

## **The ICPD Programme of Action: pious hope or a workable guide?**



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There is much to be proud of in the consensus that emerged from the tough negotiations during the Preparatory Committee Meetings and at the population conference in Cairo. The inclusion of 'development' in the official title of the conference marked a significant move away from discussing population issues in the divisive context of demographic targets, towards a global recognition that the problems associated with rapidly growing human populations were now part of a broader human development agenda. The Programme of Action, approved by consensus, contains no demographic targets. Its emphasis on the need to ensure the alleviation of poverty and equity between and within nations served further to reduce significantly some of the North-South conflicts that were present at the 1974 Bucharest World Population Conference, where it was argued by several developing countries that 'development is the best contraceptive', and the 1984 Mexico City International Conference on Population, where it was agreed that population and development were two sides of the same coin, but where the United States and the Vatican, plus a handful of countries, opposed all discussion of abortion, and played down the importance of family planning.

The ICPD Programme of Action recognizes women's education, equality and empowerment as paramount, and the importance of providing family planning within the context of full sexual and reproductive health care is stressed. It applies basic human rights principles to population and family planning programs, and rejects coercion, violence and discrimination. It recognizes the central role of sexuality and gender relations in women's health and rights; asserts that men must be fully involved, but without veto, in decisions involving fertility, sexual behaviour, sexually transmitted disease and the welfare of their partners and children; and recognizes unsafe abortion as a major public health issue.

Beyond that, Cairo signalled an understanding that population is at last seen as part of the necessary investment in people, without which none of our development or environmental problems will be solved. Educating girls and making women truly equal partners in development, reducing infant and child mortality, promoting safe motherhood, giving access to quality family planning, tackling the problems of STDs, and providing clean water and adequate food and nutrition, are all connected with improving reproductive and family health and reducing family size. Slowing population growth, in turn, will feed back its social, economic and environmental benefits.

Another major Cairo achievement was that NGOs were very fully involved in the ICPD process at all stages, and many representatives of non-governmental family planning associations were also members of their national delegations. As a result, the Programme of Action reflects several concerns that emanate from the NGO sector rather than governmental positions. Traditionally NGOs have played an important role in providing information and services to groups in society not well served by government programs, such as the poor, ethnic minorities, adolescents and prostitutes. They have also addressed sensitive issues such as abortion, violence against women and female genital mutilation. All these are areas

emphasized by the Cairo and Beijing conferences. Already there is evidence that governments are working with NGOs to help them implement the programs which they signed up to in Cairo and Beijing. NGOs are also helping in other areas which ICPD stressed, such as the decentralization of public health programs to promote community participation in reproductive health care.

An important Cairo achievement was the avoidance of major North-South conflicts, and this was largely because the conference preparatory process and the Programme of Action clearly recognized the globality of population, sustainable development and environment problems. It was accepted relatively early in the preparatory process that affluent lifestyles and excessive waste production in the wealthier Northern countries, and not only rapid population growth in the poorer South, contribute to global population and sustainable development problems.

The need for poverty alleviation programs was also accepted—and this was taken forward at the Copenhagen Social Summit—which is an essential plank to all attempts to lower fertility and human numbers. But, arguably, the main achievement was the acceptance that population problems cannot be tackled through a macro-numbers approach: solutions must be found at the micro level. So much of what needs to be done turns on a proper understanding of people as individuals and communities, on the status of women and the provision of proper sexual and reproductive health care.

The Fourth World Conference on Women endorsed this approach, and indeed proposed further steps towards improving women's status, education, empowerment and reproductive and sexual health. It is important to acknowledge the influence of the feminist movements on the enlarging of the program base which has been reflected in the achievements of the Cairo and Beijing conferences. Their campaign against women's bodies being 'used' by demographic and target-based population programs has been a powerful one. Although some women's groups may go too far in their rejection of modern contraceptive methods, and may fail to give full credit to the empowering effect of fertility control on women's lives, it is clear that their opposition to coercive programs has been largely useful and positive; and indeed, their position on caring, demand-driven programs has been supported or reinforced by recent demographic research.

The Cairo recommendations therefore challenged us to change our approach to population programs, family planning and reproductive health and not to give them up. First, the high-quality data that became available from the World Fertility Survey in the 1970s and more recently from the Demographic and Health Surveys have shown a high level of unwanted fertility in almost all countries covered. These surveys confirmed the universal desire of people to have smaller families, to control the timing of births and to have access to the means to do so. The unmet need, and the demand, for family planning were shown still to be vast.

The most conservative estimates of unmet need were based on the proportions of women who expressed a wish to delay or avoid pregnancy but who had not obtained contraceptive protection. These calculations yielded a range of figures from 12 to 21 per cent of women in the developing world. These were based on the early DHSs which, in the main, omitted single women, as well as couples using an unsuitable, unsafe or unreliable method, and those who were dissatisfied with the method they were currently using. Including such couples would obviously increase the estimates of demand for family planning greatly.

It became clear, as people began to look at why there was so much unmet need, that the lack of availability or the inaccessibility of services was only one reason. There would be much more uptake of family planning if services were planned with community involvement, and oriented towards clients, offering them real choices and paying more attention to them as individuals and their total circumstances. This expansion is at the heart of the Cairo agenda.

Meanwhile, the call for concerted action over rapid population growth continued, sparked by groups in the economic development and the environment communities. These groups saw the growth in human numbers as a block on achieving both economic growth and sustainable environment. This renewed fears of a revival of demographically driven family planning programs just as the need for programs which sought to put clients' needs first were being recognized.

It was research led by our colleague and the organizer of this meeting, Steve Sinding, that bridged the gap between those who saw a need for demographic goals and those supporting individual rights. He showed in 1992 that confrontation between these two groups was not necessary: programs designed to respond to the individual reproductive needs and aspirations of women or couples could achieve as much as those designed to achieve demographic targets. If women could have only the number of children they desired, he found, the effect on total fertility rates would, in 13 out of 17 countries where the government had quantitative targets to reduce fertility, more than exceed those targets. Applying the same procedure globally, meeting the contraceptive needs of the 17 per cent of women of reproductive age in developing countries, outside China, who were not achieving their family size preference, would result in a fall in total fertility rate that more than matched that required to meet the UN medium projection for 2000.

A rise in 15 percentage points in contraceptive prevalence is associated with decline of around one point in the total fertility rate, so if the 12 per cent figure of unmet need were satisfied, the result would be a 0.87 decline in the present developing country total fertility rate to one of 3.03. If the more liberal estimate of 15-17 per cent unmet need were to be used, the result would be even more dramatic and approach the UN low population variant projection by the year 2000 of a TFR of 2.855.

By the time of ICPD, there was a clear consensus on the need for a more comprehensive, client-centred view of services and for family planning to be part of a wider reproductive health approach. In this approach, the whole life cycle of people's health needs in relation to sexuality and reproduction is taken into account. The unfinished agenda to increase access to and improve the quality of existing family planning services still remains, but the range of services is expanded according to the particular needs of communities. Under this holistic approach, these extra services may include providing care for women during pregnancy and for mothers and babies after delivery; providing gender-sensitive information, education and counselling on sexuality; taking care of people's concerns of sexually transmitted diseases and infertility; HIV/AIDS prevention; the prevention and management of unsafe abortion and the provision of safe abortion services where legal.

All these different elements of sexual and reproductive health are connected, and 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 when they find their other needs and concerns are being recognized as well. One example is of a family planning client who is screened for risk of sexually transmitted disease before being fitted with an IUD. A good family planning provider will of course make sure a client who is found to be at risk is offered an alternative method. But under the holistic approach, she will be given the chance to express and realize her needs for guidance, treatment or referral for her sexual and reproductive health concerns.

To assess the impact of ICPD on population policies and programs round the world, UNFPA invited countries to share their experiences in implementing reproductive-health interventions. Almost two-thirds of the countries which responded have begun to take steps to broaden existing family planning and related programs to include other reproductive health information and services.

Many developing countries are seriously making program and structural changes to make implementing the ICPD recommendations a reality. For example, in Mexico, post-Cairo, the Ministry of Health began by merging the maternal-child care and family planning directorates into one new directorate of reproductive health. The national reproductive health program includes family planning, adolescents' reproductive health, safe motherhood, women's health and sexually transmitted diseases, with an overall gender perspective. The new thinking in the family planning sector includes strengthening women's roles, highlighting men's responsibility in the reproductive process, and the prevention and management of infertility. Advocacy, education and communication efforts will be used to spread the message; mass media are used to tell health workers, clients and the general population about reproductive health. To help other countries mirror Mexico's efforts, the Partners in Population and Development Initiative is ready to support South-to-South transfer of experience.

Another example is the Government of India, which as a direct result of the recommendations of the Cairo Conference, has abandoned the target-based, 'births averted' approach which it had used for over 40 years, and is now pursuing a more holistic, community-based approach.

Most African countries, always uneasy about family planning, have welcomed the new approach and are actively seeking both technical and resource help for implementation. Donor agencies are also providing the necessary stimulus and guidance to ensure the broader approach. In 1995 USAID held a major conference-workshop in Nairobi to formulate an agenda, based on experience, to integrate family planning and reproductive health care.

The UN and its agencies have undertaken various specific measures to ensure follow-up of the recommendations of ICPD. There is an inter-agency group chaired by UNFPA to work out the aspects of implementation that each relevant agency would undertake. It also is to help provide a centre for co-ordination of the activities.

In the area of reproductive health the World Health Organization has helped to identify various elements which should go into a comprehensive health program and have started popularizing this. This Family and Reproductive Health Programme has been given extra visibility by being headed by an Executive Director, the equivalent of an Assistant Director-General. Under her have been grouped various divisions and units dealing with different aspects of reproductive health. These include the HRP (Program for Research in Human Reproduction), adolescent health, child health and development, and the unit on women and health.

This innovative approach by WHO is a signal to all government health authorities as to what they can do to help implement the ICPD recommendations. The more overt involvement of UNICEF recently in the issue of Safe Motherhood and birth spacing would probably not have happened without the shift in program thinking that Cairo agreed.

The holistic approach advocated by ICPD is in harmony with all modern thinking on development, and should not be taken as a de-emphasizing of the importance of fertility reduction activities. The fact that there are 'add-ons' and new approaches in the ICPD Programme of Action was not intended to imply that family planning was considered less important: it is just as important, but is now seen in a wider context. More tellingly, some object that to expand family planning to embrace all sexual and reproductive health services will inevitably lead to a dilution of basic services and that family planning associations will be unable to cope or afford the extra services they are expected to provide.

It is true that some will be unable to cope; but the proof that it is possible is that some were already providing much fuller services before Cairo, and others have started doing so since. And part of the spirit of Cairo is to encourage all family health organizations to co-operate more closely with each other and other agencies. The other side of the coin is that many agencies which could have played a role in fertility management were not doing so

when the programs were so narrowly focused. With the new approach more agencies are able to see their potential more clearly. The new approach, if anything, provides a broader base and a greater variety of acceptable agencies and individuals advocating the cause of population and family planning in development.

The question about cost is however a very real one. Of course it costs more money to provide extra services, and this was recognized in the ICPD funding targets. It is true that some of the wealthier nations have so far not shown much sign of honouring the commitments made in Cairo; and if they do not, implementation will naturally be difficult and the benefits for human development and lower population growth are unlikely to be achieved. But this difficulty surely should not be turned into a criticism of the Cairo concept of extending sexual and reproductive health care to all.