uterine sounds are generally highly utilized (ranging from 81-94%), information and educational materials are used only in 5-22% of (new) client-provider interactions in clinics which have such materials available. Likewise with the utilization of water: where water is available in the exam room, providers only washed hands before pelvic exams in 26% of 1024 observed cases. (Haberland, Miller, Bruce, Fassihian, forthcoming). While it should be noted that great differences existed among countries on some of these issues the findings indicate that there is great scope for improving RH service provision even with existing resources. See also the quality of care discussion below.

A last issue is the cost, both in financial and human terms, of not offering RH services. Financial costs occur when productive lives are lost due to maternal deaths or HIV/AIDS or when the capabilities of individuals suffer under disease. While the cost of such consequences has been attempted with measurements such as disability adjusted life years (DALYS), the human / psychological costs of infertility, unwanted pregnancies and STDs can not at this time be established. The following figures nonetheless indicate the potentia scope of the funding crisis: UNFPA has estimated that if the ICPD POA is not implemented due to financial constraints, an additional 44-80 million couples -- depending on the implementing scenario -- will not be using a contraceptive method in the year 2000; in 1995-2000, 130-230 million additional unintended or unwanted pregnancies, 50-90 million additional induced abortions and 59-110 million extra unintended births will occur; and as a result an additional 300,000-540,000 women will suffer maternal mortality. (UNFPA, 1997).

The redistribution of resources and even the more effective use of resources is still lacking in the majority of provisions made to implement reproductive health.

Role of donors: Although RH programmes are the responsibility of countries, many governments depend a great degree on donor contributions. Donors often negotiate with governments their contribution to RH implementation. Changes of donor's policies after ICPD are critical to implement reproductive health in numerous countries. What follows is an assessment of the policy changes of multilateral and bilateral donors in support of reproductive health.

Changes in Policies of Bi-Lateral and Multi-Lateral Donors

The ICPD-POA significantly influenced the RH agenda of international multilateral and bilateral agencies. An inter-agency task force was established in 1995 to collaborate and coordinate the implementation of the ICPD-POA. A donor workshop, co-sponsored by the USAID and UKODA in June 1995, helped in determining their role in reproductive health. The participant donors agreed that there is probably no single package that suits reproductive health needs of all people and that national as well as donor priorities are likely to differ. However, priority should be given to coordinate strategies and activities in each country. In the same workshop, donors agreed that where they provided financial assistance, they needed evidence that programmes were working. Further improvement in the capacity to monitor programme outcomes therefore, becomes critical to measuring success and managing effectively.

Multilateral donors: Following the ICPD, UNFPA revised its guidelines “UNFPA Support for Family Planning” to broaden the focus of its support in line of reproductive health. The guidelines acquired a new title: “UNFPA Support for Reproductive Health, including Family Planning and Sexual Health”. The demographic rationale for FP was abandoned. The new guidelines focussed on an integrated approach defined as “*a constellation of linked, coordinated or integrated services to meet all the reproductive health needs of women and men*”. Because of UNFPA’s experience in FP, a central focus was, however, maintained on FP. Reproductive health was framed in the context of reproductive rights. In funding matters, UNFPA’s support for reproductive health has increased, accounting for about 70% of programme allocations. The remaining 30% of its budget is devoted to advocacy and population and development activities. After 1994, UNFPA reviewed and assessed reproductive health in most of their country programmes. The majority of UNFPA country programmes are now in line with the ICPD Programme of Action on reproductive health.

WHO acknowledged its role in RH arising from the ICPD, especially for advocacy, technical support, research, development of technologies and mobilizing national and international alliances. The WHO RH programme aims at strengthening national capacity to promote and protect sexual and reproductive health and access to services as needed. The normative role of WHO involves development of international consensus on RH issues, tools and methods to deal with them and establishment of standards. WHO has adopted its institutional set up to accommodate these new roles.

UNICEF has increased programming and advocacy to improve reproductive health. In this regard, UNICEF has followed its policy of a multi-sectoral approach which includes education, access to RH information, safe motherhood, reducing violence, increased economic opportunities and promotion of women's rights to participate in the social and political life. UNICEF has strengthened its country programmes in the areas of women's reproductive and maternal health, given greater attention to STDs including HIV/AIDS, redefined safe motherhood as a human right, increased staff awareness of reproductive health and strengthened commitment to reduce maternal mortality. Training workshops have been organized in all regional offices to determine best strategies in this regard.

The World Bank has adopted six objectives for how the Bank will implement reproductive health in its health, nutrition and population work. The objectives include access and choice in FP; maternal care; prevention and control of STDs (including HIV); prevention and treatment of cervical cancer; promotion of adolescent health; and support for positive health practices. Recognizing that improved reproductive health would be critical to poverty reduction, the Bank projects on RH have been complemented by projects in education (in Bangladesh), training to increase female teachers (in Pakistan) and Women's development activities (in Gambia). The Bank assistance in India has shifted from a predominant focus on FP to a broader reproductive and child health. Similar assistance in Tunisia has improved coverage and quality of care through integration of FP with other RH services. A project has been developed for Gambia addressing broader reproductive health. Overall, RH accounts for nearly 40 per cent of the Bank's loan on health, nutrition and population.

Bilateral donors: USAID's Population, Health and Nutrition (PHN) strategies incorporates ICPD-POA principles. Since the ICPD, USAID has implemented an integrated approach to reproductive health while maintaining a strong focus on client-centered FP services. Four strategic PHN objectives are to reduce unwanted pregnancy, maternal mortality, infant and child mortality and transmission of HIV/AIDS. The PHN programme focus is on quality of care, access to FP and reproductive health with sustainability and integration as essential themes.

UK's population assistance programme closely follows the broad ICPD definition of reproductive health. Within the RH framework, the assistance emphasizes adolescent reproductive and sexual health and maternal mortality. UK's commitment to innovation in reproductive health is reflected in the Seedcorn Fund, a special fund earmarked for innovative, action-oriented RH programmes.

Sweden is one of few donors with a published policy on population and RH. In 1997, the Swedish agency for international development assistance, (SIDA) revised its action plan for Improving Sexual and Reproductive Health and published a strategy for sexual and reproductive health and rights prepared for the ICPD. SIDA describes strategic actions in a broad range of areas related to RH, SH and women's equality.

Between 1994 and 1996, the Netherlands' population assistance increased by 250%, of which, in 1996, 78% went for RH, FP and STDs, including HIV/AIDS. Recently Dutch policy has shifted in favour of health systems from service provision. Denmark and Norway also actively support implementation of the ICPD POA, especially RH services, with their population assistance channeled

mainly through UNFPA. With the recent decline in financial contribution, Japan is focusing more on technical support. Most other bilateral donors have also endorsed and supported RH concept in their assistance programme.

Donor coordination at country level was weak. To broaden the scope of country level coordination, the mandate of the inter-agency task force was expanded in 1996 to include follow-up on other global conferences. Following the ICPD, donor collaboration has improved and in some countries increased donor coordination is part of health sector reform but this is not the general trend in the majority of countries.

4. Designing Quality RH Services

The description above of the process involved in achieving policy change along with the recent date of some of the policies explains why some countries are more advanced in moving from policy adjustments to actual implementation of the RH approach while others are just setting out to undertake changes in service delivery. This contrast should be kept in mind for the following analysis. Nonetheless, with lead countries in all continents (Brazil, Mexico, Peru, Thailand, Bangladesh, Ghana, Tunisia), it is possible to identify prevalent strategies and key issues in implementing the RH approach at the national level. In addition, even where the national health care systems have not changed to implementing RH, NGOs are often already doing so.

In some countries, specific regions or provinces have been chosen as models for implementing reproductive health in the hope that this would provide accumulated experience for scaling up or because autonomous states are more advanced in the understanding and support for reproductive health. For example, in the Philipines, RH services are being implemented in three provinces and in the state of Ceara in Brazil, RH is being integrated into the primary health care system. The model with “test areas” has successfully been used in the Rajasthan, India, as evident from box 4.

Integrating and Broadening Services Delivery

Two key strategic aspects of moving towards a RH approach have been how to integrate existing services and how to broaden the constellation of available services. Managerial concerns include institutional set-up, training and supervision.

Box 4:**Rajasthan, India**

The State of Rajasthan, India, provides a notable example of design and implementation of a client-oriented and needs-based approach, developed in response to the target-free policy of India. The Vikalp programme, Vikalp meaning “alternative” in Sanskrit, is implemented by the Rajasthan Government in a state of 50 million people with the noteworthy result that contraceptive use of four different methods has increased with between 19% and 63% between 1995-96 and 1996-97. Rajasthan and three other states used to be poor-performing in raising contraceptive use. In the other states contraceptive use of all four methods have decreased in the period studied.

The four pillars of the Rajasthan approach are:

C Provision of client-based services. The initial study of the programme identified a considerable unmet need especially among those with low socio-economic indices and found that high inflation rates and increasing unemployment have made smaller families more desirable. The reason identified for potential clients not using existing services were poor accessibility, poor availability, inadequate follow-up and poor quality.

C Inclusion of non-medical issues. In a client-oriented approach, motivation, counselling and health education becomes essential components in order to enable clients to promote their health behaviour for instance with regard to RTIs/STDs and nutrition. This aspect is also important in order to reach adolescents and in order to promote the involvement of men.

C Integration of MCH with FP. In the existing system different aspects of MCH and FP services were offered at different service delivery points by different providers. The Vikalp framework introduces a rationalization of the existing structures.

C A focused approach. The three essential components of the focused approach are: 1) An essential package of FP/MCH services which can be built on towards a broader RH approach in the future; 2) An initial focus on the target group with unmet needs, and gradual expansion towards other groups; 3) Full-time managers at state and district levels; and 4) Organizational restructure to focus on the above issue with a clear-cut line of reference / supervision.

Other factors in the Rajasthan programme contribute to its success. Among the most important are: 1) A clear distinction between preventive and curative service delivery. Previously, curative service delivery took away from preventive service delivery. 2) A strong MIS system, in which the service provider is responsible for both collecting information and for following-up on identified needs. At the managerial level, the MIS system ensures that contraceptives are made available in a timely fashion, and that the workload of service providers is appropriate. 3) Community Involvement. A “Link person” is identified at the village level and NGOs, traditional practitioners and other stakeholders are involved as supply depot holders. 4) Quality of services involving for instance that clients are counselled and screened in order to ensure that they choose a suitable method of contraception and that follow-up is conducted to ensure the satisfaction with the method. (Kothari *et al*, 1997).

Integration: In many countries, the vertical organizational structure of health care systems constitutes the main institutional barrier to a more integrated approach. When service delivery activities are divided for instance between FP and health structures, possibly managed by different Ministries, countries have experienced parallel systems and wasted resources. This is indicated in the example given in box 4, where a significantly greater output is achieved by a more efficient use of existing resources through integrated services. Institutional integration does, however, seem to constitute a major hurdle even in countries which have made integration a priority issue: In Peru, four programmes for reproductive health components have now been assembled under the Directorate of Social Programs and in Mexico, the government has merged the FP and the MCH units into the General Directorate of Reproductive Health. Still, only coordination has been achieved, not

integration. (Hardee *et al.*, 1998, p. 12). Reasons include personal interest and power; that managers consider an integrated approach less efficient; and that service providers consider it extra work. In Morocco, model centres have been established partly to overcome resistance from service providers towards an integrated approach (see box 5). It is a good indication of the user-friendliness of integrated services that many privately run clinics offer integrated services.

This leads us to look at integration not at the institutional level but rather at the service delivery level. Here countries have made progress through initiatives -- often been initiated before 1994 -- in integrating MCH and FP services. Since the ICPD the focus has been to further integrate these services with STD/HIV/AIDS prevention, screening and treatment. Such integration may, however, only involve that services are offered at the same service delivery place while different providers continue to address individual aspects of reproductive health, for instance screening, counselling and method provision. This largely falls back on the training aspect of service providers which will be dealt with in more detail below. Examples also exist where services are offered at the same place and by the same personnel but on different days.

Box 5:

Morocco

RH programmes started over a decade ago but since the ICPD the Government has placed higher priority on RH, and gender issues as well as various new components have now been included in RH/IEC programmes. Interventions in RH are conducted through decentralized programmes at the provincial level designed to meet government policy. Key activities in implementing RH include:

C Multi-sectorial provincial teams. These local teams are directly involved in developing RH programmes, which allow for the considerations of local constraints and resources.

C Model centres for integrated RH/FP. The centres are developed with the aim of modifying the attitude and behaviour of the health care staff through training on the benefits of an integrated RH/FP model, and upgrading the patient management system to support an integrated delivery of care.

C Improved vertical and horizontal referral. Community-level service providers are being linked to higher level obstetrical facilities and links between maternity hospitals and peripheral structures and service providers are being strengthened to contribute to an integrated RH/Safe motherhood approach.

C Improvement of quality of care. Strategies to improve quality of care include emphasizing awareness and training in technical and communication skills in order to ensure increased receptivity to patients' needs; confidentiality; better follow-up; and improved exchanges among facilities.

Broadening the scope of services: This does not necessarily involve the institutional problems of integration as new services can be placed under the same roof as existing services. Also, a broader approach to service delivery can occur even within vertical structures which has been the case where service providers have been trained for instance in counselling skills, gender main streaming and male involvement. Broadening services involves many of the same considerations regarding training as integrating services.

Referral systems: Referral systems relate both to the integration of services and broadening of the scope of programmes. The establishment of horizontal referral systems has been identified as useful as a first step in integration where vertical structures still exist. Vertical referral systems are also

essential with regard to certain aspects of reproductive health, for instance with regard to maternal care, in which referral, including logistics, to emergency obstetric care is an essential intervention to lower maternal mortality.

Components of RH Programme Design

Whether countries in their overall programme design have adopted the approach of integrating services or broadening the scope of available services, or have focussed only on providing a few components of reproductive health, a development towards a more comprehensive RH approach can be distinguished in a majority of countries even if looking only briefly at the key components of reproductive health.

Family Planning: FP remains the central focus of most programmes. A reproductive health approach to FP has been the first step taken in the majority of countries where implementation has begun. This means that efforts now are concentrated on the meeting the needs of clients. This includes reconsidering the range of contraceptive methods that are made available; information and counselling services to enable contraceptive choice in the context of assessing the individual's sexuality, partner's relations, gender issues and the social context; and information and counselling on side effects and their management. NGOs such as IPPF family planning associations (FPAs) and women NGOs are leading in this domain. However, national programmes are also progressing in this area, although at a different pace.

STD prevention and management: There is a widespread agreement that RTI and STD prevention and treatment should be an integral component of RH programmes but at the time of the ICPD it was an unanswered question how to include STD management into existing services. Since then, programmes have tried to develop and test strategies and while the immediate success of initiatives have differed, such studies have generally confirmed the doability and desirability of integration. In 1995, in Africa, a conference with key stakeholders was held to establish approaches to integrating STD/HIV/AIDS services into FP programmes. It concluded that an enabling climate can be created throughout Africa for integrated RH services to become more available, accessible, affordable to meet the needs of target groups, including young people, more effectively. (Pathfinder, 1997, p.57-68). Some case studies have pointed to the training not being sufficient and effective in changing service provision to include IEC and counselling. For instance, four case studies conducted in East and Southern Africa underlined the need for providers to be sufficiently prepared with regard to training, available equipment and implementation aides, but also identified the providers' willingness to discuss sexuality and STDs with clients and their ability to correctly identify risk cases for screening as important factors for the success of integration. (Askew, Maggwa and Kangas, 1998).

Maternal health: With WHO and UNICEF estimating 600.000 maternal deaths yearly, maternal care is a RH component which a number of countries have chosen to place special emphasis on during the past few years. The present emphasis in maternal care is to have child births attended by skilled personnel; to offer focused pre-natal care; and to establish linkages including logistics to ensure referral in emergency cases. In Sri Lanka, where the maternal mortality rate is among the lowest in

the developing world at 70 deaths per 100,000 live births, focussed investments in general health and maternal health have contributed to an institutional delivery rate of over 90% and over 96% of deliveries are attended by a trained attendant. It is also part of the story that women enjoy a relatively high status in Sri Lanka and that the general health infrastructure as well as a good road network facilitate access to health services. (Starrs *et al.* 1998). Also Iran, Indonesia, Mexico and Ghana have improved maternal mortality figures by increasing access to maternal health services. The challenge to maternal health services remains on how to integrate these services into reproductive health.

Prevention of unsafe abortion: Since Cairo the main developments have been that a number of countries have put greater emphasis on the prevention of abortion independent on their abortion laws and that some countries where abortion is legal even for limited reasons have chosen to offer more extensive abortion services despite the limitations in the laws. For instance in Romania, where abortion is legal and where there is a high reliance on abortion, the prevention of abortion and promotion of FP are now priority areas. (Ghetau, 1997) In Bangladesh and Brazil, where legal abortion is restricted it has, nevertheless, been made a priority to make safe services available for legal abortions in order to decrease abortion related maternal mortality. In countries where abortion is against the law, the challenge continues to be to provide post abortion services including referral services for FP. Patients with abortion complications are stigmatized and strategies to deal with this important issue are generally not being implemented.

Training

A number of countries have involved training institutions very early in the process of implementing the RH approach to institutionalize RH training. Also training curricula for both initial and in-service training has been adapted to the RH client-centered, needs-based approach even where a full-fledged integration has not taken place. In Romania, the training of staff in FP to integrate this in primary health care has been a priority as a means of overcoming lack of information and disinformation among service providers (personal communication with Katy Schroff, Romania). In Bangladesh -- where a main constraint has been identified as inadequate competence among existing health care providers -- a training programme has achieved a broader scope of services which are now delivered by the same service providers (Gill, 1997).

Gender training: As stated above training is also key in integrating cross-cutting issues such as counselling, gender main streaming and male involvement. The enhancement of gender skills of staff has been identified as a first and crucial step in main-streaming gender. (Mehrotra and Singh, 1997). Progress in this area includes the development of techniques for gender in reproductive health training and expanding the availability of such training. For instance a Core Curriculum in gender and reproductive health has been developed by WHO, the Women's Health Project, South Africa, and Harvard School of Public Health, USA. Training and further curriculum development for the purpose of establishing five training centers of excellence (in Kenya, Argentina, Egypt, Australia and China) continues. In smaller scale programmes, it has been found that a combination of theoretical and practical training / exposure is useful for staff to understand how to implement gender sensitive services. (Mehrotra and Singh, 1997). IPPF/Western Hemisphere has recently developed a tool to

assess quality of care from a gender prospective. The study was conducted in the RH clinics of the Family Planning Associations of Colombia, Dominican Republic and Peru. The study provided very useful information about how to develop a gender sensitive training curricula.

Supervision: Continued supervision, especially as a follow-up to training activities, have been identified as a key to success. Practitioners may hesitate to change their practices after training, especially if they are uncertain about any aspect of the new services they are to offer. Supervision at the service delivery point has been an efficient tool to overcome this initial hesitance and has also served to improve service delivery as practitioners has taken the opportunity to discuss problematic cases and other questions (Gill, 1997).

Constraints: A problem identified in training in the African context -- but the problem may apply elsewhere -- is that, historically, vertical training curricula have been developed for what now constitute the components of reproductive health. In other words, providers have been trained to carry out certain programme functions rather than to acquire certain skills which would be applicable within an array of programmes. For example, the focus of training has been on vaccination, which is in fact an injection skill, or on health screening, which involves the same skills as required for STD screening. The problem of this traditional approach is that providers have been trained only in a narrow range of skills and they have not been made aware of the full potential of the skills. It follows that skills-oriented and broader training is key to achieving the RH approach. This goes both for initial and in-service training. In many places in-service training continues to be provided component by component. In a typical situation, training on family planning, post-abortion care, sexually transmitted diseases, HIV/AIDS and safe motherhood are each given as separate training sessions. This situation may well reflect the segregation of budgets and lack of coordination within programmes that have been identified as important constraints to integration.

Although in Latin America and the Caribbean, more integrated training curriculums have been developed (Peru, Mexico, Colombia and Jamaica), issues related to sexuality, which are critical to sexual and reproductive health, are often absent or 'diluted' in the reproductive health part of the whole concept. Reproductive rights, the gender perspectives and the resulting effect on client-provider interaction are also missing. Perhaps the further effort of the above mentioned on-going activities on the development of methodologies for gender training will help improve these issues.

An obstacle to developing and implementing training programmes lies in the shortage of appropriately trained staff. This is the case at the national level where human resources are in need to redesign training curricula and carry out training of trainers, but decentralization of programme activities has also highlighted the limited human resources available at the local level. (Personal communication with, Helene Zoughlami, Tunisia), (Economic and Social Commission for Asia and the Pacific (a), 1998, a, p. 9).

Quality of Care - Implementing Reproductive Rights

Quality of care framework: The ICPD POA reflects the Bruce framework definition of quality of care. The six components of this framework are: 1) client choice of methods; 2) information for and counselling of users; 3) technical competence of providers; 4) interpersonal relations between providers and clients; 5) mechanisms for follow-up and continuity of care; and 6) an appropriate constellation of services. (Bruce, 1989). In discussions of quality of care, point 4 has been defined as “[t]he interpersonal process is the vehicle by which technical care is implemented and on which its success depends ... Privacy, confidentiality, informed choice, concern, empathy, honesty, tact, sensitivity -- all these and more are virtues that the interpersonal relationship is expected to have” (Donabedian, 1988, quoted in Kahn, Boon-Ann and Mehta, 1998, p. 2).

Quality of care has also often been equated with services provided by technically competent providers in well-equipped facilities. (Kahn, Boon-Ann and Mehta, 1998, p. 2). Compared to this definition the Bruce framework also emphasizes the communication and interpersonal relations between client and providers. It follows that quality of services forms part of quality of care.

International organizations are working in the development of quality-improvement tools. For example the Association for Voluntary Safe Contraception (AVSC) developed COPE (Client-oriented, provider-efficient services) which is a tool that facilitates self-assessment and problem solving by all clinic staff. COPE is now used worldwide in more than 30 countries. COPE focuses on the process of service delivery, reflecting the reality that the way services are delivered is often a determinant of their use.

Implementation: Many countries have adopted the quality of care language and have focussed on providing the determining factors for quality of care. They include appropriate service facilities; appropriate technology; availability of a variety of contraceptive methods, and training of personnel in counselling and communication skills. Great advances have been made on these areas. As mentioned above, of the clinics studied in five Sub-Saharan African countries, 81% had at least four different contraceptive methods in stock. (Haberland, Miller, Bruce, Fassihian, forthcoming). In 1997, 90 countries reported to UNFPA to have undertaken IEC and training on counselling for HIV prevention primarily for service providers. (UNFPA AIDS Update 1997).

Despite the encouraging emphasis on improving the determinants for quality of care it has been found that this does not automatically lead to clients in fact receiving quality of care. As mentioned above a secondary analysis of five Situation Analysis studies found that at the clinics with four or more different contraceptive methods in stock only 34% of new spacing clients were informed about at least three methods. Moreover, only 24% received further information and counselling on how properly to use the selected method and on potential side effects of the method. Significant differences existed between countries with 50% of clients in Kenya receiving full information and only 10% and 11% in Burkina Faso and Senegal respectively. It is also worth repeating that the analysis finds that in only 5-22% of client-provider interactions in clinics which have informational materials available are these materials used and that between 23% and 88% of providers with water readily available did not wash their hands before a pelvic exam. (Haberland, Miller, Bruce, Fassihian, forthcoming).

Box 6:**Brazil**

In Brazil, Paisme is a movement organized to promote and provide decentralized women's health services. Created in 1984, the movement is an early example of co-operation between the government, the women's health movement and the academia. Paisme functions in the context of the public health approach and is based on the recognition that fertility regulation is a right of citizenship. The aims of Paisme indicate an integrated and comprehensive approach to women's health and include training of health providers and midwives; MCH services; quality of care in service provision; FP; detection and management of breast, cervical, and uterine cancer; prevention of STDs; and diagnosing and treating infertility.

This indicates that PAISME implemented the Cairo POA already before the ICPD, but in fact the case of Brazil offers an interesting example of what has happened since Cairo. While taking a broad approach in its objectives in the first ten years of implementation, Paisme has in reality put very little focus on certain RH aspects including STDs and HIV/AIDS; abortion within the legal provisions and post-abortion care (in a country where more than 30% of maternal mortality is related to abortion complications); and the RH needs of other groups, for instance adolescents. This has led to a dissociation among Paisme and other RH programmes relevant to an integrated approach, visible for instance in separate training facilities for different programmes.

The ICPD triggered a new commitment to RH in Brazil both at government and local levels and among some donors. At the national level a National Commission on Population has been created comprised by representatives of the ministries of Planning and Budget, Health, Labor, Environment, Social Security, Education and Justice, and Foreign Relations as well as eight representatives of the civil society. The Commission is responsible for formulating policies and implement actions on population and development. It is also charged with following up on the recommendations of the ICPD. This has been identified as a chance to rethink Paisme to work through further implementation of the ICPD. (Jaqueline Pintanguy in Ford Foundation, 1997).

At the local level, positive experiences since the ICPD have come about thanks to the sustained efforts of RH advocates, the involvement of committed women and NGOs, and in some cases thanks to the effectiveness and consistency of service providers themselves. In other cases local programmes have gained impulse and quality under the influence of international funding the priorities of which have changed in the post-Cairo period.

In 1995, protocols to deliver reproductive health in a context of reproductive rights were developed. This included control of cervical cancer, family planning, prevention of RTI, STD and HIV/AIDS, and prevention of maternal mortality. An area which exemplifies that an even broader RH approach has been achieved in the post-ICPD period is the issue of the provision of abortion services in the public health system under legal circumstances (which are to save the life of a mother or in the case of rape. Previously, regardless of it being legal, it was generally not available. NGOs, women's groups, professional organizations and the MOH advocated that safe services should be available for legal abortions and an increasing number of service delivery points have offered services since 1994. The discussion on preventing unwanted pregnancy has resulted in emergency contraception now being provided through Paisme.

In a study on integrating STD screening and management into FP services in Jakarta, Indonesia, where service providers were trained on RTI/STD diagnosis and case management, only with one client were the health effects of RTI/STDs reviewed and a connection to birth control made. The condom was only mentioned to two of 312 participating clients and the study found that client

counseling was generally neglected. New or disinfected gloves were used for 79% of pelvic exams but providers only washed hands before and after the exam in 20% of the observed examinations. (The Population Council, 1997).

In addition to these studies it has also been found that in many countries in Asia and especially in countries with targets, service providers persist in failing to provide comprehensive information, especially information on possible side effects. The rationale for this lack of information is the providers' belief that cautionary data would discourage women from using a contraceptive method. (Khan, Boon-Ann and Mehta, 1998).

It should be noted as a precaution that these studies and findings are only indicative, but they do raise the question of how to ensure that clients receive quality services. This question pertains to the question of indicators and management information systems for reproductive health which will be discussed in more detail below.

The indicated problems not only hampers the quality of care as an end in itself but also as a means to implement reproductive rights. Counselling and interpersonal communication between service provider and client are key aspects of ensuring informed and voluntary reproductive choices.

Management Information Systems

Management Information Systems is also a key issue in the design of quality reproductive health services. Iran as well as Rajasthan, India (box 4) offer examples of efficient MIS designs: They are simple and clear to use at the service delivery level; only the most essential data is collected; appropriate technology is applied; and findings are of immediate use at the service delivery level, but also at higher levels of the health care system. These aspects are of general importance to MIS in all countries to ensure the sustainability and usefulness of MIS.

Indicators: However, the essential question regarding the quality of MIS is the question of indicators. When identifying indicators, it should be considered whether they measure process or output; and whether they are qualitative or quantitative. The above discussion of quality of care illustrates why a focus on process is essential not only for quality of care, and thus for the RH approach, but also for explaining the output. A number of international agencies including UNFPA, WHO, World Bank and the Evaluation Group supported by USAID have developed groups of global indicators and overall a lot of work is ongoing regarding the development of indicators. However, these indicators have not yet been tested in the field.

In gender indicators it should be noted that merely collecting data for women and men separately does not imply that a gender perspective is taken; it is only a sex perspective. A gender perspective must look at the development of gender roles. However, an obstacle in assessing and monitoring the gender situation has been a lack of data and indicators. At this point no methodology is widely used but since the ICPD, initiatives have been taken to develop such methodologies. For instance, four NGOs in Latin-America / Caribbean are presently developing a research protocol for assessing

reproductive health services from a gender perspective. (Cardich *et al.*, 1998)

Participation: At the national level it has been found to be an advantage if all stakeholders, i.e. all parties that can make use of the information (e.g. community representatives, service provider, programme managers, researchers), come together in designing the MIS. They need to identify what information they need, how should it be analyzed and how should the results be presented to different users. For example, the Latin American and Caribbean Health Network -- in collaboration with some Governments in the region -- has identified six thematic issues to monitor in each country they work in including sexuality and the reproductive health of adolescents, quality of care, management of unsafe abortion, male involvement and the participation of women in decision-making. Qualitative and quantitative indicators have been elaborated for each of these issues that will be used to assess the reproductive health situation in each country.

Addressing Gender-Based Violence

Our review has found that, generally, violence against women is not widely addressed in RH needs assessments and programme design for RH service delivery. However, NGOs are very active in providing legal and clinical services for women suffering from violence. A large proportion respondents to the UNFPA NGO survey are working in this area. Flora Tristan, an NGO with almost 20 years of experience in the field in Peru, addresses this neglected issue by training police officers as well as providing legal support to victims. In Brazil, Centro Da Mulher 8 Marzo is developing a data base on violence against women based on articles published in newspapers. They also provide training for health professionals on how to diagnose, treat and refer women who have been victims of violence.

Legal framework: Laws may not protect women against domestic violence. In the above mentioned study of seven Anglophone African countries it was found that “Domestic violence is a serious problem in all of the countries, exacerbated by customary norms that permit husbands to assault their wives, at least to a certain degree” (The Center for Reproductive Law and Policy, 1997, p. 170). Of the seven countries only South Africa recognize marital rape as a crime. Examples of national activities that address these issues are few but include Morocco, where a survey is being undertaken under the Ministry of Justice on violence against women. The purpose of this survey is to form the basis for advocacy activities as well as for seminars to raise awareness on the topic.

Female genital mutilation: The ICPD also put focus on the specific form of sexual violence referred to as FGM. In countries in Sub-Saharan Africa where the practice of FGM exists, many interventions are in the pipeline in the public sector aimed at addressing FGM. The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children has established national committees in 23 countries. They have sponsored workshops, seminars, training for nurses and traditional birth attendants, information campaigns and research on various aspects of FGM including its effect on women’s health. In Uganda, the government has already initiated a community-based education and awareness-raising intervention for the elimination of the practice among the Sebei of the Kapchorwa District. In the first year of its implementation (1996) the District registered more

than 30% reduction among girls of the target age for FGM. NGOs are involved in making service providers aware of disinformation, such as ostensibly positive health consequences of the procedure; in making parents aware of the actual health consequences; and in promoting alternative practices to sustain the cultural significance of the practice while eliminating the practice itself. Community-based interventions are generally the most successful in addressing culturally defined practices.

5. Accessibility

As is evident from the above, important steps have been taken in many countries around the world towards designing and setting up the institutional framework for quality RH services. Such steps alone do not, however, ensure universal access to services. This may be caused by such factors as lack of service delivery points; lack of knowledge of their existence; lacking recognition for need of services (which may be related to low decision making capacity, social context and poverty), and limited access for certain groups in need, for instance adolescents. Accessibility issues involves other sectors than the health sector and other providers than the government including NGOs and the private sector.

IEC Needs and Activities

A DHS comparative study has found that in five of eleven Sub-Saharan countries less than half of married women had spontaneous knowledge of any contraceptive method, modern or traditional. A high level of awareness (over 70%) existed in five of five countries studied in Latin America and in four of six countries studied in Asia/Near East/North America. (Curtis and Neitzel, 1996). The figures for Sub-Saharan Africa underline the crucial need for information.

According to the findings of the UNFPA NGO survey, NGOs are involved in campaigns promoting the use of RH services among women, men and adolescents. For example, in India, Voices has developed a RH information kit designed for health workers to reach out to and empower women and men of the community to make decisions regarding their reproductive needs. (UN, Economic and Social Commission, 1997, p. 4 and 8).

It has also found that, increasingly, IEC activities are being conducted in "every place". Consequently, issues of responsible sexual and reproductive behaviour, prevention of HIV infection and of abortion are now talked about in public places and gatherings of all kinds including churches, political meetings, community groups, market places as well as in the media. The same is true for advocacy for women empowerment. Such public debate is important to increase the use of existing services and to involve the community in creating public consensus and acceptance of the need for broader services or on the need for offering services to new target groups, such as adolescents.

Service Provision

The private sector, comprised of NGOs, private practitioners, clinics, hospitals and commercial outlets such as pharmacies and shops, provides substantial coverage in many countries and has

considerable potential for increase accessibility and making greater contribution with appropriate government support.

Community-based programmes: Some strategies implemented to increase access to services (mainly family planning) involve the diversification of service providers. For example, a recent study found that community-based distribution programmes (CBD) are effective sources of information in countries like Kenya, and many provide a significant proportion of contraceptive supplies to users, particularly women using pills. Village-based family planning workers in Pakistan have been successful in improving rural women's access to a range of family planning services. In Guatemala, contraceptive use increased by training bilingual teachers to conduct reproductive health classes.

NGOs: In many countries, NGOs play a major role in service delivery, often especially in remote areas or for specific target groups, such as adolescents and refugees. This role has expanded since the ICPD. In many instances NGOs have redefined their own principles for service provision. The UNFPA NGO survey found that although there are still some NGOs working on traditional population-based and stand-alone FP programmes, many of the NGO respondents reported that the ICPD POA had greatly influenced them to integrate FP and other RH services. Almost a third of the NGO respondents from developing countries provide all of the following services: family planning, maternal health; and prevention of RTIs/STDs, including HIV/AIDS. In addition, a broad analysis of the work conducted by service providing NGOs indicates that quality of care and adolescents are the areas that attract particular attention. (UN, Economic and Social Commission, 1997, p. 9).

The role of NGOs in service provision seems particularly important when official law and policy in support of reproductive health does not yet exist. For instance, in countries in Sub-Saharan Africa where political leaders have supported the RH concept, but where enforcing mechanisms have not been established, NGOs -- as opposed to the public sector on behalf of which the political leaders speak -- offer a broader scope of RH services. The same is true in potentially controversial service provision such as services for adolescents or post-abortion care. Here, too, have NGOs showed the way forward with innovative, successful projects.

NGOs were among the first to realize the needs of adolescents and the importance of meeting these needs. NGOs have also been the first to listen to adolescents and have therefore been able to come up with new approaches. Examples include "enter-educate" approaches where entertainment and education are mixed in the sense that information is provided through for example songs and soap operas. The need to establish linkages between information and services have been met for instance by providing telephone hotlines, promoted through the media. Linkages to other activities, such as youth clubs and sports, have also been established by NGOs to provide information and services in a place and manner that adolescents are comfortable with. Also youth organizations such as for instance Boy Scouts and Girl Guides have become involved in RH issues. Adolescents sexual and reproductive health is one of the main areas in which NGOs report to be active. While these activities are essential in promoting a field which governments are only coming around to incorporate in national policy and programmes, the next step will have to be to upscale programmes in order for the many well-designed, innovative project to reach significant proportions of adolescents.

The commercial sector also offers lessons to learn from. As mention above, it often offers integrated services which indicates the true preference of clients. The commercial sector's examples also offers the lessons that when clients pay for services, the feel entitled to good quality and they gain ownership over the client-provider encounter. This indicates that some sort of payment - even if only a token payment - for public services could play a role in increasing the demand for quality services.

Social marketing projects have increased over the past few years. Their appeal seem to lie in the fact that they offer easily accessible services in communities for a price that clients are willing to pay. This again puts focus on the finding that if only services are of high quality and appeal to clients, people are willing to pay for RH services as they have also done traditionally.

6. Creating Necessary Conditions for Implementing Sexual and Reproductive Health and Rights

Providing access to information and services is just one side of the coin when it comes to help people attain sexual and reproductive health and enjoy reproductive rights. The other side is the daily life of women and men. It is here that women and men can take action to protect or jeopardize their own health or the health of others and it is as part of everyday life that reproductive decisions are made. The issues involved in the health consequences of everyday life are manifold, but for the sexual and reproductive health of women and men the main issues are gender equality and women's empowerment.

Equality: A December 1996 DHS study which compared data from 25 countries (12 in Sub-Saharan Africa, 2 in North Africa, 5 Asia/Near East and 6 in Latin America/Caribbean) found that equality in female / male access to education exists only in seven of the countries, most of them Latin American / Caribbean. Only few of the others showed a decreasing gap between male / female access in the comparison of older and younger generations. In most countries wives are less educated than their husbands. Women are more likely to be employed for cash earnings if their husbands work in a modern occupation. (Kishor and Neitzel, 1996).

In Sub-Saharan Africa only half of all women discuss the desired number of children with her husband. In Asia, North Africa and Latin America/Caribbean (except Egypt and Pakistan) more than 60% of couples discuss family size. (Kishor and Neitzel, 1996). The low Sub-Saharan level is consistent with the low level of awareness of contraceptive methods among women in Sub-Saharan Africa referred to above.

These figures show that women remain less educated than men and that it is men's exposure to modern values that is decisive for women's opportunities to gain status outside the home. This indicates a low level of autonomy for women. However, the low level of discussion on family size, especially in Sub-Saharan Africa, can not necessarily be translated into a conclusion that men make the decision. Another DHS comparative study, which included 17 countries in Africa and Asia, found that reproductive preferences and men's and women's attitudes toward family planning are similar in most countries in East Africa, North Africa, and Asia, and only substantially different in countries

of West Africa (except Ghana) where women's approval of FP largely exceeds that of men, and where men's desired family size exceed that of women by 2-4 children. (Ezeh, Seroussi and Riggers, 1996).

Reproductive rights: Although reproductive rights are guaranteed by modern-day constitutions and other civil codes in a large number of countries, many people, especially women, are unaware of these provisions. Service providers, responsible for implementing certain aspects of reproductive rights, notably informed choice, may not be aware of the provision for reproductive rights or of their responsibility in this matter. However, some countries have introduced ethical standards for service provision. Still, again it should be emphasized that implementing reproductive rights goes beyond the service delivery point and pertains to empowering people -- and especially women -- to claim rights and responsibilities and to enabling people to recognize and respect the rights of others.

Empowerment of women: Apart from recognizing equality and the equal rights of women and men in law and policy, national activities to increase the empowerment of women include initiatives to increase girls education, income-generating activities for women, and promotion of women's participation in decision-making at local and national levels. Activities focused especially on disseminating information on rights to have women, men and adolescents understand their own rights and the need to respect the rights of others are also being undertaken.

Male involvement: With regard to recognizing and respecting the rights of others the buzz word since the ICPD has been "male involvement". However, male involvement has been interpreted in different ways: First, as empowering men to adopt responsible sexual and reproductive behaviour -- for example, through male-friendly services -- and second, as men's supportive approval of his female partner's reproductive health freedom, right and access to services. The first interpretation involves increasing men's ability to protect their own reproductive rights and the second involves the recognition and respect for the rights of others - i.e. women. Obviously both interpretations are valid and in accordance with the ICPD, but it seems to be a bit unfortunate that there are not specific terms to cover the two different interpretations. This is particularly relevant where women suffer especially low status and where the crucial need is to have men recognize and respect women's rights and change behaviour accordingly.

Most activities in male involvement appears to have been in the first category, for instance through the establishment of men-only clinics but the UNFPA NGO survey found that even through NGOs are just beginning to work with males, the development of this work does include working with men on sexuality and gender roles. (UN, Economic and Social Commission, 1997, p. 12). When such work is only starting up it may be because the concept of "gender" as different from "women" has needed some time first to be understood, and then to be acted on. In sub-Saharan Africa it has, for instance, been found that programme activities are still primarily women-centered although in some countries such as Burundi, women development centers have become gender development centers and have effectively started to include men in their membership and activities.

Protection of rights: NGOs are also involved more directly in protecting reproductive rights and have

found the ICPD POA useful in this endeavor. One example is of the Philippine Center for Investigative Journalism, which used the POA as a platform to speak out on women's rights, with the endorsement of the government, when a governor in a province south of Manila ordered a ban on modern contraceptives. (UN, Economic and Social Council, 1998, p. 7). In Sub-Saharan Africa, in countries where women are not protected under civil law due to customary or religious custom and law women's advocacy groups including parliamentarians have since the ICPD been advocating for genderisation and harmonization of these laws. It seems that the cultural sensitivity that once appeared to constitute insurmountable obstacles to such activities has not actively prevented recent advocacy on the freedom of choice and reproductive rights including rights of women within marriage.

7. Conclusion

Almost four years after Cairo, a rapid assessment of reproductive health implementation around the world shows that many countries are in the process of developing or have by this time developed policies that address sexual and reproductive health and rights issues. Many countries have embarked on building up consensus regarding the reproductive health concept and revisiting relevant policies. Although the full understanding of the concept of reproductive health implies a longer process than the development of policies itself, this is a first positive step in the long road towards the provision of comprehensive reproductive health services and ensure women decide freely on the number of children to have in a healthful manner.

When national delegations returned to their respective countries after the Conference, there was a general understanding that the new agenda adopted in Cairo on sexual and reproductive health had to be implemented incrementally. Because it was clear that capacity to deliver comprehensive reproductive health was inadequate, most countries needed to define priority areas for implementation. This needs assessment process included not only the decision to select priority reproductive health components but also to allocate or re-allocate resources. For those countries that seriously embarked in adopting the reproductive health and rights approach, the complex process involved in deciding these two critical issues -- what and how -- characterize the initial steps taken during the almost four years of work already accomplished in implementing the POA.

There are critical examples of change in policies but less have been accomplished in implementing comprehensive, integrated reproductive health services. However, four years is probably a short period of time to see substantial changes. It is nevertheless clear by now that pieces of reproductive health policies and services related to many of the elements of reproductive health are available in many countries. In particular, countries that involved stakeholders in the decision making process and invested time and resources in the process itself show signs towards advancing the implementation of the Cairo agenda. Where there was an organized demand for services, results are also encouraging.

Separate budget allocations, administrative structures and personnel prevents inter-sectoral collaboration and coordination among ministries in numerous countries. As a result, reproductive health services are fragmented and not integrated nor linked. The challenge of Cairo continues to be

the integration and collaboration of different institutional structures that have segregated budgets so that each ministry can play its part. The family planning structure is being used in many cases to provide additional reproductive health services. Now the challenge is how to place family planning and reproductive health in the context of primary health care and in the overall picture of health sector reform. Donors have a key role to play in ensuring that RH is included in this reform.

The consensus reached in Cairo includes quality of care as one of the most critical reproductive health issues. Because many of the ideas regarding quality of care may not be achieved immediately, the priority should be the creation of minimum standards. Progress achieved towards quality of care includes a notable expansion of contraceptive choice in many countries but unfortunately this does not necessarily mean that clients receive quality of care: However critical, improvements in logistics are not enough. Women need to be informed about the availability of contraceptive mix and choices after her sexual and social relations have been assessed. Many studies reveal that such fundamental improvements can occur without investing many resources but it takes that programmes make quality of care a priority issue.

Creating the necessary conditions to achieve the reproductive health paradigm implies that a minimum set of conditions should be ensured. The social context, in which the sexual life of people takes place, partner relations including gender issues, and the empowerment of women are critical if not imperative for reproductive health to succeed. Basic human rights should be guaranteed. Serious efforts should be made to ensure that FGM and other harmful practices are eliminated. But in order to be central to all spheres of development, the agenda on women's empowerment should be placed in the context of population policies. Young people also need to be reached for the purpose of the empowerment of women. Because behaviors develop very early in life, women's empowerment is also about young people.

Although ideas are changing favorably in support of reproductive health in almost all regions in the world, the challenge is now how to put these ideas into action in a context of diminishing foreign aid and limited national budgets. Creativity, innovation and an incremental approach is probably part of the work that remains for the future.

Bibliography:

Askew, Ian; Maggwa, Ndugga; Kangas, Lenni:

“Integrating STI and HIV/AIDS Services Into MCH/FP Programs in East and Southern Africa”

1998, The Population Council and USAID, Paper presented at: 1998 Annual meeting of the Population Association of America, Chicago, Illinois.

Bruce, Judith:

“Fundamental Elements of Quality of Care: A Simple Framework”

1989, Population Council Working Paper No. 19, and Studies in Family Planning, 21(2):61-91.

Budlander, Debbie (ed.):

“The Second Women’s Budget”

1997, Idasa, Capetown.

Cardich, Rosario; Helzner, Judith; Marques, Magaly; Schutt-Aine, Jessi; Ward, Victoria; Williams, Tim:

“Estudio de Calided Desde la Perspectiva de Genero. DRAFT”

1998, IPPF/RHO; Profamilia, Colombia; Profamilia, Republica Dominicana; Inppares, Peru, Unpublished.

The Center for Reproductive Law and Policy and International Federation of Women Lawyers (Kenya Chapter):

“Women of the World: Laws and Policies Affecting Their Reproductive Lives. Anglophone Africa”

1997, The Center for Reproductive Law and Policy, New York.

Curtis, Sian L.; Neitzel, Katherine:

“Contraceptive Knowledge, Use, and Sources”

1996, Demographic and Health Surveys, Comparative Studies No. 19, Macro International Inc., Maryland.

Donabedian, A.:

“The Quality of Care: How Can it be Assessed?”

1988, Journal of American Medical Association, 160-(12):1743-1748.

Economic and Social Commission for Asia and the Pacific (a):

“Report and Key Future Actions Required to Achieve the Goals of the ICPD POA and Bali Declaration”

1998, ESCAP, ESCAP(LIV)/INF.4, Bangkok.

Economic and Social Commission for Asia and the Pacific (b):

“Implementation of the Programme of Action of the International Conference on Population and Development and the Bali Declaration: Constraints and Challenges (Analysis of Country Questionnaires)”

1998, ESCAP, POP/ICPD/10, Bangkok.

Ezeh, Alex C.; Seroussi, Michka; Raggars, Hendrik:

“Men’s Fertility, Contraceptive Use, and Reproductive Preferences”

1996, Demographic and Health Surveys, Comparative Studies No. 18, Macro International Inc., Maryland.

Family Care International:

“Implementation of ICPD Commitments on Women’s Reproductive & Sexual Health”

1998, Family Care International, New York.

Ford Foundation:

“Report from the Meeting on ‘Accountability Mechanisms: Marking progress in the Implementation of ICPD’”

1997, Ford Foundation, The Working Group on Reproductive Health and Family Planning, New York.

Ghetau, Vasile:

“Maternal Mortality and Abortion in Romania, 1989 - 1966”

1997, UNFPA, Bucharest.

Gill, Zafar U.:

“ICPD 1994, RH Agenda: Experience of Turning Dream into Reality in Bangladesh”

1997, (unpublished).

Government of Bangladesh:

“National Reproductive Health Strategy”

1997, Ministry of Health and Family Welfare, Government of Peoples’ Republic of Bangladesh, Bangladesh.

Haberland, Miller, Bruce, Fassihian:

“Unused Quality and Missed Opportunities”

Forthcoming, The Population Council, New York.

Hardee, Karen; Agarwal, Kokila; Luke, Nancy; Wilson, Ellen; Pendzich, Margaret; Cross, Harry:

“Post-Cairo Reproductive Health Policies: A Comparative Study of Eight Countries”

1998, March 27, The Futures Group International, Durham, North Carolina, in collaboration with Research Triangle Institute and The Centre for Development and Population Activities.

- Jones, Gavin W.:
“The Bali Declaration and the Programme of Action of the International Conference on Population and Development in the Context of the Population Dynamics of the Asian and Pacific Region”
 1998, Economic and Social Commission for Asia and the Pacific and UNFPA, Bangkok.
- Khan, Atiqur Rahman; Boon-Ann, Tan; Mehta, Suman:
“Quality of Care and Target-Free Approach for Family Planning Programmes”
 1998, Economic and Social Commission for Asia and the Pacific and UNFPA, Bangkok.
- Kishor, Sunita; Neitzel, Katherine:
“The Status of Women: Indicators for Twenty-Five Countries”
 1996, Demographic and Health Surveys, Comparative Studies No. 21, Macro International Inc., Maryland.
- Kisobi, Wilson; Farmer, Francesta; Sturgis, Richard:
“An African response to The Challenge of Integrating STD/HIV-AIDS Services into Family Planning Programs”
 1997, Patherfinder International, USA
- Mehrotra, Firoza; Singh, Ena:
“Assessment of Gender Mainstreaming in UNFPA Programmes and Projects: The India Country programme”, 1997
 1997.
- The Population Council:
“Final Report of Activities for ‘Improved Reproductive Health and STD Services for Women presenting to Family Planning Services in North Jakarta’”
 1997, The Population Council, Asia & Near East Operations Research and Technical Assistance Project, Jakarta.
- Rahman, Anika; Katzive, Laura; Henshaw, Stanley K.:
“A Global Review of Laws on Induced Abortion, 1985-1997”
 1998, Alan Guttmacher Institute: “International Family Planning Perspectives”, Vol. 24(2), June 1998.
- Singh, J.S.:
“A target-free Approach in Family Planning”
 1997, e-mail communication KZPG Overpopulation Network.

Singha, Anil Chandra:

“Reproductive Health Situation in Bangladesh”

1997, Presentation at the UNFPA “Operationalizing Reproductive Health Programmes” regional forum, 22-26 September 1997, New Delhi.

Starrs, Ann in collaboration with the Inter-Agency Group for Safe Motherhood:

“Report on the Safe Motherhood Technical Consultation, 18-23 October 1997, Colombo, Sri Lanka”

1997, draft report, unpublished.

Stevens, Marion:

“Health”

1997, Chapter 9 of Burlander (ed.), 1997.

Thailand:

“Thailand Country Report”

1998, for the Economic and Social Commission for Asia and the Pacific (ESCAP) and the UNFPA: “High level Meeting to Review the Implementation of ICPD POA and Bali Declaration on Population and Sustainable Development and Make Recommendations for Further Action”, 24-27 March 1998, Bangkok.

UN, Economic and Social Council:

“Report on the Activities Conducted by Non-Governmental Organizations and Intergovernmental Organizations in Sexual and Reproductive Health and Rights: Three Years after Cairo”

1997, Report of the Secretary-General to the Commission on Population and Development, 31st session, New York.

UNFPA:

“Meeting the Goals of the ICPD: consequences of Resource Shortfalls up to the Year 2000”

1997, UNFPA, DP/FPA/1997/2, New York.

UNFPA:

“AIDS Update 1997”

1998, UNFPA, New York.

UNFPA:

“Reorientation of National Family Planning Programmes Toward a Broader Reproductive Health, including Family Planning and Sexual Health, Approach in East and South-East Asia”

1998, UNFPA Country Support Team for East and South-East Asia, (Occasional Paper Series no. 5), Bangkok.

Visaria, Leela; Jejeebhoy, Shireen; and Merrick, Tom:

“From Family Planning to Reproductive Health: Challenges Facing India”

1996, paper presented at Session F.07 XXIII General Population Conference of the IUSSP, Beijing.

Warakamin, Suwanna:

“Reproductive Health in Thailand”

1998, Department of Health, Ministry of Public Health, Thailand.

Zambia:

“Family Planning in Reproductive Health. Policy Framework. Strategies. Guidelines”

1997, Ministry of Health and Central Board of Health, Zambia.

Personal Communication with:

Vincent Fauveau, UNFPA, Morocco

Helene Zoughlami, UNFPA, Tunisia

Katy Schoff, WHO, Romania

Sidiqui Coulibaly, UNFPA, Senegal