

## **The International Conference on Population and Development, Cairo, 1994. Is its *Plan of Action* important, desirable and feasible?**



### **The nature of the forum**

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The *Review's* editors identified ICPD, Cairo as being one of the most important events of our time in the field of reproductive health, population and development. From their different viewpoints, all our forum contributors concur. Accordingly, we felt that this forum was the place to debate the reality behind the rhetoric and the wishful hopes. We invited a range of persons to contribute, from those most identified with women's reproductive health to those whose background is mostly population and development, and this spectrum approximately determines the order in which the contributions have been assembled (with the exception of Minister Haryono Suyono's piece which is placed last so as to provide at that stage a view from the apex of one of the world's largest population programs). The original design has been modified by events: many fewer persons working in reproductive health either accepted our invitation to contribute or ultimately wrote a paper than did those with a greater family planning orientation.

The contributors are more cast from one mould than their disagreements might at first give appearance. None have placed themselves beyond participating in the dialogue which Margaret Hempel regards as now necessary. All believe in more technical aid for Third World countries, an improved situation for women in those countries, and higher quality family planning services. None identify with those First World politicians and sectors of their electorates who believe in reducing development assistance budgets. There is even near agreement with Hempel's statement that 'reproductive health is, fundamentally, a different agenda with different goals from the traditional approach to population programs', although division remains as to the priority that should be allocated to it.

Perhaps, after nearly 40 years of association with Third World family planning programs, I might be allowed to differ from one strand of thought which was evident in the corridors and meeting rooms of ICPD and to some extent in this forum. That view held that the proponents of Third World family planning during most of that period, especially the foreign advisers and their institutions in the First World, were so fixated by global population numbers and so patriarchal in outlook that they decided that women should be the sole vehicle for curtailing population growth, and gave little thought to their comfort, desires or safety. I knew few people of this type. Nearly all worried that most forms of fertility control related to women, although some worked in societies where women clearly preferred the degree of control over their reproduction that this gave them. All believed that providing the option to control family numbers and to space births further apart raised the position of women and their future chances in life as well as limiting the reproductive ill-health that threatened them.

We had hoped that more of the forum would focus on the extent to which the identification of reproductive ill-health is possible in remote rural areas and urban slums of very poor countries; the possibility of effective treatment; whether the costs would cripple or

limit family planning programs; and whether family planning programs should proceed in areas where full reproductive health cannot be guaranteed. The first papers do address these issues but the treatment is limited, clearly because the answers are not yet in. Margaret Hempel argues that we can only find out from experience in trying to improve women's reproductive health. Huda Zurayk is somewhat reassuring with her evidence that 'Experience in ... Egypt has shown that a clinical strategy with minimal laboratory services is workable in taking care of reproductive health problems of women provided there is proper follow-up and referral'. Nevertheless, this evidence raises the question as to whether family planning programs should venture beyond the reach of clinics manned by physicians.

There is agreement that NGOs transformed the ICPD, thus making it an unusual United Nations meeting in that its *Plan of Action* has very considerable potential for changing the world. There is disagreement whether the priorities were correctly assigned. There is less worry about whether 'precoms', held in New York City and dominated by *avant-garde* Western groups, should be able to largely determine a plan before most of the world's governments have seriously considered it. It is not very worrying when you largely agree with the outcome, but may some day be less agreeable when different forces learn these tactics. The whole process supports the view I have expressed that the United Nations is one of the world's most powerful Westernizing mechanisms and that much of the advocacy of the UN is for aims supported totally only by Western progressive minorities. Again, I usually agree with their aims.

Most of the other papers have three main complaints. The first is that, by attacking past family planning programs and by making it sound as if all were coercive and uncaring, many individuals and NGOs involved with ICPD undermined the conviction of donor governments that they should exert themselves to contribute to such programs. The second is that the emphasis on the individual, the attack on concern with numbers, and the extraordinary lack of concern about the long-term implications of rapid global population growth gave much less emphasis to social, community and national issues than was warranted and thereby eroded the will of donor governments to strain themselves to support foreign family planning programs or the will of Third World governments to give them high priority. The third complaint is that the Cairo agenda appeared to be making population programs and their budgets support huge health, educational and employment objectives which really were the responsibility of the full range of government.

The truth is that most concerned persons, certainly those represented in this forum, do hope for Third World family planning programs that reach everyone; that do their best to improve the reproductive health of the women they contact and to ensure that the acceptance of contraception does not reduce their level of health; and that make it possible for women to bear fewer children and the world lesser population than threatens to be the case. Those of us supporting the ICPD Plan of Action should realize that First World electorates and their representatives are increasingly unlikely to believe these objectives to be so important that their incomes should be taxed to achieve them; and accordingly, we should put a convincing case for continued support. If money for Third World family planning programs declines, then the chance that more can be done for the reproductive health of women in those countries will also be diminished. Finally, it might be noted that a major aspect of the Asian national family planning programs, which have made the major contribution to the decline in world population growth, has been, as is noted by Haryono Suyono, an emphasis on government leadership in convincing the population that they will be better off with smaller families. Hardly anyone at Cairo or in this forum has dared to mention this.

## **Reproductive health and rights: origins of and challenges to the ICPD Agenda**

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In September 1994, at the International Conference on Population and Development, 184 governments met in Cairo to discuss, debate and, in the end, come to consensus on a new approach to population and development issues (UN 1994). The final Programme of Action represents a critical shift of focus in the population field from a concern with achieving demographic targets, largely through the provision of family planning services, to an emphasis on improving individuals' quality of life. Central to this analysis is the role of women, not just as beneficiaries of services but as active agents of change. The document emphasizes the importance of human rights and the links between population and development concerns. In terms of services, the document not only stresses the need for quality family planning services but also includes, as integral to reproductive health, attention to safe pregnancy, sexually transmitted diseases and HIV/AIDS. It addresses the problem of unsafe abortion and calls for programs for adolescents and men. In addition to specific recommendations for expanding existing services (Alcala 1994; Germain and Kyte 1995), the ICPD also challenges those working in this field to think beyond providing services for policy. It calls for multisectoral approaches to the fundamental determinants, economic, cultural, legal and social, of sexual and reproductive health. This ambitious agenda should not, however, be read as a list of requirements. Rather it is a vision of where the field is headed, assigning new roles and responsibilities to the advocacy, service, research and government sectors.

This broadened approach is mainly due to the fact that feminist health and women's non-governmental organizations (NGOs) from developing and developed countries played an active role in all phases of the conference preparations, from national-level working groups to international UN preparatory meetings. These dynamic, broad-based coalitions of women's NGOs were joined by progressive voices within the family planning, health, environment, development, human rights and research communities who were challenging their respective sectors' approaches to and analysis of these issues. Together, they provided much of the vision and the data on which the final Programme for Action is grounded. The challenge now is to build on this process and maintain the collaboration between NGOs, policymakers and the research community to continue to advance our understanding of reproductive health and to develop services and policies that reflect this new approach.

### **The emergence of a reproductive health agenda**

The concept, or at least the language, of reproductive health has been adopted in international policy and many national settings with remarkable speed. Though critics have argued that these concepts were imposed by a small group of Western feminists organized around the ICPD, a brief review of their history reveals that the concept of reproductive health had already taken root not just in the feminist health community but also in the service and research sectors of both developing and developed countries. Indeed, the ICPD is best understood as part of a broader process that began more than a decade ago and will continue to transform the scope and structure of population programs in the years ahead.

### **Developments in the women's health and advocacy sectors**

In the early 1980s, searching for alternatives to the narrowly focused government and private family planning programs, women's health advocates in developing and developed countries started some of the early models of comprehensive care, providing women with access to a greater range of choices in contraceptives and other services, including abortion and menstrual regulation. In contrast to the often target-driven, sometimes coercive national family planning programs, these services emphasized counselling and attention to interpersonal dynamics, including empowering women to make informed decisions about their health. Such models were grounded in the understanding that reproductive health needs are related to a wider set of economic, social and familial circumstances in which women live. For example, the Bangladesh Women's Health Coalition, founded in 1980, and the Feminist Health Collective, founded in 1984 in Brazil, provide not only a wide range of health care and counselling but also legal aid, social and advocacy services (Kay, Germain and Bangser 1991; Diaz and Rogow 1994). In the United States, the National Black Women's Health Project has been providing preventive health care information and services to poor women through its network of self-help groups since 1983. Building on these experiences of direct service provision, many providers and women's health advocates also began to push for greater attention to the range and quality of services provided by national health and family planning programs (Mueller and Germain 1993).

In the early 1990s, there was intensified discussion on population policies among feminist health groups from developing and developed countries. For example, at the International Women and Health Meeting in Manila, in 1990, some participants argued that population policies were inherently coercive and could not be reconciled with women's rights. Others felt it was important to persuade the existing power structures — donors, national governments and the UN system — to change their priorities and expand the scope of their programs.<sup>1</sup> One example of a subsequent effort to describe feminist population policies was the 'Women's Declaration on Population Policies' produced by an international network of women's health advocates. This declaration outlined minimum program requirements and set out some basic principles including respect for women as responsible decision makers in their families and in society, and principles of equity, non-coercion and inclusion of women at all levels of policy making. It also began to define in more depth the increasingly used concept of male responsibility, stating that 'men have personal and social responsibility for their own sexual behavior and fertility and for the effects of that behavior on their partner's and children's health and well-being.'<sup>2</sup> In January 1994, over 200 women's health advocates from 80 countries met in Brazil at the Reproductive Health and Justice: International Women and Health Conference for Cairo '94, where population policies were discussed from diverse perspectives. While not a consensus document, the final report highlighted several areas of unanimity among the participants, emphasizing the need for greater human development efforts aimed at the empowerment of women and respect for and protection of women's rights. It also noted the need for high-quality health services for women that provide more than contraceptives, and recognized safe abortion as an intrinsic part of health and human rights (Hartman 1994). While these debates contributed to a synthesis view that placed reproductive health in the broader social and economic frameworks that affect women's and men's lives, discussions within the feminist health groups continue on the relative importance

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<sup>1</sup> Examples of these different perspectives can be found in Mueller (1993); ISIS (1993); Berer (1993); Hartman (1987); *Reproductive Health and Justice* (1994).

<sup>2</sup> 'Women's Declaration on Population Policies' (ISIS 1993).

given by governments and NGOs to population programs versus broader social and economic development goals, and whether these are inherently contradictory approaches.<sup>3</sup>

These different meetings and organizing efforts challenged the prevailing view that considered women only in terms of their reproductive capacity; instead they argued that women's health and well-being were important goals in their own right and not merely for improving the effectiveness of population programs.

#### **Developments in the international agencies and family planning sectors**

The idea that family planning and health programs needed to address the full range of women's health needs throughout their life-cycle was also promoted by progressive staff within international agencies and the family planning sectors. Rosenfield and Maine's 'Where is the M in MCH?' article in 1985 criticized traditional maternal and child health programs for their focus on the health of the foetus and newborn (Rosenfield and Maine 1985). The global Safe Motherhood conference, held in Nairobi in 1987, helped focus attention on the problems of maternal mortality and morbidity. Subsequent national and regional Safe Motherhood workshops were held in countries around the world, bringing together NGOs, service providers, policy-makers and media representatives to address these concerns in their particular country contexts.<sup>4</sup> A similar cross-section of constituencies, including physicians, feminists, lawyers, public health professionals, social science researchers, and policy-makers participated in an international meeting on women's health in Brazil in 1989.<sup>5</sup> In addition to focusing on unwanted pregnancy and abortion, the papers presented at this symposium represent some of the earlier thinking on what a broader reproductive health approach would entail in services and policies (Rosenfield et al. 1989). Several papers, for example, discussed reproductive tract infections as a serious health burden for women.

Some of the major international family planning organizations such as the International Planned Parenthood Federation (IPPF) and the Population Council also began efforts to improve service design and delivery. IPPF's 'Vision 2000' put forward in 1992 a broad approach to reproductive health that includes gender relations and sexuality and promotes attention to these issues throughout a woman's life cycle (IPPF 1992). Staff at the Population Council in the late 1980s and early 1990s defined and advanced a 'quality of care' framework. This approach focused on improving the quality of family planning services from the client's perspective. Later adaptations have incorporated other reproductive health services and greater attention to gender dynamics involved in service provision (Bruce 1990).

By the late 1980s, family planning programs that were experimenting with ways to improve the quality and scope of services could be found in most countries, from the Indonesian Planned Parenthood Association to Profamilia in Colombia. At the same time, funding agencies such as the Ford Foundation and the MacArthur Foundation began programs that emphasized a broader reproductive health approach (Barzelatto and Hempel 1991).

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<sup>3</sup> For a discussion of how the ICPD advanced a progressive reproductive health framework but failed to push a similarly progressive economic agenda, see Petchesky (1995).

<sup>4</sup> From 1988 to 1995, over 100 countries participated in national or regional Safe Motherhood meetings. A full listing and copies of conference reports (or referrals to correct source) are available from Family Care International, New York, NY.

<sup>5</sup> Organized by the International Women's Health Coalition, the Christopher Tietze International Symposium on Women's Health in the Third World: The Impact of Unwanted Pregnancy (see Rosenfield et al. 1989).

### **Developments in the research sector**

Researchers in the 1980s gave increased attention to the social, economic and political factors in fertility. Population research began to investigate how gender roles and economic forces, among other factors, shape demographic outcomes. By the 1990s, the effect of the HIV/AIDS epidemic also began to influence research. With no cure for AIDS and no vaccine to prevent the spread of HIV likely in the foreseeable future, researchers and policy-makers began to realize that effective prevention required better information on what motivated sexual behaviour and attitudes and how to change them. The resulting research, while still limited by its disease orientation, engaged a broader cross-section of social scientists from the fields of anthropology, sociology, and political science. This, coupled with work under way in feminist scholarship examining the social construction of gender roles, created the base from which to explore the interface of social and cultural roles with reproductive health issues and sexuality.

These emerging academic lines of work were also taken up by several key research organizations and networks. WHO's Special Programme of Research, Development and Research Training in Human Reproduction (HRP), traditionally a biomedically oriented program, expanded its work on social sciences during the 1980s. HRP materials from the mid-1980s defined reproductive health to include maternity care, infant and child health, prevention and control of sexually transmitted diseases (STDs) and attention to infertility. HRP also recognized the importance of social issues:

Improving reproductive health will not be achieved with machines, devices or drugs without taking into consideration the human element. Changes in behavior and social attitudes are often needed to achieve lasting improvements in health (WHO 1987)<sup>6</sup>.

The Council for International Organizations of Medical Sciences, together with HRP, organized an international meeting on Ethics and Human Values in Family Planning. A multidisciplinary audience of biomedical and social science researchers, lawyers, ethicists and theologians considered the underlying cultural, religious and ethical concerns raised not just in family planning service provision but also as related to infertility and prenatal care (Bankowski, Barzelatto and Capron 1989). In the early 1990s, the International Union for the Scientific Study of Population established committees on gender, anthropological demography and HIV/AIDS. Social science associations, such as the International Federation of Institutes for Advanced Studies, also began to address issues of women's health.

Aiming to make these findings more accessible to broader audiences, organizations and individuals also began to develop more popular versions of academic articles and participated in efforts to educate policy-makers. This proliferation of outreach efforts and publications, many of them designed to provide an overview of the substantive questions that would be debated in Cairo, greatly enriched the policy debates. Publications focused on the role of religions and of ethics in shaping a reproductive health agenda (Development Law and Policy Program 1994), elucidated women's diverse perspectives on reproductive rights,<sup>7</sup> provided gender-based analyses of population and development issues (Correa 1994) and highlighted the widespread but neglected problem of STDs (Germain, Nowrojee and Payne 1994; Zurayk, Younis and Kattab 1994).

By the early 1990s, the concept of reproductive health was widespread in feminist health groups and increasingly used in the service and research sectors. The willingness and ability of these NGOs to then interact across fields and to engage more systematically in the policy

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<sup>6</sup> See introduction by Jose Barzelatto and concluding chapter by Mahmoud Fathalla.

<sup>7</sup> See reports from International Reproductive Rights Research Action Group, Hunter College, New York, NY; Steve Isaacs and Lynn Freedman, Columbia University.

process created a synergy that was critical to developing the consensus framework achieved in the conference process.

### **NGOs transform the ICPD**

With these changes already under way, the ICPD preparations provided an important opportunity for health advocates, service providers and researchers to discuss with each other reproductive health issues. In this process, women's health and rights groups played a leading role not only in articulating a new paradigm for population programs but also in challenging the traditional ways of running such conferences. Previous UN conferences on population in Bucharest in 1974 and Mexico City in 1984 had been largely the domain of male government delegations, with input from a few key demographers and population organizations. In contrast, the ICPD process had broad NGO involvement, with strong leadership provided by people in the feminist and social-justice movements of the developing world. Many of the leaders had participated in the 1992 UN Conference on Environment and Development (UNCED) and the 1993 UN Conference on Human Rights. As a result of their efforts, women's concerns were incorporated in UNCED's 'Agenda 21' and women's rights were recognized for the first time as human rights in the Vienna Declaration.

Such success encouraged NGOs to participate more fully in the preparations for the ICPD. In Brazil, China, Colombia, Egypt, India, Mexico, Nigeria, and the Philippines, NGOs formed national networks to influence their government's positions at the preparatory meetings and at the conference itself. While these networks and their strategies varied from country to country, they shared an emphasis on collaboration among the service, advocacy and research groups and a focus on publicity and public education.

As a result of the activities described above, the level of NGO involvement in the conference preparations was unprecedented. Over 4,000 individuals from 1,700 organizations participated in the ICPD and the NGO activities that ran parallel to the government negotiations. Some NGOs lobbied as outside pressure groups, others participated as official representatives on government delegations, still others acted as resource persons providing technical advice and research data for the governmental discussions. For many organizations, these roles were fluid, with staff participating in different capacities. Forums such as the Women's Caucus provided opportunities for exchange of ideas and strategies among NGOs and between NGOs and government representatives.<sup>8</sup> The increasingly hostile attacks on the conference agenda by the Vatican and conservative Catholic and Islamic delegations also encouraged increased collaboration among the diverse sectors working towards an expanded reproductive health agenda.

Thus NGOs transformed the ICPD, not only by helping advance a new reproductive health framework but also by establishing effective ways of working with governments. Such collaboration, that built on UNCED and the Human Rights Conference, has remained integral to subsequent UN conferences on Social Development in Copenhagen, the Fourth World Conference on Women held in Beijing 1995 and the Habitat Conference scheduled for June 1996. NGOs have helped government delegations (whose representatives were, for the most part, different for each conference) make the connections between different documents and hold firm to commitments made at previous conferences. For example, at the Beijing Conference, rather than giving ground on reproductive health concepts as many had feared,

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<sup>8</sup> At the preparatory meetings and in Cairo, the Women's Environment and Development Organization (WEDO), a worldwide network of women's groups, organized the 'Women's Caucus', a daily briefing session open to all NGOs and government representatives to share information and develop common gender-based analyses of the documents being negotiated.

governments accepted an even broader understanding of sexual and reproductive health, emphasizing a woman's right to control her own sexuality (UN 1995:paragraph 96).

The series of UN conferences following so closely on each other has given NGOs and governments an opportunity to link the issues of environment, human rights, population and development, social development and the status of women. Moreover, by engaging in these meetings, many NGOs have improved their advocacy skills and developed contacts they are now using at the national level to ensure that the words in the conference documents are translated into action.

## **ICPD Follow-up: the challenges ahead**

### **Political will and NGO involvement**

For many NGOs that participated in the UN conference processes, developing continuing mechanisms and relationships that will help hold their governments accountable to these international agreements and guide national programs is a logical and critical next phase of work. In fact, the ICPD document encourages the growth of this collaboration between NGOs and governments as crucial to implementing the Programme of Action. It recognizes that NGOs have provided much of the expertise on the development of policies that are more responsive to women's needs. Since they have also provided models for improved service delivery, it is important that they be involved in broader efforts to scale up these innovations and integrate components of reproductive health into larger programs.

In several countries, the ICPD commitments have already provided a framework for NGO-government collaboration that could greatly advance the reproductive health agenda. Of the 56 countries responding to a one-year follow-up report, two-thirds make explicit mention of involving NGOs, through increased consultation, formal participation in government projects or, in the case of five country reports, increased funding for NGOs (Hamilton 1995). Materials prepared for the UN Commission on Population and Development noted that the trend among the 78 countries that submitted reports was towards greater NGO involvement in national reproductive health activities (UN 1996). It is also encouraging that some of the leading population donors, including the United Nations Population Fund (UNFPA), the World Bank and USAID are supporting women's NGOs to implement new approaches for reproductive health care. For example, the USAID office in Peru made a shared award of \$19 million over five years to three leading NGOs with extensive experience in reproductive health, gender and community development: Movimiento Manuela Ramos, Flora Tristan, and the Centro de Investigacion Social y Educacion Popular Alternativa. The project will work with community-based organizations and use participatory methods to identify and then respond to the reproductive health needs of the communities involved. Included are finance for micro-enterprise loan funds and other measures to respond to the social and economic needs of the women concerned.

It is important to ensure, however, that governments and donors see NGOs as innovative collaborators and not as a means to relieve government responsibility for the Cairo agenda. The NGO sector has neither the funds nor the reach in most countries to provide reproductive health care to all those in need. Furthermore, while NGOs can raise questions and assist in connecting different policy sectors — education, health, family planning, finance — such collaborations will require, in the end, the commitment of governments to reassess their approach to population and development issues at the national level. The reports mentioned above do not show much progress in this regard. In the Commission document, it is clear that NGOs are viewed more as filling gaps in the service sector than as colleagues in developing national policies. The Earth Summit Report's reviewers, working with developing-country

colleagues, found that in many cases it was not clear who or which departments within national governments had responsibility for following up the ICPD.

The lack of significant state action on ICPD implementation in many countries raises questions about the level of government commitment to this new agenda. Given competing demands for limited resources, reproductive health issues are often not made a priority by many governments. In some countries, governments and NGOs face domestic political pressures that make championing a broader reproductive agenda more difficult than in the international context of a UN conference. Indeed, many NGOs are finding that without the international attention surrounding the ICPD and the other UN conferences, open and participatory relationships with their governments are difficult to maintain. In some cases, governments resist collaboration because NGOs are seen as anti-government. And in many countries, there is little precedent and few effective models for NGO-government collaboration.

For NGOs, there are also tensions regarding whether and how to engage with government agencies. Some prefer to retain their role as 'outside' critics. Also, many providers focused on the day-to-day delivery of services are less concerned with engaging actively in larger-scale policy formulation. Some NGOs are also concerned that governments' positions may be largely rhetorical and that closer collaboration will lead to very limited advances. They thus fear that their participation may lend legitimacy to a process in which they would have little power. For NGOs that include advocacy as part of their mandate, accepting government funds can create a conflict of interest or limit their ability to act and speak independently of the government priorities. At the same time, with the majority of funds for family planning and health provided by governments and international agencies, NGOs need to find ways of access to these resources.

Clearly each NGO will need to decide where on this continuum they can be most effective: working from outside to keep pressure on governments and donors or working in some degree of partnership to help develop new program and policy models. Both approaches are needed to advance the goals of the ICPD.

In addition to national efforts, the cross-national networking among NGOs that proved so effective in shaping the agenda of these conferences will also be critical in developing mechanisms to hold both individual governments and bilateral and multilateral agencies accountable to the commitments made in Cairo. Such coalitions will need to build on the ICPD process that gave greater voice and priority to the perspective of women in developing countries. This will require developing modes of communication that allow for shared agenda-setting as well as a division of labour and sharing of expertise among groups working at the national, regional and international levels. Some beginning examples in this regard are WEDO's Women Watching ICPD that links with their efforts to monitor UN and World Bank activities and the network, HERA 2000, an alliance of women from developing and developed countries who were closely involved in the Cairo conference.

#### **Multisectoral approaches**

Implementing this broad agenda that recognizes the relationships between issues such as girls' education or improved employment opportunities for women and reproductive health services will require the involvement of other sectors beyond the family planning or population divisions of government. Some have argued that this broadened mandate may dilute what population programs do well : provide contraceptive services. Others fear that it will cause funds allocated for family planning services to be diverted to education and development. In fact, the ICPD document specifies that implementation of this agenda is not the sole responsibility of the population sector but requires the technical and financial involvement of the health, education, planning and finance ministries. This broader approach has the

potential to strengthen national-level responses by calling on a wider array of participants in these issues.

One example of a multisectoral approach is found in the Philippines. The Population Commission established a program in 1994 to better integrate attention to gender and reproductive health within all levels of the Commission and its programs, including information to previously ignored groups such as adolescents and men. An advisory committee was established that includes representatives of the Departments of Health; Education, Culture and Sports; Social Welfare and Development; Labor and Employment; Interior and Local Government and the National Economic Development Authority, as well as NGO representatives from universities and gender, reproductive health and women's rights advocates. A complementary effort at the provincial level is seeking to develop models of community engagement in policy dialogue and in the agenda setting process.

### **Reproductive health indicators**

Also necessary for genuine advancement in this area is the development of new indicators for services and programs that measure more than numbers of contraceptives delivered or couple-years of protection. A new framework would incorporate concepts related to quality of care and client satisfaction and would look at outcomes beyond numbers of births to include women's health and morbidity. Some work has been initiated in this regard, including Jain's Helping Individuals Achieve their Reproductive Intentions (HARI) index to measure program success by whether each individual client was able to achieve her desired fertility in a healthful manner.<sup>9</sup> Central to this approach is the concept of following the individual woman to assess how services meet her needs. Others have been exploring more effective management techniques that would address the quality of care clients receive at the service site.<sup>10</sup>

Most of these still focus, however, on contraceptive delivery. Much less has been done to develop indicators for the broader reproductive health services and policies recommended in the ICPD. Initial efforts include work by IPPF Western Hemisphere Region and the USAID funded EVALUATION project. The latter is developing indicators for six key reproductive health interventions, including safe pregnancy, post-abortion care, breastfeeding, STDs and HIV and adolescents. Some potential markers include the percentage of adolescents receiving reproductive health education and services, and percentage of women admitted to hospitals with obstructed labour or ruptured uterus not delivered within two hours (Bertrand and Steward 1995).

Also needed, however, are indicators that can be used to assess progress in promoting sexual and reproductive health at the national level, using measures that go beyond service indicators to capture elements of broader social change. For example, how would we assess the impact of multisectoral programs' effect on women's empowerment and improved reproductive health? How would a community assess the effectiveness of an integrated program to address women's economic, educational and health needs? What indicators would one use to determine if particular programs or policies were facilitating or hindering improved sexual health? Little has been done to date to show what these broader indicators might be and, even less on how these would be monitored. One example is work by Schuler

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<sup>9</sup> See Jain and Bruce (1994). In this model, clients are classified by those who want and those who do not want another child for 24 months. The program would then follow each woman to see if she met this goal and, if not, why not, including attention to method failure, information failure, a related morbidity, etc.

<sup>10</sup> See Association for Voluntary Contraception's (AVSC) COPE model.

and Hashemi (1994) looking at the links between credit programs, empowerment and contraceptive use in Bangladesh. Additional insights might be gained from looking at work under way in other sectors including gender and development to identify and develop monitoring systems for broader social indicators.

### **Resource requirements**

A discussion of the challenges facing implementation of the ICPD would not be complete without mention of the resources needed to support this agenda. Certainly more funds are required. However, reproductive health cannot be seen as an addition to existing services that will happen only if and when additional funds are provided. Rather reproductive health is an agenda and a commitment to transform provision of services and implementation of policies. In times of scarce resources for social services, it is important to think creatively about what to do with the funds already available.

Many reproductive health services can be implemented within existing structures and budgets (Germain, Nowrojee and Pyne 1994). In many cases, at least in the first phase of moving towards a reproductive health approach, efforts to change attitudes, improve interpersonal skills, and design service hours and content to better meet the needs of a diverse clientele, may be as helpful as additional funds. In some cases reorganizing or better integration of services may even result in savings. The ICPD document notes that while improving quality of care in family planning programs may, in some cases, increase expenses, these are likely to be offset by declining costs per user as contraceptive prevalence increases. In this changed context, additional resources would then be more efficiently used and would contribute more directly to improved reproductive health.

The ICPD document includes some general estimates of the level of funding required for this expanded reproductive health agenda, breaking out costs for family planning, reproductive health, HIV/AIDS and research. Such efforts to document the financial requirements, however, have done as much to show the inadequacy of our estimates as to give hard figures of what is needed. First, international statistics may give us broad goals for international development but in aggregate do little to help nations plan for their particular reproductive health needs. As pointed out by Zeitlin, Govindaraj and Chen (1994), analyses of current population and health expenditures are severely deficient because of poor data. Furthermore, understanding the full range of reproductive health costs requires considering not just population budgets that tend to be largely spent on contraceptive services, but also current expenditure on HIV/AIDS, Safe Motherhood, Maternal and Child Health and Child Survival. Similarly, policy-makers should estimate the level of social expenditures allocated to education or development programs that also incorporate elements of reproductive health. Some countries have begun to identify the content and financial requirements for essential reproductive health services, but these are still very preliminary (cf. World Bank 1995). Once governments better understand what they already allocate towards an expanded reproductive health agenda, they can make effective decisions to reorganize their priorities. Though it is important to encourage international agencies to support expanded programs, national-level re-ordering of priorities is perhaps more important, since most funds for reproductive health are provided by national governments and the users.

At the service level, such financial analyses are also needed. As opponents of an expanded reproductive-health agenda are likely to use cost excuses for not expanding services, those committed to reproductive health must begin to document the real costs of such programs. Some preliminary efforts in this regard indicate that reproductive health services are indeed cost-effective (Diaz and Rogow 1994; Aitken and Reichenback 1994). These estimates need to consider direct service costs and also those associated with poor services, women switching methods and leaving the health system through dissatisfaction

with the services provided, etc. Only with such figures can we see what reproductive health will cost, and the social and economic costs of not providing such services.

Questions of resources are hard to separate from the fact that new reproductive health is a different agenda with different goals from the traditional approach to population programs. Thus comparisons between them are difficult as most cost-benefit analysis is intended to compare progress towards a common goal. Nonetheless, estimates of cost effectiveness of the broader approach would also help inform the debate about whether the two world views can be reconciled.

### **Conclusion: contested concepts**

For those working intensively on the ICPD, the preparations provided an opportunity for a shared understanding of a reproductive health agenda and for expanding the network of people and organizations conversant with this. Outside the organizations closely involved with the ICPD, the concept of reproductive health is still relatively new. In some languages there is no word for it, and where there are common terms, the concepts still mean very different things to different people. The lack of clarity on the concepts among those now responsible for implementing the ICPD agenda, from service providers to ministerial personnel, may prove to be one of the biggest challenges to the reproductive health agenda. Thus high priority should be given to training staff and to communication at the national level and within each sector concerned to better understand the concepts of sexual and reproductive health. There should be national and local efforts to experiment with and publicize policy and program models that incorporate elements of this expanded agenda. Such efforts may help clarify areas of the ICPD that remain contentious or unclear.

In addition to the many areas where broad consensus was fairly easily reached, the ICPD was also marked by intense debate over several core issues that are critical to its comprehensive approach. These include access to safe abortion, services and education for adolescents, sexuality, recognition of changing and diverse family norms and structures, and women's unequal positions in family and society. While consensus was reached on these topics, it was achieved less through a change in perspective than through finding language that was general enough to allow for diverse interpretations. For example, the recognition of unsafe abortion as a major public health problem is followed by a statement that any changes related to abortion must be determined according to the legislative process of each country. In practice, this could be interpreted to mean that it is the responsibility of governments to ensure women have access to safe abortion services, or to mean that the way to eradicate unsafe abortion is to impose stricter legislative sanctions against it. The links between reproductive health and rights, including sexual rights, also need discussion to further clarify what they mean and who is responsible for ensuring these rights.

The intensity of these debates, and the fact that reproductive health concerns often challenge deeply held cultural beliefs and stereotypes, show the need to continue discussion at national levels where the political and cultural challenges may be even more acute than in the halls of the UN. Indeed, the post-ICPD and certainly post-Beijing climate has seen some vocal opposition to the ICPD agreements from conservative groups in a number of countries. A reasoned and constructive response to these differences can only be advanced by discussion of the diverse ethical and religious values involved. Most religions affirm principles of compassion and social justice which may provide a common ground for further debate on a range of reproductive health concerns. Ethics too provides such an opportunity. For example, discussion of basic principles such as 'do no harm' has proved to be effective points of departure for reproductive health policy and program discussions across a wide range of cultural contexts.

In the post-conference era, it is important that advocates, researchers and practitioners continue to push the frontiers of our analysis, to explore the concepts that are less well understood or are still contested. Such analyses must be grounded in the realities of the countries and communities concerned and the findings integrated into evolving program and policy agendas. As these dialogues take place at the national level and involve a wider circle of people and disciplines in the discussions, it is likely that the concepts advanced at the international level will be further refined and adapted.

The ICPD process and the resulting document were based on the reality of women's lives, the experiences of service providers and the findings of those researchers exploring the conventional boundaries of their disciplines. Yet the document itself is ultimately the product of a political process, shaped by events of the time, the constraints and priorities of participating governments' domestic agendas and the active lobbying and engagement of diverse groups of NGOs. Indeed the ICPD's importance and potential strength lie precisely in the advocacy process that led up to it and the fact that it is a statement of political will on the part of governments. It sets an international standard against which population and development programs and policies can now be assessed. Like all such international agreements that are non-binding under the law, its implementation will depend on whether governments maintain it as a priority. Ultimately, this will be determined largely by the extent to which NGOs and others affected by the policies and programs hold their governments and the international agencies accountable to such commitments.

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## **Population Policy Revisited: Examining ICPD**

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The International Conference on Population and Development, held in Cairo in 1994, marked the first time that women's movements had been able to help define the parameters of the discourse on population. Women from the North and the South had a distinct and important role in changing the focus of the conference and the resulting document away from population control to reproductive health. The focus on women is a crucial and long awaited change to the analysis of population and development. Though the Cairo document mostly reflects the crucial role that women's movements had on ICPD, a particularly important issue that needs further analysis is the connection between population and development.

The most significant contribution from women's movements both in developed and developing countries is the placement of women at the centre of the population debate. Gender equity and gender equality were addressed in the preamble, as well as in the set of principles that set the tone for the entire document. Two separate chapters were devoted to addressing gender equality, equity, empowerment, and reproductive rights and reproductive health. This clearly marked a victory for the women's movement.

The document recognized that women's empowerment and improvement in status are important ends in themselves and essential to the achievement of sustainable development. This is in direct opposition to the prevailing notion in the population field that women are merely a means to reach a preordained target of population growth. The importance of male responsibility and the need to pay particular attention to the girl child are crucial to a long-term change in the way population and family planning policies are carried out (ICPD *Plan of Action*). The target-driven population policies guided by demographers have finally been replaced by the considerations of the rights of women and men to make informed and responsible decisions about the number and frequency of childbirths.

Human sexuality and gender relations, the definition of the family, connecting HIV/AIDS to family planning issues, and the inclusion of adolescents are a shift towards a reproductive health approach. Along with the change in the field, the reproductive health approach also brings about a clearly demedicalized notion of health that examines its social, economic and psychological components. The ICPD is the first UN population conference with a particularly feminist agenda. It has reversed at least the rhetoric in the population field, giving women a central role.

The document very early in the preamble expanded the focus to recognize the connection between population, poverty, patterns of consumption and production. The need to understand population growth in a wider context was another important principle initiated at UNCED in Rio. The development agenda, however, is narrow, and does not reflect the progressive rhetoric of the rest of the document in that economic growth, though in the context of sustainable development, becomes the overriding principle.

Some have argued that the focus on reproductive health was responsible for the neglect of the more important issue of development, inequity between North and South, and the unequal and exploitative transfer of resources. The placement of reproductive health and rights in the centre has been seen, especially by some in the South, as a way to limit women to a primarily reproductive role which does not include the more important need to understand women's economic and social dimensions.

The focus on reproductive rights, the empowerment of women and reproductive health is a step toward changing the direction of the population control policies that have been carried out for the last few decades, especially on women in the South and poor women in the North. Woman's unequal position in society is linked in many ways to her reproductive role, and attaining control of our reproductive lives should be part of a progressive agenda either in the North or the South. The need for women to force the re-articulation of the field is of crucial importance in determining the way in which population policies will be carried out.

What concerns me is not reproductive health versus development but to understand when, how, and why population as such became an important public policy issue. We have yet to challenge the prevailing paradigm that poverty is caused by population growth and, more recently, that the sustainability of the environment is primarily threatened by worldwide population growth.

Though ICPD claims to understand the connections between population, development, poverty, patterns of consumption and production, it does not explain what the connections are or should be. It assumes that population growth is inherently opposed to the economic well-being of people and/or the sustainability of the earth. What is lacking in the challenge to the dominant paradigm is the questioning of assumptions which link population and development.

The ICPD document fails to address the cause of environmental degradation. The document promotes the idea that economic growth can be carried out in the context of sustainable development. However, we are actively promoting an economic system globally that cannot survive without the constant consumption of new products at the expense of sustainable development. The only people who have little concern for the large population of the South are the transnational corporations who are actively searching the world for populations where they can create a need that they can then fulfil. Both in the North and increasingly in the South a very small percentage of the people are consuming most of the world's resources.

The ICPD is a step forward insofar as it has shifted the discourse on population to emphasize women and gender issues. Petchesky argues that

the Cairo document begins to approach a conceptual framework of interdependence and non-linear causation that departs significantly from Malthusian thinking...Population growth, according to the document, is only one variable in a complex array of interconnected problems, including women's low status, widespread poverty, resource depletion, 'social and economic inequality' and unsustainable patterns of production and consumption (Petchesky 1995:157).

The next step for the feminist challenge is to question further assumptions, to clarify the appropriate significance of the variable of population growth in addressing inequality and environmental degradation. We need to be attentive to a global economic system that is in its structure of production removed from the interests of its members, and can only survive with a never-ending growth of consumption, regardless of justifiable social needs. We need to be able to demand women's reproductive freedom, gender equality, equity and empowerment for their own sake, even if it means that women will then have more children.

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## **The Cairo consensus and women's reproductive health in less developed countries**

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The recommendations agreed upon at the International Conference on Population and Development in Cairo have been celebrated as a 'quantum leap to a higher state of energy' (Sadik 1994). Not everybody agrees, however, on the immediate consequences of the Cairo consensus over the access to fertility regulation by women and men in less developed countries.

The difference between previous conferences on population and development and the Cairo Conference, is that while the previous international agreements had set demographic targets for world population with family planning being the instrument to achieve those goals, in Cairo, women's reproductive and sexual rights were recognized, for the first time, independent of their role as mothers.

The Cairo consensus also placed great emphasis on development, education and employment, but its greatest effect derived from the priority given to gender equality and the new perspective of family planning. The latter was no longer seen as just a means to achieve demographic objectives; the emphasis moved from quantity to quality, with contraception becoming part of reproductive health services.

The influence of the Cairo Consensus on women's capacity to control their fertility goes beyond the recommendations directly related to reproductive health. There is no doubt that expanded access to education and employment and a reduction in the gender power imbalance are equally important in helping women control their own fertility. However, in this paper, discussion is limited to the effect of the recent reproductive health approach on family planning activities in developing countries.

This 'new' approach was seen as a threat to the success of family planning programs by many population agencies, governments and donors, who believe population growth should have the highest priority. They are concerned about the problem of limited resources and are confused about how to restructure health care facilities to provide comprehensive reproductive health care.

The argument by those who are unhappy with the idea of a full range of reproductive health services, rather than vertical family planning programs, is that existing facilities and human resources for health and family planning are already insufficient to respond to the demand. Consequently, the adoption of a broader reproductive health approach would not be feasible or would reduce the access to fertility regulation and increase unmet needs, with disastrous consequences.

Some of the premises on which the above concern is based are that there is no chance of increasing resources allocated to primary health care; primary health care facilities are already providing services at their maximum capacity; improvements in quality of services will create a much greater demand on human and other resources; and other reproductive health services that are currently available should not be taken into consideration.

From my personal experience in several Latin American countries, I believe that these four premises are not necessarily correct, and that the reproductive health approach not only is fair for women's health and well-being, and a human right, but has the potential to improve access to contraception and reduce unmet need for fertility regulation. In order to be systematic, the four premises listed above are discussed one by one, in the same order, although there is some overlapping between them.

#### **No chance of increasing resources for primary health care**

In most Latin American countries, with few exceptions, the percentage of the government's budget allocated to health is shamefully small, almost always in single digits. This is in sharp contrast to the political platform on which almost every candidate to executive office, at the central or local level, runs, invariably promising to give higher priority to the health needs of the people.

Once the candidate is in office, many of these promises are not fulfilled, but there is almost universal awareness that greater investment in health is needed. The chances are relatively good for increased investment in women's reproductive health through two possible mechanisms, not mutually exclusive. One is by increasing the health budget, which is easier, the lower the current proportion of the total budget and the better the economic perspectives of the country. The other is a redistribution with emphasis on reproductive health within the current health budget. This will strongly depend on the political leverage of the women's movement in each country. At the present time, the political power of organized women's groups is increasing in most, if not all, Latin American countries.

#### **Primary health care facilities already at their maximum capacity**

This argument is frequently raised on the basis of anecdotal examples, and by physicians complaining that they are overwhelmed by the demand. It is undoubtedly true that the primary health care system in most Latin American countries lacks sufficient equipment, supplies and human resources, and that those deficiencies limit its capacity to respond to the health needs of the population. Basic equipment is either missing or not functioning, with no system available for repairing or replacing parts. Supplies are often discontinued and there is rarely a good logistics system. Physicians' salaries are usually unacceptably low and paramedical personnel are scarce, and frequently include staff with little or no formal training. This depressing general picture of the primary health care system appears to justify the idea that the right solution is to implement specially funded and separate, vertical family planning programs.

But looking more carefully at the basic elements of the system, the clinic or health post, one almost invariably finds that the facilities are underused, human resources are improperly used, and there is ample possibility of delivering more services through better organization, planning, supervision and management. If elementary health planning principles are applied, the system is frequently found to use only two-thirds or less of its total capacity to provide health care. Consequently, there is often ample space for expanding the services offered and the population covered.

This will not happen automatically: improvements in management, service statistics, logistics and supervision are required, but this would not be difficult to achieve with the appropriate support from government and donors. This does not necessarily mean increased funding, but reallocation of resources to improve efficiency.

### **Improvements in quality of services will create greater demand**

The argument that improved quality will increase to unbearable limits the work-load of primary health care staff also appears reasonable if one applies Bruce's (1989) definition of quality of care in family planning. It is true that it is easier to simply prescribe a contraceptive method than to provide complete information on all available contraceptives and let the women choose the one they prefer. But that is more an issue of organization than of increasing work-load. Good counselling can be provided in small groups, which offers more advantages than individual counselling. The latter is boring for the counsellor and the quality drops during the course of the day. Also, not all women feel comfortable asking questions when they do not understand and are intimidated by the provider. On the whole, counsellors need a lot less time for small-group counselling than for individual counselling and have more time to explain each method clearly and in greater detail. Also, clients who are more timid will benefit from the questions raised by other women who are more outspoken.

The question of confidentiality and privacy is part of another element of quality of care: client-provider interaction. After counselling, each woman has to be seen individually for history taking and examination, and at this time more intimate details can be discussed. Good interaction means being gentle, listening to what the clients have to say, and responding to their questions. It can be argued that this takes longer than just providing a method, inserting an IUD, or prescribing a hormonal or barrier method. If the mean time spent attending one client is 15 minutes, appropriate interaction requires only goodwill on the part of the providers.

The fact that many physicians spend much less time consulting with each patient, and neither listen to nor answer their questions, is due not to limited resources, but to the lack of proper training, absence of good supervision, and the community's limited or non-existent capacity to exert social control over the service providers.

Providing reproductive health services together with family planning was also part of the original six elements of quality of care proposed by Bruce. Those concerned that it would be detrimental to the provision of contraception are not aware that the additional effort is, in fact, minimal, and does not necessarily mean doubling the duration of each client visit.

Some of the 'new' reproductive health care activities, such as measurement of blood pressure, a properly taken personal history, and a basic pelvic examination, are required for proper provision of contraception. To extend services beyond family planning to respond to women's other health needs means placing more emphasis on women's reproductive history and the observation of the vagina and cervix; the identification and treatment of reproductive tract infections; and an increase in the examination time by a few seconds in order to take a Pap smear before inserting an IUD. Providing good quality of care and broadening services' scope to include other health needs of women does increase the duration of each visit, but that the increase in time and effort is relatively small and is compensated by the benefits and time saved in the medium and long term.

The benefits are obvious and the medium or long-term time savings derive from a decrease in the frequency of follow-up and emergency visits, when the quality of services provided at each visit improves. If women are well informed, allowed to freely choose and use methods they really like, they will have fewer complaints, will use the methods longer and will demand follow-up care less frequently, and ultimately reduce the demand on clinics. If other reproductive health needs are attended in a timely manner, more severe complications will be avoided, again reducing the demand on the services. Thus, the initial investment in time and care will be compensated without overwhelming the clinics' capacity.

It is also well known that satisfied users are excellent advocates of family planning for other clients, and thereby contribute to reducing unmet needs. On the other hand, clinics with better services promote trust in their clients and consequently, increase the chance of them

requesting other methods when they are no longer satisfied with their current method. The providers themselves will gain the appreciation and respect of their communities, to which they are always sensitive.

This may appear to be an artificially rosy picture, but it has worked well in places where it has been tried.

#### **Other reproductive health services currently available**

What is frequently ignored is that at the primary health care level other reproductive health services are more often offered than family planning. The traditional primary health care centre provides antenatal, postnatal, infant and child care. Family planning, cervical cancer prevention and treatment of reproductive tract infections are rarely part of the activities at this level. Thus, broadening the scope of services and viewing each woman as a whole person with multiple needs, not only as a pregnant uterus or as the mother of a child, will increase the access to fertility regulation of many women who at present are seen by the system only as mothers.

Those who argue that the reproductive health approach will reduce the resources allocated to family planning appear to envisage only clinics currently exclusively dedicated to providing contraceptive services, where the provision of other services would divert part of their existing resources. They do not take into account that integration means that contraceptives would be offered in all the health posts that now provide only antenatal and postnatal care. It would mean multiplying the service delivery points offering contraceptive services at a fraction of the cost of installing new clinics which offer only family planning. A health post that already exists, with its infrastructure and staff, can support the addition of family planning and other reproductive health activities with minimal investments in training and supplies. In the medium and long term, the unwanted and unintended pregnancies averted by the availability of contraception will reduce the demand for antenatal visits, liberating resources for cancer prevention, treatment of reproductive tract infections and contraception.

Having considered the four premises that are the basis for the concern about the 'new' reproductive health approach, readers may wonder whether all the arguments above are not theoretical nonsense which never would be put into practice. Fortunately, there are practical experiences that show that, given the political support, these concepts can be applied with excellent results.

The UNFPA-funded national family planning program for 1974-75 in the Dominican Republic originally allocated resources to increase the number of family planning clinics from the existing 58 to about 80, adding 20 additional clinics in the country in two years. The project followed the vertical approach applied up to that time; the 58 family planning clinics functioned within public hospitals or outpatient clinics, only during certain hours of the day and not every day of the week. The clinic usually consisted of a well-equipped outpatient room that remained locked and unused more than half the time, while the rest of the centre was poorly equipped and a lot busier, providing mostly antenatal and infant care.

The Dominican authorities and the donors accepted the idea of switching from that original proposal to an alternative one, using the same resources to add contraceptive services to all existing service delivery points providing women's health care, previously limited to antenatal care. The result was that, with the same resources, the number of service delivery points providing family planning increased from 58 to 204 (instead of only 80), the number of new acceptors more than doubled in two years, and the prevalence of contraceptive use rose from 2.8 to 8.0 per cent between December 1973 and December 1975. Although these data seem too good to be true, they were confirmed by comparison of the results of the National Demographic Surveys carried out in 1970 and in late 1975 (Faundes and Hardy 1977).

At the same time, the supervision and logistic structure created and funded to serve family planning activities exclusively was used to also cover antenatal care and cervical cancer prevention. One measurable consequence was a steady increase in the number of Pap smears taken and reported, although not at the same pace as contraceptive use.

All that was achieved without increasing the original budget, which had been allocated for a less ambitious target in terms of new acceptors and contraceptive prevalence. This is a well-documented example of how the use of resources originally allocated to contraception for other reproductive health care activities does not necessarily jeopardize the family planning program and can be more than made up for by the use of the existing structure, originally intended for antenatal care, also for other reproductive health needs, of which contraception is usually in greater demand.

The benefit of the approach integrating family planning and reproductive health was crystal clear. It was not greater because at the central level, the separation of family planning and MCH remained, in spite of the integration at the provincial and primary health care level. The problem was that this experience was ahead of its time; it did not receive the attention that is now given to the integrated reproductive health approach.

Nevertheless, there are possible negative effects of the Cairo consensus on the availability of contraception for women and men in less developed countries. These consequences are not related to the capacity of the primary health care system but to the interpretation and political reaction of governments in developed countries, international organizations and other donors, whose main objectives are demographic; they may believe that the new approach means that their money will not produce the expected results, they will not maintain their support at the same level, and all services will suffer the effects of reduced funding.

On the positive side, family planning will receive the full support of women's groups, which were previously against vertical programs or ambiguous about them. The Cairo consensus will also provide them with strong arguments to obtain local and central government support for reproductive health, including family planning. This new approach will also gain the support of public health professionals, who previously were suspicious that family planning was not being offered to improve women's health and well-being, but to reduce population growth, which foreign countries considered the only determinant of poverty and underdevelopment.

The comprehensive reproductive health approach not only is a fair response to women's legitimate demands but will improve access to fertility regulation, if existing funding is not cut. If funding in fact increases, as the conference recommended, the reduction of fertility and improvement in women's health and well-being may be dramatic.

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## **A holistic reproductive health approach in developing countries: necessity and feasibility**

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One of the most important contributions of the International Conference on Population and Development, held in Cairo in September 1994, is its adoption of a reproductive health approach in the Plan of Action. As an interdisciplinary group of researchers including medical and social science specializations, women and men, we have been undertaking research in Egypt since 1989 within a reproductive health framework, as part of a larger regional Reproductive Health Working Group. The Group sees the reproductive health approach as advancing a holistic and integrated perspective of reproduction and its health consequences for women, from adolescence to the reproductive years and beyond, and including also men and other relevant family members. This is how women perceive the process of reproduction, and herein lies an element of strength of this approach, that it is consistent with the reality of the outlook of women whom it aims to serve. A reproductive health approach is also sensitive to the social context of women's lives and is aware of the existence of local systems of knowledge and practice, all of which have to be taken into account in planning for working with women and communities towards the goal of improving reproductive health.

In ideal terms reproductive health is defined to include reproductive choice, healthy reproduction, avoidance of gynaecological and associated problems, and dignity. This is far from the reality of the situation of women in the developing world. We believe that working towards this ideal requires more than a medical approach, focused on the supply side of service delivery. Attention is required, in addition, to the demand side including as active agents women, men, families and communities. Yet this multidimensional and holistic approach to reproductive health has unfortunately created a concern for some over the cost of service programs, in view of limited resources, and of competition with more narrowly defined goals that have received priority in the past, paramount among them being control of fertility through family planning programs in the developing world.

Perhaps this concern over cost has been influenced by recent writings that present comprehensive frameworks for reproductive health care, including detailed service elements within an integrated perspective (Pachauri 1995; Hardee and Yount 1995). These frameworks are valuable attempts to delimit what is involved in a reproductive health approach. However, they must be taken as providing a topography of service elements which developing countries must view selectively, carefully choosing what to adopt, and at different rates and forms, depending on the reproductive health situation each country faces and on available resources.

This concern over the cost of adopting a reproductive health approach is probably also influenced by an over-technological perspective. Many of the pressing reproductive health problems in developing countries, such as reproductive tract infections, require what are as yet relatively expensive laboratory procedures to diagnose. However, it is possible to avoid

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\* The Reproductive Health Working Group was established in 1988 by the Population Council Regional Office in Cairo for West Asia and North Africa (WANA). Its co-ordinator is a staff member of the Population Council. It is composed of an independent network of regional scholars from medical and social science disciplines undertaking research individually and in groups on priority topics in women's reproductive health as defined by the Group.

such procedures by adopting a strategy that relies first on a preventive approach. Such an approach would address health services and providers to ensure, for example, that sterile procedures are adopted in all services including family planning. It would also address women through health education and counselling on topics such as hygienic behaviour and recognition of symptoms for early treatment.

A strategy involving a simplified perspective of care would also rely on clinical services to the extent possible providing adequate training to health care providers. This training will have to include sensitization to women's perspectives and social realities so that a provider can draw the needed information for a diagnosis well-informed by a woman's complaint, when there is no recourse to advanced technology. A strategy relying on clinical diagnosis would have to be complemented by a proper system of follow-up and by implementation of adequate referral procedures to take care of persistent and serious cases.

Our own research in the two Giza villages of Egypt has shown a discrepancy between women's reporting of symptoms of reproductive tract infections and diagnosis based on laboratory examinations (Zurayk et al. 1993). However, the collection of information on women's reports was undertaken through survey research using an interview questionnaire in the woman's home. What we are considering here is a clinic situation with a physician giving careful attention to case history taking and follow-up. Experience in a clinic situation in Damietta, another rural area of Egypt, following the Giza Morbidity Study, has shown us that a clinical strategy with minimal laboratory services is workable in taking care of reproductive health problems of women provided there is proper follow-up and referral (Delta Consultants 1996).

The reproductive health approach represents a holistic perspective on women's health care and not a system of services. Services within a reproductive health approach can vary in scope and in level of technology used, and can thus be kept within available resources. In addition, more attention should be given to the possible cost-saving implications of this approach. A holistic reproductive health approach involves a framework of health care which is attractive to women. It would succeed in bringing more women to health services and would thus reduce the cost of recruitment of clients to vertical services such as those of family planning programs. It would also avoid the costly complications of some of these services when they do not give due attention to health implications and side-effects, such as infections due to non-aseptic insertion of IUDs, and such as bleeding much feared by women.

There is a great need currently for projects in various settings of the developing world that involve design and implementation of interventions, within a reproductive health approach, to establish evidence that this approach is tenable within available resources and effective in improving the reproductive health of women in the developing world. We are currently undertaking such a project in the Giza villages in Egypt that were the scene of the Giza Morbidity Study we undertook in 1989-90. The Giza Morbidity Study gave unique evidence of the heavy burden of gynaecological and related conditions that women bear in silence. It also highlighted constraints within the social context, low awareness level of women and quality of care considerations, as affecting women's health and health-seeking behaviour (Khattab 1992; Zurayk et al. 1993; Younis et al. 1993; Zurayk, Younis and Khattab 1994).

On the basis of these findings we are currently undertaking a project, with UNFPA funding, to develop and test an intervention framework that takes a holistic approach to women's reproductive health involving a three-dimensional intervention. The intervention includes:

1. A health services component that involves selective upgrading of the current Family Planning and Maternal Child Health services being provided at the health centres, as well as introduction of elements of gynaecological services that address gynaecological and related

morbidity conditions revealed as prevalent by the Giza Morbidity Study. The physical set-up at the clinic will also be upgraded in necessary medical equipment and supplies, and in cleanliness and privacy concerns.

2. A provider component that involves training to enhance providers' awareness and technical skills to enable them to better address reproductive health problems in prevention and treatment. Providers will also be sensitized to women's perceptions of health and illness and to the socio-economic constraints imposed on them, in order to make communication with women and treatment regimes more suitable for the realities of women's lives.

3. A health education component which is aimed at raising awareness in women and men of how to prevent reproductive health problems, of symptoms of these problems and of when to seek medical help for their treatment and management.

This project has a more general concern with learning how to improve reproductive health care nationally in Egypt. The project is therefore conducted in collaboration with the Ministry of Health in Egypt and involves contribution from key personnel in the Ministry in the design, implementation, monitoring and evaluation of the project with a view to scaling-up the intervention for gradual integration within the Ministry's Primary Health Care Program. The project gives priority concern to effect, as well as to cost, feasibility and sustainability of the intervention. It is developing indicators to monitor and evaluate the progress and performance of the intervention. It will involve dissemination to professionals and organizations interested in similar efforts in Egypt, in the region and in the developing world.

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## **ICPD and Family Planning Associations**

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The International Conference on Population and Development (ICPD) in Cairo in September 1994 and the Fourth World Conference on Women (FWCW) in Beijing in September 1995 were important milestones not only for the International Planned Parenthood Federation (IPPF) but for the world as a whole.

ICPD was critically important because it moved the debate from the demographic way of thinking about population programs towards the broader concept of sexual and reproductive health, including family planning, and emphasized the importance of women's interests, needs and rights as essential components of development. The Beijing Conference focused on how to achieve equality and empowerment for women in all areas of life.

The ICPD gave an important impetus to the reproductive and sexual health agenda. This conference was a decisive one in that it firmly moved the focus of family planning away from fertility targets and national demographic goals towards meeting the needs of individuals for family planning and reproductive and sexual health care. It made it a goal for the world's governments to make available universal access to a full range of high-quality reproductive health services by the year 2015. It emphasized people's rights to reproductive health and most important, quality services: services should be accessible, acceptable and convenient to all users. This reflected IPPF's own endeavour to introduce a client-centred approach that stressed the rights of those being provided with services for quality care.

Family planning services, including counselling, information, education, communication and contraceptive supplies, remain at the core of sexual and reproductive health care. The difference lies in taking a lifetime view of people's sexuality, so additional elements are also considered important. These include gender-sensitive education and counselling on sexuality; providing care during pregnancy, delivery and postpartum; monitoring infant growth and development with particular attention to the girl-child and her nutrition to ensure that she grows up in an environment conducive to the development of her sexuality; taking care of people's concerns over sexually transmitted diseases and infertility; HIV/AIDS prevention; and the prevention and management of unsafe abortion and the provision of safe abortion services where legal.

Since all these different elements of sexual and reproductive health are connected, gains in one area will more than probably have beneficial repercussions in other areas. People are much more likely to take advantage of family planning services when they find their other sexual and reproductive health needs are being recognized as well.

As the ICPD Programme of Action records, surveys suggest that if more accurate information and affordable services were easily available, as many as 120 million more women would be using a modern family planning method than do so currently. The growth in demand for services and the continuity of contraceptive use are often directly related to the quality of family planning programs. The quality of services has been lessened by lack of adequate management skills, particularly in the least developed countries. Governments in Cairo noted their responsibility for creating a climate favourable to high-quality reproductive and sexual health care, but also acknowledged the important role of non-government organizations which are closer to their constituent groups and often better able to represent their voices.

The Conference stressed that the full involvement of client groups is an essential element in ensuring the acceptability and appropriateness of information and services to their users and to an assessment of quality. Women are often not treated with respect, or guaranteed privacy or confidentiality, nor do they always receive full information about the options and services available. These basic rights are elements of quality of care highlighted in the Cairo document.

The sad reality is that sex is still a potentially dangerous business for women: pregnancy and unsafe abortion are still the leading causes of death among women of reproductive age in many countries. Regrettably, decrease in public health spending and structural adjustment programs in many countries have adversely affected access to health services, including those for reproductive health services. Too many governments have been slow to provide the information, education and services women require. Establishing sexual and reproductive health service costs money. Frequently, it costs political capital too. In many parts of the world, both kinds of currency have been in short supply.

It is intrinsic to the new approach that Family Planning Associations should look at priority needs and this may require them to move resources away from thriving, successful clinical programs to concentrate on reaching the poor and under-served through more difficult and expensive outreach services. This not only creates a dilemma about the existing program, but raises concerns about how these actions are to be justified to donors.

However, a number of Family Planning Associations in different regions have been successful in making programs sustainable through cost recovery or alternative sources of funding, allowing them to shift resources to areas of greater need. Some Family Planning Associations have found that adopting the sexual and reproductive health dimension increases their popularity, allowing additional costs to be recovered from clients.

Many Family Planning Associations have collaborated at the regional level to take forward the messages from Cairo through innovative initiatives to increase women's empowerment and ultimately control over their own reproductive health.

In the South Asia Region, there is a shortage of basic information about sex and reproductive health, especially since these subjects are not widely or openly discussed. A major sex and reproductive health education project, known as 'Sexwise', has been undertaken with the BBC World Service Radio to broadcast programs on different aspects of sexual health in eight regional languages.

The Cairo document refers specifically to the active discouragement of harmful practices such as female genital mutilation. Several Family Planning Associations in Africa have intensified their efforts and emphasis in their programs to campaign with community leaders for the eradication of this practice. The Kenyan Family Planning Association's program against female genital mutilation is particularly effective in its approach and results.

Other initiatives have sought to raise the profile of the Cairo Programme of Action. A conference organized by the IPPF Arab World Region on operationalizing ICPD was held earlier this year. The need to translate the enthusiasm generated at the ICPD into effective action in the region was stressed at the Conference, in addition to the duty of non-government organizations to remind governments of the commitments they have made. At Cairo, there was a clear acknowledgement of the important part these organizations have to play in mobilizing community and family support for reproductive health programs and in co-operating with governments to ensure promises are followed by action. Programs are much more likely to succeed if they are owned by those who will be affected by them, starting at the grassroots. The involvement at Cairo of religious leaders in the population debate also represented a crucial step in raising awareness of reproductive health as an issue of human development.

Under the Federation's newly appointed Secretary-General, Mrs Ingar Brueggemann, IPPF itself convened an expert group meeting in London in October 1995 on Operationalizing Sexual and Reproductive Health. Under the chairmanship of Professor Mahmoud Fathalla, senior international and regional staff and representatives of national family planning associations discussed and clarified the concepts and contents of sexual and reproductive health programmes, and provided guidance to family planning associations on the kind of options available and the criteria for choosing among them. A report on the meeting is available from IPPF (1995).<sup>11</sup>

Many donors are aware of the risk-taking role played by Family Planning Associations and it is generally acknowledged that a transitional period is necessary when benefits may be limited or difficult to show. Efforts to make donors partners in the sexual and reproductive health approach might lead to a middle ground, where donors' concerns to address the needs of individuals are met and in the process development and demographic considerations are also satisfied.

The Cairo Conference called for spending on family planning and broader reproductive health programs to rise to US \$17 billion by the year 2000, of which about a third, or US \$5.7 billion, would come from the international donors, the remaining two-thirds continuing to be found by the developing countries. So far, there are few signs that international donors are willing to provide these additional resources. Family planning associations and other non-government organizations therefore face problems on how far they should undertake the full range of sexual and reproductive health services.

Whether or not extra funding is forthcoming on the necessary scale, progress can still be made by multilateral organizations and all development assistance agencies intensifying their collaboration and seeking ways of achieving complementarity in providing services. Without the infusion of funds from international donors and the realization of a common purpose to accommodate the needs identified in the Cairo Programme of Action, ICPD will, in the words of Dr Nafis Sadik, 'remain a paper promise'.

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## **Implementing the ICPD's message**

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Progressive elements of the population establishment and of women's groups managed to achieve a consensus at the International Conference on Population and Development (ICPD) in Cairo on how to stabilize the world's growing population and, at the same time, improve women's health and well-being. While the academic community will continue the sterile debate on the relative importance of development versus family planning programs for fertility reduction, the issue was put to rest, at least in the international policy arena, for the first time at the conference. Both the need for providing the means to reduce unwanted fertility and the importance of creating conditions favourable to promoting the desire for smaller families have been recognized. The main message constitutes two elements: provide contraceptive methods within broader reproductive health services, and enhance women's equality in education, health, and economic opportunity. These are tall orders for any government.

The implementation of the ICPD's main message would require an ideological transformation both for the population and for the development establishments, and a realignment of turfs in the national and international bureaucracies, which are used to working with sectoral mandates.

### **Implementation of a broadened population policy**

Traditionally, population policies, concerned with the reduction of population growth and fertility, have been implemented by means of organized family planning programs. A broadened population policy, concerned with improvements in gender equality, would, therefore, present a major challenge to existing institutional mechanisms.

To bring about a reduction in gender disparities with regard to education, health, and economic opportunity would require implementation of gender-sensitive social and economic policies. Implementation of such policies, however, falls outside the purview of a country's family planning program (designed for the population sector), but this is exactly what the entire development sector is supposed to do. About 98 per cent of the funds allocated for all development activities are spent on sectors other than that of population. The efficiency of these expenditures must, therefore, be improved in order to promote women's equality and to create conditions conducive to lower family-size preference. In brief, the mainstream development process must incorporate the reduction of gender disparities as its primary goal.

Not only do population and women's groups have no leverage concerning the way funds for development are spent but also no bureaucratic mechanism exists to implement such an agenda. Within the United Nations system, for example, the United Nations Population Fund has no influence over the resources allocated for improving child health, female education, or economic opportunities for women. These funds are controlled by other UN agencies. Similarly, the Office of Population within the United States Agency for International Development and the departments of family planning in other national governments have no leverage over the funds required to empower women so as to create conditions favourable to a preference for smaller families. Some mechanism, therefore, must be created to make expenditures for development consistent with the objective of reducing gender disparities.

### **Reproductive health and family planning programs**

Whether to provide reproductive health services is not an issue. The issues are: who should provide and pay for these services and why?

Since the ICPD, much discussion has centred around the question of how to integrate reproductive health and family planning. At one level, the solution is simple: because the spread of contraceptive use is expected to reduce the risk of pregnancy and, therefore, maternal mortality (and consequently can be viewed as a part of reproductive health), a simple computer program could be used to search for and replace the phrase 'family planning' with 'reproductive health and family planning' in all official documents. This change, however, would not affect the scope of the services provided.

It can be argued that contraceptive services should be subsumed within reproductive health programs, which, in turn, would be subsumed within broader health services. The problem here is that reproductive health may not receive as high a priority among all health issues as its advocates wish. Moreover, both contraceptive and health services have their own separate constituencies and budgets; by contrast, reproductive health has some constituency but no independent budget. Thus, reproductive health advocates would have to work both with family planning programs and with health programs to ensure the delivery of all reproductive health services.

In order to design family planning programs that provide reproductive health services beyond those required to distribute contraceptive methods, we need to understand why these programs have not paid attention to health issues related to reproduction.

While the establishment of family planning programs has been guided by multiple rationales, the overriding intent of governments and donors has been to reduce fertility and population growth. By contrast, the reproductive health approach focuses on individual rights and well-being. Because of the demands made by reproductive health advocates, family planning programs are now being pulled in two directions: they are expected to improve individual well-being and to reduce a society's overall fertility. A focus on individual well-being would contribute to the achievement of the social objective by reducing unwanted fertility. In this respect, the two objectives are consistent. However, a focus on the reduction of population growth and total (wanted and unwanted) fertility has led some programs to use undesirable means, such as monetary incentives to clients and providers, method-specific quotas, and coercion. In this fashion, the two objectives, under certain circumstances, can be inconsistent.

Some managers and donors (internal as well as external) of family planning programs are likely to be concerned that a focus on only individual well-being may reduce funds for these programs. Moreover, a reproductive health approach would divert funds from contraceptive to reproductive health services. Under these circumstances, managers are likely to implement the reproductive health approach only if they think it is a cost-effective way to reduce total fertility or if the primary objective of family planning programs is redefined. A convergence of the interests of reproductive health advocates and family planning program managers is easy to envisage in terms of the provision of services for safe abortions, because the availability of these services would reduce fertility, expand choice, and reduce maternal morbidity and mortality. However, no empirical evidence supports the idea that adding other reproductive health services, such as treatment for reproductive tract infections or sexually transmitted diseases, is a cost-effective way of lowering fertility. Furthermore, efforts to gather such evidence are unlikely to be productive. What if empirical research shows that the addition of services to diagnose and treat such conditions is not as cost-effective in reducing fertility as are incentives to providers and clients? Moreover, since the objective of offering reproductive health services is to improve the health of individuals, provision of these

services for the purpose of reducing fertility and evaluating their effectiveness based on their ability to attain that goal would not be justified.

In order to include reproductive health services within family planning programs, the primary objective of these programs should be defined in terms of empowering individuals to achieve their own reproductive intentions in a healthful manner. The first part of this objective maintains the link with fertility reduction by focusing on unwanted childbearing, and the second part extends the link with reproductive health services. A practical strategy could be designed so that those reproductive health services that interact directly to reduce unwanted childbearing safely are paid for and delivered by family planning programs, whereas other issues of reproductive health become the responsibility of health programs.

Acceptance of the proposed objective for family planning programs will have profound implications for the design of services, their costs, and the evaluation of their performance. One way to redesign contraceptive services from a reproductive health perspective is to deal with the contra-indications of each method, by developing standards for screening, and focusing as well on diagnosis and treatment (including referral for treatment) of these conditions. Monitoring compliance and incorporating the occurrence and treatment of reproductive morbidities should also be part of the evaluation of these programs. The cost estimates of offering a method through a program with such an approach should include not only commodity costs but also the costs of screening for and diagnosis of contra-indications, and treatment of such conditions, and the costs of diagnosis and treatment of adverse reactions to that contraceptive method. The effect of family planning programs could then be assessed in terms of their combined outcome, reflecting both the avoidance of unwanted and unplanned childbearing and associated reproductive morbidity. Such an assessment could be facilitated by an index called HARI, an acronym for Helping Individuals Achieve their Reproductive Intentions (Jain and Bruce 1994).

#### **Suggested role of the population sector**

Implementation of the ICPD's main message would require that we go about the tasks of development and family planning differently. What can the population sector do to facilitate the entire process? While the temptation may be strong for it to focus only on the scope of services, to neglect completely the development and implementation of a broadened population policy would be a mistake.

First, the population sector can promote the elements of the main message to a wider audience so that they may be endorsed at various national and international forums. Second, it must accept that the achievement of replacement fertility sooner rather than later will require more than organized family planning programs. Third, it should revise the primary objective of and the main evaluation criteria for family planning programs in such a way that serious attention is paid to reproductive health issues. Fourth, it should forge alliances with like-minded development professionals so that other development sectors increase their efforts to reduce gender and other kinds of inequalities in education, health, and economic opportunity. Fifth, the population sector must mobilize and devote the resources required to delineate these roles and responsibilities and to identify institutional mechanisms to implement the population and women's agendas.

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## **A view from Turkey: men as well as women**

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The Programme of Action says (4.24),

... in most societies men exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and programme decisions taken at all levels of Government. It is essential to improve communication between men and women on issues of sexuality and reproductive health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private life.

Then the objective is stated (4.25): 'to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles'.

The Programme of Action mainly focuses on empowering women so that they can make their own reproductive decisions (independently from men?), using contraception and health care provided by the health system. To be even handed, male reproductive health ought also to be considered, which would require attention to urology and infertility as well as gynaecology in the reproductive health services. However, in the Programme the place of men is mostly not considered, except for the quotations above, which ask that men support women; the theme is 'responsibility', which translates roughly into 'give support, but do not interfere', consistent with the North American feminist demand that women have total control.

In this view from Turkey, we try to ground these generalities about men's and women's roles and relationships by showing what they are in fact. These notes present the views of people themselves about one of the important issues in reproductive health: choice of methods of birth control and considerations of reproductive health that are part of the choice process. They are based on ethnographic field research among working-class people in Istanbul during 1994 and 1995 (Angin and Shorter 1995).

In Turkey, during the decline of fertility which has reached near-replacement levels today, the principal method of birth control has been, and still is, male methods, mostly withdrawal, but also condoms. The family planners have achieved only limited success in persuading couples to use female-controlled medical methods. These facts about method choice are usually interpreted as showing that men are all-powerful and that they determine both the level of fertility and the way it is achieved. As Santow (1993) writes, referring to populations in the Ottoman region, inclusive of Turkey:

While the care of small children is a matter for women, the actual begetting of children or, rather, not begetting them, is a matter for men: just as husbands are expected to be the ones to initiate sexual activity, so are they expected to take charge of contraception (Santow 1993:779, 782).

The narratives collected in our ethnographic research warn us against thinking that the association of methods of birth control with the male or female body is enough information to know who decided when to control fertility and how to do so. Such associations are not able to explain the relative power positions and gender responsibilities for the choice of method. Thus, by observation of the method alone, one would not know how it came to be selected. One cannot say that the use of male methods engenders absolute power in male hands for the

management of fertility control and the effects this may have on reproductive health, even though in particular cases where men do have absolute power in matters of reproduction they choose the male method.

Furthermore, female power and negotiation with the spouse is often part of the 'equation' that results in the choice of male method. Both women and men in our study claim that choosing male methods and practising male responsibility are ways to escape from the risks of medicine. In many cases, men are persuaded to practise either withdrawal or condoms by women and by the cultural beliefs which say that male methods are natural, secure, and uncomplicated solutions for preventing pregnancies. We interviewed men who use condoms and withdrawal but who complained at the same time about reduced pleasure and that this was known by their wives as well, who nevertheless insisted upon it. The choice is 'reasonable' for them if they and their wives are concerned at the same time about the health and beauty of the wife, who they think would be adversely affected by one of the 'modern' contraceptives. From one of the narratives:

During the delivery you have to go to a doctor. They 'scratch' inside of you (she means that while doing something necessary, they create additional problems and pain). I do not want to go there for any other reason (except deliveries). I am really afraid ... still I use condoms. In fact, my husband does not want to use them. He wants me to have an IUD inserted. I heard that it is not useful for everybody. It can move to the stomach. My skin is very sensitive, it takes two years to heal. We will continue using condoms as long as he will use them—as long as I can 'deceive' him. In fact, they are *temiz* (no complications) in a way. You do not intervene in any way. That is, it is good.

Individuals culturally construct their own knowledge about reproduction and contraceptive methods, different from medical knowledge. As with other kinds of knowledge, the knowledge of reproduction and birth control is uncertain, unstable, constructed and imposed through relations of power (see Foucault 1976). Cultural beliefs about the methods of birth control and their degrees of pleasure, efficiency, healthiness and protection against infection circulate in the same way as 'natural truths' do throughout the society. As Kleinman (1988:10) puts it:

what is natural depends on shared understandings in particular cultures and not infrequently diverges among social groups. The meanings ... are standardized 'truths' in a local cultural system inasmuch as the groups' categories are projected onto the world, then called natural because they are found there.

Many women in the study want to keep their bodies in their natural harmony by staying away from doctors and medicine concerning the issues of choosing and obtaining a method of birth control and follow-up controls of the methods. Men and women believe that pills cause weight gain, headaches, and cancer. One should take a break while using them to prevent side effects.

When an IUD is used, this does not signify that the woman has obtained absolute power to manage her fertility. The IUD is sometimes a male choice and a means by which he can pass the action of contraception to his wife and monitor her behaviour at the same time. He may oversee her access to a health centre where she would have to go to have it removed. As explained in this man's narrative:

The best is an IUD. Others are harmful for one's health. In birth control, what fits my mind is an IUD ... On some issues one must think logically. Pills are harmful for a women's health. Those pills cause some women to gain weight. She has to take them regularly on

time. It is highly risky. The best is an IUD. It is guaranteed with respect to the others. 1500% ... IUDs are very good for some women. It is a matter of getting used to it. It is a device like a colander. You have it placed in the woman. She needs only a few days to become used to it. It may cause an allergy. It may cause injury. It may cause nothing. If you see there is something wrong with your wife, it means you cannot use it. You have to have it taken out. It may even cause cancer. Of course, it does if there is a problem with the adaptation, but if it is okay ... Anyway when we had it inserted, the doctor said: 'you will come to me for a check-up one week later'. When you go for the check-up after one week or fifteen days, if you feel OK, the IUD is the best. Those pills and others are a tale. I mean they are a bit of a primitive method. There is a problem if you do not take them on time.

As these notes show, men are implicated in matters of women's reproductive health, they do take 'responsibility' in the ways that this culture understands, and women are often partners in persuading them to do so. Limits on the number of children are as much a male as female concern. The principle of the Programme of Action that these matters should be the exclusive concern of women is simply not accepted. Public policy and services must address both parties and find a way of accepting male as well as female determination of the courses of action that affect reproductive health—of both parties.

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### **Family planning reproductive health: the neglected factor**

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A fundamental theme in the discussions surrounding ICPD and at the Cairo conference itself was that institutional population programs are too often concerned with demographic targets at the expense of women's needs and women's dignity and autonomy. Family planning, in such a context, had become simply the means to an end, that of lowering fertility, rather than 'a legitimate end in itself' (Cohen 1993).

The Programme of Action adopted at ICPD attempted to respond to these criticisms by redefining the role of family planning. The document (UN 1995:30) states that the reproductive health, within the WHO context of complete physical, mental and social well-being, implies 'that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so'. Implicit in this last condition, the Plan continues, is the right of information about, and a choice of methods for, family planning.

Thus the right to choose, first enunciated at international level in the 1968 Teheran Declaration of Human Rights but still an unfulfilled goal emblazoned upon feminist lapel

buttons, has moved from being an underlying principle to a 'legitimate end in itself'. Indeed, the sole aim of family planning programs, as described in the document,

must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and have the information and means to do so and to ensure informed choices and make available a full range of safe and effective methods (UN 1995:30).

Family planning, then, is unequivocally a reproductive right; what is its relationship with reproductive health? This is not easy to establish, in part because the chapter 'Reproductive rights and reproductive health' is remarkably unspecific about reproductive health issues. Sexually transmitted disease and HIV/AIDS do get considerable attention, but otherwise there are only scattered references to such items as female genital mutilation, or adolescent pregnancies. If one turns to the chapter on 'Health, morbidity and mortality' in search of further clues, it is to discover that here women's health means maternal, rather than more generally reproductive, health. Nevertheless, within that context, the chapter does at least identify complications relating to pregnancy and childbirth, unsafe abortions, and nutritional deficiencies, and suggests that family planning programs have a role to play in reducing morbidity and mortality from these conditions.

By contrast, while the Programme's chapter on 'Reproductive rights and reproductive health' does have, as one of the six Objectives described under the section on family planning, 'the prevention of unwanted pregnancies and morbidity and mortality' (UN 1995:30) the detailed recommendations for action make no reference to any possible role of family planning programs in such an objective, except through helping to prevent the spread of sexually transmitted diseases and HIV/AIDS. The sole mention of birth-spacing, better maternal and child health and child survival comes in the context of breastfeeding, which family planning programs are urged to promote because breastfeeding contributes to such health gains.

In short, one chapter talks a great deal about (undefined) reproductive health, in which reproductive choice is simply a free-standing ingredient and an end in itself; the other concentrates on maternal health and includes family planning among the means to improve health outcomes. Contradictions between the two viewpoints are compounded when the latter chapter, apparently reaffirming the Alma Ata Declaration on primary health care, changes the original. Where 'maternal and child health care, including family planning' was among the primary health care components, countries are now asked to provide 'reproductive health care'.

Neither position is entirely satisfactory as a blueprint for future programs, but the first is perhaps the most dangerous. Family planning is not just an end in itself, but an essential component of primary health care which provides a major contribution to reproductive health. In terms of reductions in mortality, the direct benefits to women and their children of postponing early childbearing and spacing pregnancies are well-established, and surely do not need repeating here (see, e.g. WHO 1992; UN 1994).

In addition, however, contraception offers the possibility of considerable reductions in reproductive morbidity amongst women which, as with all morbidity, is less well documented, but is nevertheless recognized. A reduction in the number of pregnancies itself reduces the frequency of risk of childbirth-related ill-health, including for example genital prolapse, which appears to be common amongst women in the Third World (Younis et al. 1994). Nutritional deficiencies including anaemia, the prevalence of which amongst pregnant women rises from 40 per cent in Africa to 88 per cent in India (World Bank 1993), are exacerbated by frequent pregnancies and breastfeeding. Menstrual problems, especially dysmenorrhoea, which are widely-reported reproductive complaints (Omran and Standley

1976) can be considerably reduced by use of the oral contraceptive. The most common cause of female infertility, infections leading to disease of the Fallopian tubes, may be reduced by the use of condoms. Other consequences of pelvic infections (which condoms could help women to avoid) include increased risk of ectopic pregnancy and cervical cancer, as well as continuing pain and discomfort. Pelvic infections may also affect the survivors of unsafe abortions, the incidence of which could be reduced by access to contraceptives.

If contraception is good preventive medicine, it is also a significant ingredient in the broader agenda for women which was outlined at ICPD and spelled out more fully at the Beijing International Conference on Women, 1995. The ability of women to complete schooling and further training is all too often thwarted by pregnancy, whether outside or within marriage: so too is the chance of employment. More subtly but fundamentally, a woman's empowerment is dependent to a considerable extent on her ability to make her own fertility decisions. If reproductive health is indeed a matter of mental and social, as well as physical, well-being then these attributes of family planning are also health benefits.

Reproductive health programs which fail to take into account this primary health care function of family planning are likely to concentrate disproportionate effort and resource on curative interventions. Those interventions in themselves create the kind of expanding spiral all too familiar in the history of medicine, in which, as the scale of the immediate 'problem' is better recognized, resources are diverted increasingly to its containment. The resources are not simply financial. Staff, too, whether doctors or health workers, are more likely to respond to the challenge of alleviating or curing pain and sickness than to handing out the condoms or pills which might prevent its occurrence. Family planning 'integrated' into maternal and child health programs has too often become a residual: how much less will it weigh in the scales against the whole gamut of reproductive ill-health?

Furthermore, if family planning is seen solely as a question of providing choice, the issue of appropriate methods for particular circumstances may, paradoxically, receive as little attention as it has under the most demographically-driven programs. Offering a comprehensive method mix together with comprehensive information may not be enough if a woman is not aware of whether she has a reproductive tract infection, and if the service has neither the skills nor the resource to help her establish that fact. As a recent thoughtful study (Zurayk, Younis and Khatlab 1994) noted:

At a minimum, disease conditions that are contraindicated for methods of contraception should be of concern to a family planning policy, particularly those conditions prevalent in communities covered by family planning programmes.

Naturally, it can be argued that reproductive health programs would indeed concern themselves with such issues: my point is that even basic family planning programs already have, or should have, a broader mandate than facilitating fertility decisions.

The question is how far should they go? Clearly, further than merely being a component in maternal and child health programs. That alternative, classical, focus ignores the very real needs of young people and those not currently married; in a number of countries such people are specifically excluded from family planning programs. That focus gives little emphasis to the role of family planning as a change-agent in women's empowerment and status, for it concentrates upon women in the context of their most traditional role. In addition, an apparent focus on maternal and child health has, almost invariably, resulted in the real attention being given to the health of children, with a mother's health problems relevant primarily insofar as they affected child survival.

But if family planning is more than an end in itself, and more than an ingredient of maternal and child health, it does not necessarily follow that family planning programs can,

or should, attempt to shoulder the whole burden of reproductive health. Many have urged their involvement, claiming, for instance, that

Family Planning programmes can provide the appropriate contexts for the prevention activities required to stop HIV transmission. These include STD prevention and control programmes, condom promotion and IEC programmes directed at changing behaviour which facilitates HIV transmission (Oppong 1995:21).

However, as Setel (1995) notes, testing and counselling HIV-positive women in Africa have failed to induce significant changes in reproductive action, and even if counselling had a demonstrated effect, 'there are numerous practical and contextual limitations on the role that intervention can play' (Setel 1995:1). Thus, while family planning programs may have a limited role in HIV prevention (in public education and condom distribution, for example) unrealistic expectations of their scope can lead only to disillusion.

Indeed, in many countries the crucial issue is not the development of broader reproductive health programs but developing reasonable family planning programs as an intrinsic part of primary health care. In too many instances programs cannot meet even the basic conditions assessed by the Population Council (Mensch et al. 1994) under its Situation Analysis inventory: is there running water? A dustbin? An actual supply of the contraceptives theoretically offered?

The World Bank (1993) estimated that, in order to implement its minimal Essential Public Health and Essential Clinical Health Packages—both of which concentrate heavily on the health of women and children, and include family planning and safe abortion—government health spending in the poorest countries would have to be doubled. With stagnant economies across much of Africa, for instance, and serious declines in international assistance by the donor countries, such a prospect appears increasingly Utopian. But an obvious priority is to build on what already exists to ensure good family planning programs which are recognized not only as a reproductive right, but as major contributions to improving women's reproductive health.

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## **ICPD and the feminization of population and development issues**

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The ICPD's program of action is remarkable for the extent to which so many of the central issues are viewed from a feminist perspective. Of course problems of gender inequity and inequality are an important component of the population debate and need to be addressed. Most commentators would agree without hesitation to the opening statement of Chapter IV that 'the improvement of [women's] political, social, economic and health status is a highly important end in itself'. But the dominance of this theme at Cairo has some unfortunate consequences and is all the more regrettable because the 1995 Beijing Conference on women offered a more appropriate forum for detailed considerations of gender issues. In this note, I shall ignore the many admirable features of the ICPD and focus on these unfortunate consequences. They include dubious premises, biased priorities, and confusing prescriptions.

### **Dubious premises: the position of women and fertility decline**

The opening paragraph of Chapter IV provides the key intellectual link between gender and population. Specifically, the assertion is made that 'improving the status of women.... is essential for the long term success of population programmes'. This proposition provides one of the main rationales for much of the ICPD rhetoric. It also carries huge implications for social and demographic policies of nations. But is it valid?

It has long been argued that the low status of women—including limited access to resources and income-generating opportunities and subordination to the control of males—is an important obstacle to demographic modernization. Improvements in the position of women are often portrayed as a precondition for the achievement of low mortality and fertility, a view endorsed at the ICPD.

There are several plausible pathways of influence. The most obvious one rests on an assumption that men are inherently more pronatalist than women, because they reap the benefits of fatherhood without bearing the burdens of pregnancy, birth and childrearing. To the extent that women lack decision-making power, they may be reproductive prisoners of male-dominated systems. The validity of this argument rests on whether men indeed do want larger families than women. Contrary to popular belief, a rapidly increasing body of survey evidence suggests that the reproductive aspirations of men and women are broadly similar in all major developing regions (Mason and Taj 1987). While incongruence between individual couples in childbearing desires may be common, at the aggregate level it appears that men

and women have an equal interest in family size limitation. This diagnosis is consistent with the fact that, despite the paucity of male methods of contraception, approximately one-third of contracepting couples in the world rely on such methods or on techniques that demand the co-operation of men.

A second obvious link concerns lack of alternatives to childbearing. In societies where girls receive less formal schooling than boys and where non-domestic employment opportunities for females are limited, women have little incentive to curtail childbearing. This argument has played a central role in demographic theories and is both familiar and persuasive. The creation of better employment prospects for women, it is claimed, increases the opportunity costs of childbearing and fertility itself responds to the new situation.

A huge amount of research has been devoted to assessments of these and similar propositions that appear to be self-evidently true. Yet the results have been largely negative. Neither at the societal level nor at the household level, has a decisive effect of employment on reproductive behaviour or fertility aspirations been demonstrated (e.g. UN 1987). In the post-Second World War era, fertility has declined sharply in societies where the participation of women in public life, including paid employment, was, at that time, minimal: Japan in the 1950s, South Korea in the 1960s and Bangladesh in the 1980s to cite but three examples. Moreover, fertility remains extremely high in West Africa where women have long enjoyed an unusual degree of economic and financial autonomy from their husbands.

The assertion that improvement in women's status is a prerequisite for sustained fertility decline thus rests on a very fragile empirical base. Much more consistent with the evidence is the view that the advent of reproductive choice, mass use of contraception and smaller family sizes represents a giant step on the pathway towards female emancipation and equality. This sense of liberation has always been one of the forces behind the international family planning movement. It is surprising and regrettable that it was not echoed at Cairo.

### **Biased priorities**

The ICPD plan of action has a real urgency when discussing women's issues that is largely absent when discussing problems of population growth and structure. Chapter III, on interrelationships between population, economic growth and development, is disappointingly bland. And in Chapter VI devoted to population growth and structure, the topic of fertility, mortality and population growth rates is dispatched in little more than one page; it generates a miserable two paragraphs of recommended actions. For a conference ostensibly devoted to population and development, there is a perverse sense of priorities.

This criticism is not an endorsement of the apocalyptic vision of some pressure groups. No doubt the planet will survive despite the probable doubling of population by the middle of the next century. Yet this continued increase, much of it an inevitable consequence of age structure, has huge implications that should have been at the heart of the ICPD document. Instead they were virtually ignored.

One such implication concerns the steep increases in the size of the potential labour force that will occur in many developing countries. Many of these countries already face severe problems of unemployment and underemployment. While prospects for educated and skilled elites in South Asia, Latin America and Africa may be bright as more labour-intensive activities relocate to low-income economies, it is much more difficult to be sanguine about the prospects of the much larger numbers of ill-educated and unskilled persons. Even in Europe, the problem of high unemployment among less skilled workers seems intractable. But the situation in many developing countries is far worse in terms of absolute numbers, future increases in job seekers and current levels of unemployment. What development strategies are most appropriate for those countries that will see a doubling of their adult populations in the next few decades? Will further globalization of the world's economy help

or hinder the massive task of job creation? There are no easy answers but this is no excuse to ignore the issue.

While some countries face problems associated with rapid population growth, others are more concerned about impending decline accompanied by acute population ageing. Population ageing attracts five paragraphs in the ICPD report. The topic of below-replacement fertility is totally ignored. The ICPD represented an ideal forum for discussion of the role of the State in attempting to influence the reproductive decisions of its citizens, whether in pronatalist or antinatalist directions. The report, with its emphasis on the reproductive rights of individuals, appears to deny State action any legitimacy in the reproductive domain. This stance is unrealistic and mistaken. Coercion in all its forms is rightly condemned but surely governments have a right, perhaps even a duty, to advocacy.

#### **Confusing prescriptions: integrated reproductive health services**

A constant refrain in the Cairo report is that family planning provision should no longer be seen as a separate service but as a component of a wider package of reproductive health services. Much of the relevant text is contained in Chapter VII but the same sentiment recurs in many other places. The tenor of the discussion is captured in paragraph 7.13 which states that 'family planning programmes work best when they are part of, or linked to, broader reproductive health programmes' and paragraph 7.16 which asks that 'all countries should... assess the extent of national unmet need for good-quality family planning services and its integration in the reproductive health context'. The text stops short of demanding total integration of family planning and related health services but clearly represents a significant move in that direction. Is this the best way forward?

There is much to recommend this stance. Clinical examinations at family planning centres offer valuable opportunities for health screening, just as postnatal checks offer opportunities for family planning counselling. In countries where sexually transmitted diseases, including HIV, are common, it is a public health scandal that family planning services have done so little to promote methods that offer dual protection against conception and disease.

At the same time, the evolution of family planning programs over the past 50 years has often taken the opposite pathway: away from clinics and medical control and towards the community and the marketplace. The contribution of the private sector, of social marketing schemes, and of community based distribution towards overall contraceptive provision is already appreciable and is growing. These distribution strategies represent greater choice for clients, better access, greater convenience and often greater confidentiality. None of them, however, is very amenable to the concept of integrated reproductive health services, with their stress on clinical skills and diagnostic procedures.

The net result of these tensions is likely to be confusion, both at national level and among donors. Optimal solutions are likely to be context-specific. They will depend on the disease environment, and strength and nature of existing public sector services. Badly needed also is applied research to assess whether more integrated services, particularly the linking of family planning with STD services, are acceptable to clients and cost-effective. The answer is unpredictable. Historically, these two types of service have not dovetailed well. However, past failures should not thwart fresh attempts.

#### **Conclusions**

The ultimate question to be asked of the ICPD is whether it matters much, outside the UN family for whom it constitutes a blueprint for action. Past political conferences on population left no decisive imprint. At Bucharest, much of the rhetoric was hostile to family planning

programs but these were pursued with even more vigour after the conference than before. The Mexico conference, hijacked by a maverick United States delegation, is perhaps best forgotten. It remains to be seen whether the Cairo conference will have a lasting effect. Much depends on the actions of the World Bank and the larger bilateral donors who command much greater resources and influence than the UN system.

### **Cairo revisited: some thoughts on the implications of the ICPD**

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The United Nations International Conference on Population and Development (ICPD), held at Cairo in September 1994, was an important landmark in the modern history, not of population, but of the women's movement. More than any earlier intergovernmental population meeting, Cairo squarely faced many delicate issues involving the most profound interests of women. The meeting addressed the question of the education of girls and women; it took a position on the responsibilities of government to provide gainful employment of women; and it committed the world to a policy aimed at the empowerment of women. In an important sense, Cairo marked a turning point in the globalization of the women's movement. It was not, however, a step forward for the population movement, which for many years has given primacy to efforts to limit population growth.

In the aftermath of Cairo, the population movement finds itself in a quandary. Stated in the simplest terms, governments, intergovernmental bodies and non-governmental organizations have been committed to a greatly expanded mandate without assurances of increased resources. Even before the conference itself, participants in the ICPD process were aware that the proposed programs would be expensive. New ground was broken by the inclusion of rough estimates of the additional costs needed to provide a broader array of reproductive health services. Since the conference, however, efforts to extract additional financial commitments from governments, especially the rich donor governments of the West, have proved difficult. While the United Nations Secretary-General's first report on fund-raising for reproductive health, including family planning, attempts to put a good face on it, the truth is that few significant commitments have been made (United Nations, Commission on Population and Development 1995). The question of resources for the broader 'development' recommendations in the Cairo Programme of Action was not seriously addressed at Cairo but was referred to the Social Summit held in Copenhagen in 1995, where attempts to obtain commitments from governments were also only modestly successful.

To understand what happened in Cairo, and to comprehend what might be its effect on family planning programs around the world, it is not sufficient to approach the conference and its Programme of Action with the eye of a financial manager or accountant; rather, it demands a perspective that is both historical and philosophical. Cairo was not just another United Nations population conference. In the view of most participants and observers, it was a breakthrough for women's groups, which played an unprecedented role in shaping the agenda and de-emphasizing its demographic and population aims. Cairo added a critical impetus to the women's revolution that has been unfolding for many years in the West and, more recently, diffusing through cultural links to developing countries, where it is now becoming established in such diverse places as India, Brazil and Nigeria. That Cairo was co-opted by women's groups was made clear both by the ubiquitous presence of women in the preparatory process, and by their numbers and influence on national delegations at the ICPD. The power they wielded is most evident, however, in the predominance of women's concerns

among the 'new issues, new approaches and new actions' that appeared in the Programme of Action (United Nations Population Division 1995:2).

Our choice of the word 'revolution' in the context of Cairo was made advisedly to mean that we are witnessing a radical change in the role and status of women throughout the world. Changes of this sort are neither easy nor simple, nor do they happen overnight. History tells us that revolutionary forces are not monolithic but contain within them many factions that come to the fore, recede, form coalitions and split asunder in response to events that take place, often over decades. The women's movement that came together at Cairo in 1994 is no exception. Its ranks comprise many distinct entities that focus on women's health, or rights, or empowerment, or social and economic development, or other concerns that are less easily categorized. Fissiparous tendencies are also present, not only among the main categories but also within them, as national or regional factions may form around specific local interests. At Cairo, one of the strongest unifying forces was the outright rejection of 'traditional' family planning that less than a generation ago was regarded as a liberating program of social change, vital to the advancement of women. At Cairo, also, the underlying threat of cleavage was reduced by a strong tendency to close ranks against the Vatican's resolute attack on abortion liberalization, the legitimization of the 'non-traditional' family, and some aspects of reproductive health.

These considerations go some way toward explaining the difference in tone and substance between the ICPD and the two previous population conferences. In the years since Mexico City, Western feminists, together with their developing-country counterparts, had elaborated a broad agenda for action on women's issues; they had also developed a strategy for taking it to each of the major intergovernmental conferences that were planned around the United Nations' 50th anniversary in 1995. The product of the Cairo meeting, the Programme of Action, with its array of recommendations, is perhaps best viewed as a manifesto for a vision of an ideal world, rather than as a serious plan intended for full implementation.

It is a tribute to the organizational capabilities of women's groups, no less than the power of their message, that they were able to enlist and maintain the support of foundations, NGOs, and even normally intransigent government delegations. Indeed, the momentum generated by the preparatory process may have blinded participants to some of the political and economic realities that are now making their presence felt. Delegates seem to have forgotten that governments do not commonly make national policies in the glare of international meetings, but rather, in the dimmer light of home, where binding decisions are made by political leaders sensitive to budgetary constraints and aware of other proposals competing for funds. Secondly, the euphoria generated by near-universal support for the Cairo agenda obscured the mismatch between the costly budgetary requirements of the Programme of Action and the serious economic problems being experienced by virtually all of the main donor countries. A third unrealistic expectation stemmed from the failure to appreciate that while government delegates to population conferences tend to support liberal social policies, the reins of power in many donor countries are currently held by fiscal and social conservatives who are opposed to many of the Cairo provisions. Despite the leading role played by the Clinton administration in developing the Cairo agenda, for example, the fiscal year 1996 Congressional appropriation for population and family planning has been delayed, cut by 35 per cent, and required to last for 15 rather than 12 months (*Congressional Record* 25 Jan. 1996:886).

What does all this mean for the quality of family planning programs in developing countries? This is a complex question, the answers to which will not be known with any certainty for several years. Yet there are a number of points that can be made now. First, if broader, more comprehensive programs are attempted without additional funds either coverage will be reduced or quality will decline, the most likely prospect being that both

elements will suffer. Secondly, in the enthusiasm over their growing success in the Cairo preparations, the drafters of the Programme of Action have stated as established fact some critical relationships between development variables and population change that should be seen as hypothetical. For example, the Programme of Action states that 'Improving the status of women also enhances their decision-making capacity ... especially in the area of sexuality and reproduction. This ... is essential for the long term success of population programmes' (United Nations 1994, Para. 4.1). This assumption oversimplifies the relationship between women's status and fertility.

Moreover, even the relationship between women's education and fertility, which is identified as the main programmatic link between status, empowerment and fertility, appears to be somewhat complicated. While it has long been established that educated women have fewer children than uneducated women, there is growing evidence that this is not a simple relationship but one which interacts with the level of development, culture, and a number of other variables (Jejeebhoy 1992; Martin 1995). None of this is to suggest that women's education, status and empowerment are not highly desirable objectives that should be pursued in their own right; it does mean, however, that their value as instruments of population policy is yet to be established.

In considering the effect of the Programme of Action on the quality of programs, it is no longer sufficient to lump all developing countries together. In countries such as those in Southeast Asia, where family planning has become institutionalized and there has been economic and social development, it is likely that some broadening of reproductive health services could take place without loss of quality and with benefits to individuals and the community. Many of these countries, however, have lowered their birth rates and have already 'graduated' from population assistance. The present remarks address the poor countries, in which quality is uniformly low.

The Cairo document carries a pervasive sense that the quality of family planning programs should be largely defined by the breadth of the reproductive health services within which family planning services are embedded. This implicit hypothesis does not accord with the realists of the poorest countries such as many of those in sub-Saharan Africa, and in parts of Latin America and South Asia. In these countries, where fertility has barely started to decline and little socio-economic development has taken place, the quality of services is primarily conditioned by poverty. The problems facing virtually all government programs in such countries are those of limited financial and human resources, fragile organizational structures, poor education, training and supervision, coupled with growing demand derived simply from rapid population growth. Under these conditions, family planning commonly suffers from weak public demand and also, though less often than in the past, from a lack of commitment by the leadership.

In this context, it is necessary to remember that ministries of health generally lack the political muscle to be a major influence in the inter-ministerial struggle for funding. Although ministries of health routinely integrate related services, a practice in which they are encouraged by WHO, this does not mean that they have the organizational and resource capacity to include an expanded range of reproductive health services without a loss of quality.

The Cairo Programme of Action is not the first United Nations document to include family planning in an integrated combination of services. Something similar was attempted in the primary health care initiative that grew out of the World Health Organization's Alma Ata conference in 1978 (WHO 1978). Although the services subsumed under the rubric of primary health care differed from the reproductive health services of the ICPD document, it is instructive to consider the fate of the family planning component of this program. While the purely health components of primary care that were given specialized attention—oral

rehydration therapy and the expanded program of immunization, for example—family planning was most commonly allowed to languish. Although this is not the place to analyse how this neglect occurred, the sensitivity of the subject, the lack of push from the top, and the orientation of the medical profession all contributed.

Thirty years ago, the appearance on the market of safe, effective and easy-to-use contraceptives revived the Western movement for women's liberation, which had lain dormant since before the Second World War. The freedom to choose the number and timing of their children was seen by women as an essential first step in their march towards full equality with men. In 1968, the Teheran Conference on Human Rights affirmed the basic human right of couples to decide on the number and spacing of their children (International Conference on Human Rights, 1968. Resolution XVIII). Since then, the international population movement has succeeded in making that abstract right a reality in many poor countries; in doing so, it has lowered population growth, fostered social and economic development, and laid a foundation for achieving a rise in status and greater empowerment for women. The contraceptive revolution is not yet completed, however, and there remain many countries in which it has barely started.

It is still too early to measure the effect of Cairo on family planning as newly designed integrated programs have not yet gone through the bureaucratic, policy, and budgetary process to reach the field. However, without significant new resources neither family planning nor reproductive health programs will prosper. While both women's groups and family planners can find support for their positions within the several chapters of the Programme of Action, the Cairo process exposed and intensified the differences between them. The real need is to re-establish family planning as an important component of the women's revolution, not only for the benefit of the individual but also for the community and society.

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## **The crisis in international family planning**

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International family planning faces an unexpected crisis. The number of women of fertile age is rising and desired family size is falling, but many of those who want to limit the size of their families cannot afford the full cost of modern contraception. At this moment of exploding demand, the resources available to assist those who want to control their fertility are undergoing a sudden decline. This crisis is deepened by the imperative of AIDS, which can be slowed only by using some of the same technologies, logistics, service and informational systems that family planning also uses.

With increasing numbers of women of fertile age and rising contraceptive prevalence, the number of couples using family planning in developing countries (excluding China) could increase from 200 million in 1990 to between 330 and 385 million in 2000. The International Conference on Population and Development (ICPD) at Cairo in 1994 set a target of US \$17 billion annually by the year 2000 to pay for reproductive health (family planning, STD control, safe motherhood and demographic analysis) in developing countries and in the former Eastern Bloc. The family planning component was costed at US \$10.2 billion in 2000, of which an estimated US \$5.7 billion would come from the donor governments, with the remainder coming from the countries themselves.

There is no evidence that budgets set at Cairo will be reached: indeed the trend is downwards. The US Agency for International Development provided 46 per cent of the US \$774 million given by Western governments to international family planning in 1991 (PRISM 1995). As part of a continuing resolution designed to keep the US government functioning, the obligation for fiscal year 1996 was cut from \$546 to \$72 million (Potts 1996). This is an unprecedented and catastrophic cut and will not be made up by other donors. The total British foreign aid budget for 1996 has been cut by 5.4 per cent and it is expected to fall by 18.8 per cent in 1997/98. Japan and Germany have proposed increases in support of international family planning. The Wellcome Trust in the UK is giving £ 50 million over five years, but a few committed donors cannot conceal the fact that budgets are far below the ambitious trajectory set at Cairo. Despite the excellent publicity associated with the ICPD, many international donors remain wary of anything to do with family planning. France and Italy give only a few cents per capita per year. Many of the countries with greatest need of help are themselves getting poorer. For example, in 1981 the government of Kenya spent US \$9.5 per capita per annum on all aspects of health care, while it could afford only \$4.5 in 1991.

The collision between rising demands and falling resources for international family planning is immediate and real. Fortunately, the demand for family planning is so strong and so much is known about effective delivery systems that a great deal can still be achieved if clear policies are set and appropriate priorities are followed.

### **An unfocused document**

The ICPD set a series of broad goals concerning reproductive health and the status of women. Much attention was paid to definitions and philosophical objectives but numerical targets and costs were dealt with superficially. Estimated costs were calculated on the simple basis of multiplying the number of couples using family planning under the medium UN projection for global population by a constant \$16 per couple-year of protection (CYP). Some people,

however, use non-clinical methods, while others pay for their contraceptives on the open market. The estimates for the cost of safe motherhood and STD control were even more vague.

Only a little over one per cent of foreign aid flowing from OECD countries goes to family planning; and much of that small sum is not focused directly on meeting the unmet demand for family planning.

Incontestably, women in developing countries suffer many social injustices and their reproductive health is often gravely compromised. A compelling case can be made for increasing investment in all aspects of women's development. The '20/20' formula where nations and international agencies each commit 20 per cent of their budgets to the social sector deserves support. The ICPD confuses development sectors: female education, for example, must be financed from the 98 or 99 per cent of foreign aid that goes to sectors other than family planning and population. To take money out of declining family planning budgets for anything except basic family planning access would undermine already inadequate support for family planning and tragically short-change broader aspects of women's development, which deserve investments much in excess of the one or two per cent of overseas aid dedicated to family planning.

#### **Setting priorities**

Those committed to health and population have an ethical obligation to ensure that limited resources are used to the maximum advantage of the most underprivileged groups: we must not only cut our coat according to the cloth, but we must ensure the coat is used to cover those in greatest need.

Much can be learnt from the successes (and mistakes) of the past 30 years of organized family planning. In Bangladesh the total fertility rate has plummeted from 7.0 to 3.4 in 20 years. These changes are not the result of socio-economic improvement (Bangladesh is amongst the poorest countries in the world), but they are the result of governmental and non-governmental systems making a range of family planning choices available through a variety of channels and of a concerted effort to deal with the public health consequences of unsafe abortion.

On the road to comprehensive reproductive health care, family planning is the first step; and for many women it is a giant leap forward. Without access to family planning choices, including safe abortion, no woman can be free in a social or political sense. In a poor country with a weak health infrastructure, such as Nigeria, child spacing and limitation as the result of family planning is one of the most practical steps that can be taken to reduce maternal mortality.

The ICPD set a goal of achieving increased access to reproductive health services 'no later than 2015'. Given trends in funding that have emerged since Cairo, it may be impossible to meet this target, but the international community can still set a priority of making basic family planning choices universally available over the next five years. Such a policy would include widespread distribution of condoms, which are also essential for STD control and HIV prevention. The next step on the road to comprehensive reproductive health care should be improved STD diagnosis and treatment. STDs are significant in their own right and important risk factors for HIV acquisition and transmission.

These goals could be achieved, even assuming reduced levels of international assistance, if the following eight points are observed.

### **International donors must secure an adequate supply of contraceptives**

There is a large and noble literature on the need to improve the quality of family planning services, but if contraceptives run out then every other aspect of reproductive health is futile. Even today, social marketing programs in Vietnam, Tanzania and several other places are forced to ration supplies because of shortages.

In the case of pills and condoms, competition between international manufacturers keeps prices for bulk purchase low. Local production in a country solves nothing if people are too poor to buy contraceptives when they come out of the factory. For the foreseeable future, the international community will have to meet many of the contraceptive supply needs of poor countries, such as Bangladesh, Ethiopia and Nigeria. It has been suggested that the UNFPA should set up an international group to purchase contraceptives in bulk for governments, IPPF affiliates and significant NGO programs. It is an urgently needed initiative.

Unfortunately, donor governments fear the controversy and the recurrent costs of supplying commodities. But in the real world, yet another conference or another training course is less likely to prevent unintended pregnancy, or pre-empt a case of HIV infection, than an adequate supply of condoms, pills, IUDs and injectables accompanied by clear, appropriate information about their use. All serious donor agencies should have an unambiguous commitment to supply sufficient commodities to reduce fertility and fight the spread of HIV. Tokenism can frustrate genuine progress.

### **Donor agencies should support large-scale, cost-effective family planning programs**

Empirical observation suggests people will spend about one per cent of their annual per capita income on family planning (Ciszewski and Harvey 1995). In situations where modern contraception costs more than that, then the difference must be made up from the country's tax base or the donor community. It may sound obvious that attention to costs is imperative at a time of rising demand and declining resources, but it is a rule more often broken than followed. For example, Japan rated a family planning program costing over US \$100 per CYP a 'success'. The same dollar, yen or Deutschmark cannot be spent twice and failure to choose the most cost-effective programs inevitably ends up denying even basic family planning access to some in order to provide more complex and costly services for a few.

In many situations, social marketing has proved the most cost-effective and easy to manage way of distributing condoms and oral contraceptives. Prices are subsidized in order to maximize sales, rather than profits. A program selling pills and condoms in Vietnam cost US \$6.9 per CYP in the second year and it is estimated it will be below US \$5.0 in the third year, including the cost of commodities. Social marketing of condoms helps meet the imperative to slow the spread of HIV.

### **Unscientific medical barriers to family planning must be eliminated**

The Tanzanian Ministry of Health policies still require a clinical examination before prescription of oral contraceptives; in one central Asian republic women are subjected to uterine curettage (without anaesthesia) when an IUD is removed and most doctors are convinced both IUDs and pills cause breast cancer; in Vietnam women have been told to stop the pill after 6 to 12 months 'to rest their bodies'; and in parts of Francophone Africa women beginning oral contraceptives were supposed to have tests that cost the equivalent of more than one month's per capita income. Such over-engineered programs do little or nothing to enhance women's health, but end up denying family planning choices to many people. Policies must be updated

**Safe abortion must be made available**

A large part of the literature, and the policies of many countries and international agencies, imply family planning can be limited to contraception. Abortion is sometimes mentioned only to be condemned or as something to be 'eliminated' by 'better family planning'. As women all over the world recognize, reality is very different. No society has even achieved replacement levels of fertility without a significant number of abortions, and none will in the foreseeable future. It is impossible to achieve a low maternal mortality without access to safe abortion. In many countries, providing this access is the single most effective step that can be taken towards improving women's health.

Fortunately, the technology for performing early abortion is cheap, safe and effective. Vacuum aspiration abortion, where necessary using a manually operated syringe, can be made available at the primary health care level, and it is an appropriate technology to teach to non-physicians. While many communities, for example in Bangladesh or Zaire, cannot even afford the full cost of purchasing, distributing and promoting something as simple as a condom, practically everyone can find the money to pay the full cost of providing manual vacuum aspiration.

If Western donors are too mean, and developing country governments too poor, to provide the resources needed to meet the ICPD goals, then there will be even more abortions in the world than there would have been otherwise: policy makers should recognize this fact and make safe abortion available.

**There needs to be much greater involvement of the private sector in many aspects of family planning**

The emphasis given to quality in the family planning at the ICPD is often best met by giving the consumer some direct leverage on the services. Two and three decades ago, South Korea and Taiwan evolved programs where the government subsidized selected and qualified private doctors to insert IUDs or offer voluntary sterilization: the consumer, paying part of the cost, had a choice as to which private doctor to approach and the government achieved an increasing level of cost-recovery. It was a 'win-win' situation and deserves to be copied.

In an increasing number of countries, responsible non-government organizations can offer safe abortion. The fees generated can subsidize other reproductive health services. There may be limitations to advertising, and euphemisms and legally contrived explanations may be required, but in the end women get safe abortions. Government hospitals are relieved of the cost of treating botched abortions and politicians are relieved of having to deal with a topic they perceive as controversial. Responsible religious leaders recognize the need for humane solutions to a ubiquitous problem, while those who might oppose such a strategy are often so out of touch with reality that they do not see what is happening.

**Realistic policies must be adopted to deal with adolescent sexuality**

The ICPD rightly and forcefully highlights the many problems besetting young people in the contemporary developing world. With increasing modernization and urbanization, the age of marriage is going up, but the age of first intercourse is going down: the exposure to premarital sexual relations is increasing. Most STDs and exposure to HIV occur before age 25 or 30. What might have been a mistimed pregnancy for a young married couple becomes a social disaster for the unmarried, solvable only by abortion. AIDS cannot be contained without paying particular attention to the needs of adolescents.

Young people demand a high degree of confidentiality and often present genuinely complex social and clinical problems. It is essential to focus more of the limited personnel

available for counselling and the diagnosis of STDs on the needs of adolescents. Happily, there is a corresponding opportunity in many family planning programs to simplify the services for older couples in stable unions.

**As the birth rate falls voluntary sterilization becomes more important**

Voluntary sterilization is the single most important method of family planning in countries as different as the USA and China. Wherever male and female sterilization have been made available, numbers have climbed. As surgical sterilization usually provides many years of protection against pregnancy it is cost-effective, although the costs of surgery usually exceed the ability of a poor couple to pay for the operation.

Health professionals must be motivated to provide a repetitive operation. Item-of-service payments are part of the Western practice of medicine: doctors usually charge fees. But the same payment to a doctor working in difficult circumstances in a developing country has sometimes been misinterpreted as 'coercive'. One effective policy would be to set a modest charge to the client and top it up with a subsidy from the government, UNFPA or other donor. Coercion cannot exist where people pay.

Unfortunately, female sterilization is the technically most difficult item in the family planning repertoire to provide as part of a high-quality service. The trans-cervical placement of quinacrine is a woman-friendly way of offering sterilization that could be made available in any primary health care setting and the method deserves objective evaluation (Pies, Potts and Young 1994).

**The need for direct technical assistance to family planning programs from Western donors will decline**

This is a message not everyone wants to hear, but the pilot phase of family planning is long past and the major elements of HIV prevention have been clear for some time. Big, simple programs providing billions of condoms or offering millions of people the choice of sterilization may seem boring to design and administer, but they are what the world needs. Fortunately the bureaucratic work involved in setting up a US \$5 million program is often little more than that involved in a pilot project costing US \$50,000. Expatriate advisers should be used only in well defined situations: the cost of such a person, together with a housing allowance and airfares for his or her family can be equivalent to 2-4 million condoms or half a million cycles of pills a year.

**Genuine choices**

Donors have key choices to make about the allocation of funds. They can focus on small, selected populations and try to meet the full range of reproductive health needs identified in the ICPD, or they can set their sights on all those who need access to family planning. The work needs to be broken into a series of achievable steps. By any measure of impact, the starting place must be to secure universal access to family planning. With limited resources costs must be watched carefully. Unfortunately, it has become fashionable in some quarters to use the word 'targets' in a pejorative sense, although it is difficult to see how human suffering can be ameliorated unless the scale of that suffering is appreciated.

One key to providing acceptable services within a tight budget is to remember that 'integration' is not a policy to be orchestrated by a ministry of health, but it is a process that takes place at the doorstep of an individual home. It is no more difficult for an adult to 'integrate' condoms from the local kiosk, IUDs from the primary health care centre, STD treatment from an informed pharmacist and sterilization from the provincial hospital, than it

is for a household to 'integrate' their diet by buying food from the butcher, baker and grocer in different streets.

The strategy that worked best in countries as diverse as Colombia, South Korea and Thailand was to begin by setting up simple vertical programs, focusing on delivering basic family planning choices. With the passage of time, and as countries became richer, vertical programs grew naturally into more comprehensive services. Thirty years ago, for example, South Korea launched a vertical, highly focused family planning program, but today Korean women have better access to more equitable and comprehensive reproductive health services than many women in the USA.

The ICPD must not be allowed to become a mirage promising unachievable ends. The goals set are valid and inspirational. The several essential steps on the road to comprehensive reproductive health care, however, need to be taken in sequence, beginning with access to basic family planning choices. Some will have to be deferred until the current financial constraints are lifted. The alternative of improving services for a few, who would receive comprehensive reproductive health care, at the expense of the many, who would receive little or nothing, should be rejected as an unethical use of resources.

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### **Quality of care and service: some notes from the Indonesian family planning and family development movements**

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The Indonesian Population and Family Planning movement has gone through consistent evolutionary stages. When the National Family Planning Coordinating Board (BKKBN) was established in 1970, services and care were provided from the **clinical** approach. This was gradually expanded to include the active role of local communities, and ultimately from the beginning of the 1980s became the **community** approach. In the 1990s the emphasis changed to the more tangible **family** approach.

Throughout all these developments, BKKBN and all the implementing units, both in the private and public sectors and in the non-government organizations, have been committed to providing the best services and care to the clientele. Since its early years BKKBN's management has been constantly reminded that inadequate services and care would only result in method discontinuation, and hence failure to lower the fertility rates.

The following is a brief account of Indonesia's deep commitment to constantly improving the quality of services and care, all within the context of Indonesian society.

### **The Indonesian Family Planning and Family Development movements**

Through all stages since its inception to the most recent features of its development, the Indonesian program has closely adhered to the ultimate objective of the 'small, happy and prosperous family' norm, acceptable to all facets of Indonesian society and thus involving all sections of the population. This norm confirms five principles, as follows.

1. Spacing: eligible couples within the age bracket 20-30 years are motivated to have no more than two children.
2. Family health and welfare: eligible couples who are over 30 years of age are motivated not to have additional children.
3. The involvement of the youth is strongly encouraged as they will ultimately become responsible parents.
4. All parts of the society, particularly parents, are strongly motivated to support and to take an active role in the program.
5. All appropriate societal norms and values are geared towards family welfare and family development.

The apex of family development was in 1992 when Legislative Act no. 10/1992 on *Population Development and the Development of Prosperous Families* was passed. The striking feature of this Act is that it does not carry any threats of penalties for non-compliance; on the contrary, it is prescriptive and motivational. The Act does not dictate the number of children couples should have, rather it states that the number of children should be in accordance with the future secure upbringing of these children and the present welfare of the whole family.

The Act also prescribes the duties and the rights of the population, families, and each member thereof in the process of development. It defines the rights of the vulnerable segments of society, including the handicapped, the children and the women, and motivates families to take care of the underprivileged and the old, instead of committing them to institutions. It also states explicitly that all members of society, even those who seem to be incapable of participating, have significant roles in development.

This Act is the basis for the principle that population and family planning care and services are to be provided at the highest standard in accordance with prevailing needs and values.

With regard to the development of prosperous families, the Indonesian approach to societal development is founded upon the strength and potential of families, the sum of whose qualities makes up the nation. For that reason Indonesia is committed to developing the quality of all members of the family without exception.

### **Family planning care and service**

The Indonesian concept of family planning care and service is that the public has the absolute right to the best quality of service that the government can provide. Hence, the quality of care and service for family planning is determined not by the service providers, but by what the people desire. As the people's needs and aspirations progress with time and with increasing educational attainment, quality of service and care also is a dynamic concept. The following are basic considerations for quality of care and service in a family planning program.

Quality should not be a static concept, but should be related to a program's condition over time. Quality should consider not only the individual's or couple's needs, but also those of society. Quality should entail acceptance by the community based upon their cultural norms and their religion. The ultimate goal of family planning programs should be the improvement of family well-being. Programs that empower local communities and women are more sustainable than those that do not. Quality should be related to a program's

efficiency in using its resources. Quality of a program at any time and place should involve consideration of the client's perception of needs and their satisfaction. Quality of a program should also incorporate the extent to which the program actively addresses its own improvement.

#### **Determining standards**

Quality assurance and quality of services and of care are to adhere to standards of the providers' institutions; standards of the clientele's satisfaction; and standards of the society's satisfaction, including the prevailing religious, social and cultural canons.

By 'providers' institutions' it is meant that individual providers and service installations have their code of conduct and their standards with which to measure compliance, based on the prevailing technology and values. Anything imposed from outside these circles is bound to be redundant as, perhaps, the technology is not applicable or the values are not acceptable. For example, when the 'vaginal sheath' was introduced, Indonesia expressly rejected this as contrary to accepted local reproductive practices. Conversely, Implant-Norplant was introduced with the utmost care, by conducting an acceptability investigation first. Western and advanced medical standards may not be readily applicable to the Indonesian setting.

Within the context of clientele satisfaction the concern is in maintaining the clients' participation in the program, thus enabling them to materialize their needs in family planning and the welfare of their families. The Indonesian Demographic and Health Surveys (IDHS) of 1978, 1991 and 1994 have indicated significant lowering of the rates of unmet need in the program. Still, Indonesia is trying hard to meet the needs of the public, both in increased coverage of the program and in improving the quality of service. This is corroborated by the relatively high continuation rates across all contraceptive methods and the significant reduction in fertility rates.

Client satisfaction is assured by segmenting the public. For those who can afford to pay more for better service and care, the private sector is geared to cater to their needs; for those who need free or nominal-fee service the public health centres and hospitals are readily accessible. The concept of self-sufficiency in family planning care and service is elaborated in a separate section of this paper.

In Indonesia, society's satisfaction is synonymous with social acceptability, which includes religious and cultural acceptability. Imposing the government's will on the public without due consideration would only bring resistance. With regard to the religious values of the society, the majority of the Indonesian people are devout, as is apparent from the abundant attendance of Muslims during Friday prayers at the mosques, of Christians at the Sunday Mass, and of other denominations at religious ceremonies. Going against religious values could be disastrous for the program. One example of this is that because of religious considerations sterilization—better known as 'secure contraception'—is not a family planning method. Religious circles are willing to allow this only when it is done for medical reasons. Although this method is fast gaining popularity, particularly among those above 35 years of age, BKKBN has not adopted it as an official family planning method.

#### **Community development**

As community development is a popular movement involving all the people, and as quality of care deals with the satisfaction of the community, quality of care and services becomes the concern of the whole community as well. In this context the components of quality of care are determined by the community's interests: institutional commitment; dynamic attitudinal and behavioural change; education and training; economic considerations; resources and technology; marketing aspects; referrals, and management.

**Institutional commitment** becomes much more important than simple individual or group commitment. Whereas individual or group commitment is time-constrained, institutional commitment can be sustained for as long as the institution prevails. Conversely, establishing and maintaining institutional commitment becomes more strategic.

**Attitudinal and behavioural change** is the basis of any family planning program. Almost all family planning programs begin by trying to get the idea of the small family accepted by the population. The success or failure of a family planning program is reflected in the extent to which it has achieved attitudinal and behavioural change.

**Education and training** is a constant element of any successful attempt at improving the quality of service and care. This is not only for the providers but also for the clientele with the aim of making them fully aware of what they deserve to know.

The **economic considerations** of quality improvement should be readily obvious. However, as family planning services deal with human beings, caution is necessary so that cost considerations should not hinder improvements.

The availability of **resources and technology** should also be apparent, particularly that of technology. Again, Indonesia is careful to use only the most appropriate of available technology. The major consideration is not how to master the technology; it is more important to apply what is acceptable to the community and the most suitable by local and national ethical standards.

**Marketing aspects** begin to be important when it comes to persuading the clientele to pay for service and supplies. Here the principle of self-sufficiency is important, and Indonesia seizes this opportunity to boost the self-esteem of certain sections of the population.

**Referrals and the referral system** are always important in Indonesia where providers with their expertise in care and services closely adhere to established standards. Lacks and discrepancies will have the referral system to fall back on.

**Management** is perhaps one of the stronger points in the Indonesian program; without this Indonesia could not have had the successes of high prevalence and continuation rates and ultimately fertility reduction. Management of quality improvement involves quality control of contraceptive supplies and also of service delivery standards. Supervision can perhaps be used as an example in the Indonesian program, where it is not performed only by BKKBN or by other concerned agencies, rather it is the clientele on which BKKBN relies for managing quality of care and of service.

Quality assurance and control is dependent on strong and committed leadership. Indonesian experience has indicated that compliance with established and agreed-upon standards can only be achieved with this element. Leadership in this respect encompasses three major factors: leadership to effectively manage people; leadership in shaping program policy and implementation strategy; and leadership to mobilize and use all the required resources.

#### **Notes from experience**

Twenty-five years of experience result in the following checklist for quality assurance and improvement in population and family planning care and service in Indonesia.

The Indonesian concept of quality of service and care is based on what the community and the clientele dictate, and far less on what the providers prescribe. Standard indicators are needed. This, Indonesia has shown, is not a simple task. The standards of the clientele and the providers may compete, and the two parties are not always compatible. Indonesia has also shown that convergence can be sought through consensus. Satisfaction of the clientele, religious authorities and the community must be assured. The next point is internal and external auditing procedures. Internal audits may be simply done as this falls within the purview of organizations. External audits, however, are for the most part beyond the control

of management, and can be even more complicated when one considers the public opinion poll as one of the procedures for obtaining audit information. Procurement reviews, mostly of contraceptive supplies for the public and the private and commercial sectors, ensure that procurement has been done on a timely basis, with the right quality, and in the right locations.

Process control: production and distribution are done according to established methods. Drug and Material Certification is one of the requirements in Indonesia. Inspection and testing procedures can be viewed as part of Drug and Material Certification, but can also be considered as part of production process control. These are closely monitored by BKKBN not only at the manufacturer's level, but all the way to the villages.

Indonesia is putting great emphasis on feedback from the users. From time to time, top management of BKKBN go to the villages to interview families and acceptors on their opinion about the methods they are using. Supplier and distribution rating: in a competitive diversified market such as for contraceptives, Indonesia attaches great value to the rating of all manufacturers, to ensure that they will strive for better quality. The same applies to the service providers: the best clinics will ultimately attract the most acceptors.

### **Editor's Note: An invitation to join us in Volume 6(2), October, 1996**

We intend to run a follow-up forum in the next issue. This time it will not be by prior selection but by allowing the readers to chose themselves.

If you have evidence on the neglected matters I identified in the first paper of this forum, we would especially like to hear from you: To what extent can reproductive ill health be identified and treated among poor, remote populations? What impact will this have on family planning programs? Should family planning be offered to populations where good quality treatment for reproductive ill health cannot be guaranteed?

If you have evidence on other related matters or believe we have ignored or misinterpreted relevant parts of ICPD or its *Plan of Action*, we would also like your contribution.

These contributions should reach Jeff Marck, *HTR's* Production Officer, by the end of July and should generally be confined to 1,000 words or less.

J.C.C.