The Reproductive Health Approach to Population and Development

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PAYING FOR ESSENTIALS
A POLICY PAPER SERIES

CENTER ON INTERNATIONAL COOPERATION
NEW YORK UNIVERSITY

ABOUT THE CENTER ON INTERNATIONAL COOPERATION

The Center on International Cooperation at New York University was established in 1996 to conduct a program of policy research and development on the management and financing of multilateral commitments. As global integration accelerates, the world faces unprecedented transnational problems resistant to resolution by individual states. Governments that once assumed responsibility for a wide range of multilateral activities today lack the political will or fiscal capacity to sustain the array of international organizations, development aid programs, humanitarian assistance efforts, environmental agreements, and other global public goods that they have agreed to support. At the same time, important non-state actors, including corporations and not-for-profit groups, are gaining importance in the conduct of world affairs. The cooperation of all of these stakeholders is essential to develop appropriate strategies and mobilize the financial resources necessary to meet global challenges in the years ahead.

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PREFACE

The 20th Century has been marked by a new kind of internationalism in which sovereign states have together sought to grapple with grave matters of peace and development. As interdependence has grown, so has the quest for collaborative ways to resolve interstate and transnational problems. Since the end of World War II, a proliferation of treaties, conventions, and agreements has given rise to an international public sector, and to a set of intergovernmental institutions and mechanisms designed to fulfill their mandates. Some international collaboration, such as the international courts and tribunals, are treaty-based and hence obligatory. Some, such as development aid and humanitarian assistance, are purely voluntary. A few, such as peacekeeping and post-conflict reconstruction aid, may be rooted in the aspirations of industrialized nations for regional security and expanded markets.

The UN-sponsored international conferences of the last decade embody an evolution in which member states have, on the basis of consensual agreement, virtually ordained an entire set of international public goods. These include the well-being of children (1990), a clean, healthy and sustainable environment (1992), reproductive health and population (1994), women's rights (1995), safe and productive habitats (1996), and food security (1996). All these goods rest on a set of presumptions about the universality of human rights (1993) and social development (1995).

Importantly, each of the UN conferences went beyond the interstate actions of most other international agreements to include representatives of non-governmental organizations (NGOs) and other sectors of civil society in the run up to their deliberations. Indeed, it would not be going too far to declare that the conference outcomes were strongly influenced by research and advocacy carried out by these NGOs over the last several decades. In most cases the conferences also called for a strong role for independent actors in promoting and monitoring compliance with the commitments governments have made. It is in this spirit that the Center on International Cooperation (CIC) at New York University initiated the current project: to review progress made by developing and developed (donor) countries in advancing the reproductive health agenda endorsed at the 1994 International Conference on Population and Development (ICPD), held in Cairo, Egypt.

CIC selected developing countries for this review with an eye towards regional representation; variations in economic, political, social and demographic conditions; and differences in the source (national and international) and magnitude of health financing across countries. Similarly, the choice of donor countries sought to ensure diverse trends in international support for the ICPD Programme of Action and the health sector of developing countries. A team of international experts was assembled to conduct in-depth studies in Bangladesh, Egypt, Indonesia, Mexico, South Africa, Tanzania, the United Kingdom and the United States. Brief background papers were developed on funding patterns in Sweden, France, Switzerland and Belgium. In addition, an international advisory panel was assembled for guidance in developing policy recommendations and publicizing project conclusions. (Project participants are listed in Appendix 1).

The project's case studies focus on how countries acted on the endorsement of those elements of the reproductive health approach for which cost estimates are given in the Programme of Action: family planning; reproductive health services; STD/HIV/AIDS prevention; and research, data collection, policy analysis and formulation. Each author was asked to examine the state of policy and program development and financing related to the implementation and sustainability of the reproductive health approach. Authors were requested to include data on current and alternative sources of reproductive health financing, and the current and future role of international donors and the private sector, both corporate and non-governmental.

Experts conducted each study within the respective country by reviewing existing literature and data from government and non-government sources, and interviewing a wide range of individuals, including government officials, representatives of non-government organizations and international donor agencies, academics and, in the case of developing-country studies, health care providers and users of services. Although case studies were conducted within this agreed-upon framework and methodology, CIC encouraged experts to develop their research around sets of questions that were most appropriate to each case.

This report is based on analysis of the specifics emerging from the case studies, field trips and overarching issues arising from discussions with participants and other experts. The report does not attempt to synthesize comprehensively the finer points of each country study, which could be best appreciated by reading the studies themselves. These are being published as a separate volume entitled, *Promoting Reproductive Health: Investing in Health for Development*, Lynne Rienner Publishers, 1999 (see Appendix 3). Instead, this report highlights and provides recommendations on key issues affecting the future implementation and sustainability of the reproductive health approach advanced at the ICPD.

The views contained in this report are exclusively those of the CIC and do not necessarily reflect those of the individual project participants.

EXECUTIVE SUMMARY

Approved by 180 governments, the reproductive health approach embodied in the Programme of Action of the 1994 International Conference on Population and Development (ICPD), in Cairo, Egypt, represented a major departure from previous thinking on population and development. The Programme of Action reaffirmed the importance of slowing population growth for social and economic development, but it also called for a significant shift in strategies to achieve this goal – an emphasis on meeting the needs of individual women and men rather than on achieving demographic targets.

Building on the outcomes of the World Population Conference in Bucharest in 1974, the International Conference on Population in Mexico City in 1984, and decades of experience and research, the ICPD Programme of Action calls for an approach to reproductive health that is comprehensive and client-centered, based on the interrelationship between population, human rights and sustainable development, and the principles of choice, gender equality, equity, and the empowerment of women. To satisfy reproductive health needs during all stages of the life cycle, it recommends that all countries provide, through the primary health care system, a range of information and services, including but not limited to family planning.

The reproductive health approach endorsed at the ICPD has permeated policies and programs to varying degrees in each of the countries on which this report is based. While the language of reproductive health has entered population and family planning discourse, in some countries it is still contested terrain, as overriding concern with population growth dominates population and family planning policy. In others, the integration of family planning and reproductive health envisioned in Cairo is slowly taking place, albeit constrained by established patterns of funding, bureaucratic prerogatives, organizational barriers, lack of popular understanding of the reproductive health approach and limited training opportunities for health service providers. In several cases, reproductive health inroads into the family planning agenda are due to the impetus of donor funding.

Although formidable obstacles in the identification and tracking of financial components stand in the way of thorough analysis, two patterns in financing the ICPD Programme of Action seem to have emerged. First, despite an initial spike, support from international donors has declined, making it virtually impossible to meet the financial goals set at the ICPD. Secondly, health sector financing within the six developing countries studied raise concerns about sustainability. In some countries, like Indonesia, Mexico and Tanzania, health spending has been negatively impacted by economic conditions and, in all of the countries studied, health and population spending comprises a small portion of total public sector expenditures.

Donors studied have responded differently to the commitments made at the ICPD.

The United States, the United Kingdom, and Sweden have endorsed the reproductive health approach and integrated it into their development assistance programs. Unfortunately, current donor funding patterns suggest that there is likely to be some uncertainty about the levels of financing even in the near term. This is attributable to the decreasing levels of assistance from the United States, relatively low levels of funding from a handful of countries committed to the Programme of Action, and a lack of commitment on the part of other potential donors. For example, France, Belgium and Switzerland, all of which have the capacity to contribute far more, have shown little inclination to support the ICPD Programme of Action.

In 1995, twenty bilateral donors contributed nearly $1.4 billion to population assistance, some $3.6 billion short of the total bilateral and multilateral targets projected for ICPD implementation by 2000. Furthermore, 73% of the bilateral funding was from just four countries – the United States, Germany, the United Kingdom and Japan. While the United States continues to lead in the disbursement of funds for reproductive health and population, its actual dollar commitment has declined due to Congressional cuts in the aid budget. The United Kingdom, for its part, has significantly increased its contributions as part of a generalized overseas poverty reduction program. However, unless there is a major recommitment of funds by current donors or an increase in the number of donor countries, it is highly unlikely that the 2015 target of $21.7 billion (international and national) envisioned in the Programme of Action will be available over the next 20 years. While international donors continue to play an essential role, sustaining the reproductive health approach will depend in large part on political will and resource mobilization efforts within each country.

The long-term vision of the reproductive health approach warrants reaffirmation.

Although five years is too brief a time to evaluate the impact of an ambitious 20 year agenda, it is fair to say that the reproductive health approach provides a promising framework to meet reproductive health needs and improve quality of life. Where executive and ministerial leadership is in evidence, in both developing and donor countries, the reproductive health approach has been advanced. Conversely, where leadership lags, so has progress. The advocacy and service delivery activities of non-governmental organizations (NGOs), particularly women's health and rights groups, have contributed immensely to the advancement of the ICPD Programme of Action, internationally and nationally. In particular, NGOs can be credited for keeping the voices of clients in the public discourse and holding governments accountable. Persistent community-based action is a strong tool to ensure quality reproductive health, which depends on informed choice and the availability of information and services.

The developing country case studies reveal important lessons about the way in which international assistance works and how it can be improved. First, local ownership of the design and implementation of programs is a prerequisite to their success. The Cairo Programme of Action was not intended to be implemented in a "one size fits all" fashion; national plans of action were expected to develop policies and programs according to local priorities, needs and capabilities, consistent with the

principles and goals of the ICPD. The will and capacity to implement and sustain policies and programs depends in large part on their appropriateness to local needs and aspirations. A complex set of internal and external factors affect that will and capacity. At the national level, dominant ideologies and prevailing economic conditions play a critical role. Where entrenched population programs are in place and there is little room for citizen action, little progress can be expected. Overriding debt burden and alternative claims on scarce resources for social programs and poverty alleviation also limit the scope for implementation. The financial crisis now affecting Asia and threatening Latin America raises serious questions about the ability of countries in these regions to promote reproductive health and increase health sector budgets in the short term.

A number of the developing country case studies make clear that the prevailing financial crisis, structural adjustment demands and the vagaries of external funding may pose serious threats to the sustainability of the reproductive health approach. Furthermore, many of the reproductive health programs initiated in developing countries have been strongly influenced by donors. To ensure long-lasting benefits, donor assistance should be supportive of local priorities and programs. Aid should facilitate the start-up of programs and projects that are locally sustainable and targeted to activities that strain local resource capacities, such as research and training. At the same time, donor assistance needs to be sufficiently reliable and predictable to ensure continuity in program implementation. And, it must be coordinated so that project proliferation does not overtake sound program development.

Everywhere, the long-term success of the reproductive health approach is embedded in larger questions of health sector reform. A major challenge for health managers is how to implement the reproductive health approach and health reform together. Although the two are potentially complementary, there are possible areas of conflict. Coordination between agencies differentially charged with administering health and population policies needs to be ensured. Decentralization, which is essential if services are to be approximated to client demand, requires increased investment in training so that service providers fully understand and act upon the reproductive health approach. Services must be integrated to reduce the costs of delivery, and information must be a central component so that women and families who bear the greatest financial burden for health services are able to make informed choices among available options.

In order to advance the goals established at the ICPD, the long-term vision of the reproductive health approach should be reaffirmed. Its capacity and appropriateness to address population growth concerns should be documented and made clear to policy makers and family planning practitioners. It is also necessary to support local, national and international NGOs in their roles as advocates and service providers. Reproductive health advocates should encourage governments to provide the legal framework to allow NGOs to have the freedom and financial means needed to carry out their work.

National governments will need to assume greater responsibility for resource mobilization and program implementation. Well-informed and strongly committed leaders should provide strong incentives, backed by budget line items, to firmly embed the reproductive health approach in the institutions responsible for health and family planning. Given resource constraints, alternative sources of finances and cost-sharing

mechanisms should be further explored and tested to determine whether such mechanisms can operate without damaging the principles of equity and quality embodied in the reproductive health approach. Governments should also improve and extend training programs for field personnel, and support outreach efforts to build knowledge of the reproductive health approach.

The continuing support of international donors is essential. Donors should base funding on local needs and priorities, incorporating the reproductive health approach into all international health financing activities and development aid. Efforts to shift from external funding to local sustainability should be done responsibly so that promising initiatives are not curtailed or abandoned prematurely.

Transparency and accountability need to be established as key elements of international cooperation. Stakeholders from both developed and developing countries should establish common systems for tracking and monitoring bilateral and multilateral donor aid. Central and open sources for statistical information in each country should be created to track the allocation and use of donor funds and national expenditures for reproductive health care. Stakeholders should monitor and report on implementation at regular intervals, according to agreed benchmarks, and fund research to help develop indicators of client demand for reproductive health services, gender equity in health service provision and quality of care. Finally, the global estimates of costs for reproductive health programs for the years 2000-2015 should be reviewed and revised in order to set realizable goals for both donor and developing countries.

A great deal more needs to be learned about what works best in the structuring and delivery of reproductive health services and their impact on social and economic development. In addition to program and project evaluation, donor financing should include assessments of overall system performance and the impact of external funding. Operational and action research are needed to ensure that the administration and management of services contain costs but maximize quality. Knowledge of client needs and preferences is essential to fulfillment of the reproductive health approach. Research to develop innovative strategies for health delivery, to clarify and develop the role of the private sector, and to evaluate schemes such as user fees, social marketing and insurance programs is vital and must ascertain that public resources reach those who cannot afford to pay. Five years is too soon to judge the outcomes of a transformation-the scale and scope of which comprises the ICPD Programme of Action. It is nonetheless an excellent time frame in which to evaluate progress, reiterate the essential principles and goals agreed to in Cairo, identify ways to move ahead, and recommit to effective action.

I. INTERNATIONAL CONSENSUS ON THE REPRODUCTIVE HEALTH APPROACH

THE REPRODUCTIVE HEALTH APPROACH

The 1994 International Conference on Population and Development (ICPD) was a watershed in the fields of population and development. The conference document, the Programme of Action, reaffirmed the importance of slowing population growth for social and economic development, but it also called for a significant shift in strategies to achieve this goal – an emphasis on meeting the needs of individual women and men rather than on achieving demographic targets.

The reproductive health approach endorsed in Cairo emphasizes the interrelationships between population, human rights and sustainable development. It stresses the importance of advancing gender equality, equity, and the empowerment of women, and emphasizes women's ability to control their own fertility. It envisages women involved in the planning, management, implementation and evaluation of reproductive health programs, and men as active partners in family planning and family life. The ICPD Programme of Action calls for an approach to reproductive health that is comprehensive and client-centered. To satisfy the reproductive health needs of individuals, couples and families during all stages of the life cycle, it recommends that all countries provide, through the primary health care system, a wide range of information and services, including but not limited to family planning.

Rejecting the concept of "population control", the Cairo Conference recognized that smaller families and slower population growth depend on free choice and conditions that encourage such choice. This approach is grounded in and defined by the principles of the ICPD Programme of Action which seeks to ensure "...on the basis of equality of men and women, universal access to health care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health care programs should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so."

So defined, the reproductive health approach:

- Provides the rationale for the design and implementation of client-focused programs based on the principles of choice, equity and quality of care.
- Promotes the comprehensive reproductive health care of women, through open access to information and a combination of services, without excluding the reproductive health needs of men and adolescents.
- Legitimizes client demand as a right as well as the basis for the provision of

goods and services.

- Emphasizes the synergies between health and population programs, in particular, and other development programs, in general.
- Encourages international cooperation and public/private partnerships to improve the quality of life of current and future generations.

The 1994 Cairo Conference built on the outcomes of previous international population conferences in Bucharest in 1974 and Mexico City in 1984, the Earth Summit in Rio de Janeiro in 1992, the Vienna World Conference on Human Rights in 1993, and decades of research and experience. Another influencing factor was the AIDS pandemic. The devastation caused by HIV/AIDS lent a sense of urgency for a reproductive health approach that would place increased attention on sexually transmitted diseases and on risk-free sexual behavior. In addition, the ICPD consensus exemplified years of work by women's human rights advocates and health professionals to put women's needs and concerns at the center of population and development efforts, and to recognize the central role healthy and educated women can play in alleviating poverty and promoting sustainable development. This vision received the support of more than 1500 non-governmental organizations and the endorsement of 180 government delegations.

The commitment of international donors is essential.

INTERNATIONAL ENDORSEMENT

A number of factors contributed to the endorsement of the reproductive health agenda elaborated in the ICPD Programme of Action. These are worth noting because they help to explain the achievement of the government delegations assembled in Cairo and because they contain some of the keys to sustaining the reproductive health approach over time.

Foremost among these factors was a strong and convincing demonstration of leadership. Senior officials from both developed and developing countries led their delegations and, in the case of the United States and Great Britain, carried with them the evident support of the President and Parliament, respectively. The ICPD Programme of Action fit well with larger goals of the new U.S. administration, which was seeking to redefine global security and development directions in the post-Cold War era. President and Mrs. Mubarak hosted the Conference and lent their encouragement and prestige to the agenda. A strong Mexican delegation, focused on defining a new approach to family planning and population issues since their hosting of the last population conference in 1984, provided additional impetus to the debates.

Other factors working in favor of the Programme of Action included the efforts of well-organized and highly vocal women's groups whose participation in several official delegations and in the parallel NGO forum contributed to the conference's resolve. The conference process itself -- though by no means free of debate or dissension -- ultimately encouraged consensus, and heavy lobbying by the United States delegation elicited the promise of financial contributions from European countries and Japan.

Indeed, pressure from the United States and other lead countries, the desire to show adherence to an international agreement, and the expectation of financial support were all vital factors in achieving the ICPD consensus.

The timing of the conference was also propitious, building as it did on a number of ongoing initiatives. Egypt, Mexico and many other developing countries were already reviewing existing population and family planning programs. South Africa's new government was developing an overall national policy emphasizing issues of development and human rights consonant with the reproductive health approach advocated in Cairo. Encouraged by international and domestic women's health and advocacy groups, bilateral donors, and multilateral organizations led by the United Nations Population Fund (UNFPA), a number of countries were persuaded to view the Programme of Action as a way to advance the interests and needs of their populations. For example, a series of workshops and committees sponsored and organized with the help of bilateral and international donors, and attended by prominent international public and private sector leaders, set the stage for participation by the Bangladesh Ministry of Health.

In addition, the preparatory work done by the UNFPA and the UN Commission on Population and Development should not be overlooked. Of key importance in helping to shape the agenda were the recommendations made at five regional population conferences in 1992 and 1993, and a number of subregional preparatory meetings, expert group meetings and round tables.

A final and crucial factor was the non-binding nature of the Programme of Action. The lack of definite commitments on the specific shares of respective donor and developing country financing made it easier for countries to adopt.

II. IMPLEMENTING THE REPRODUCTIVE HEALTH APPROACH

Much of the time since the ICPD has been devoted to policy development and program planning, and implementation has only recently begun. While it is still far too soon in the implementation process to make definitive assessments about impact, early evidence reinforces the expectation that the reproductive health approach will improve the health of women and populations at large. It has encouraged experimentation in program design and service delivery aimed at better care at lower cost. And it has begun to influence the national discourse around health sector reform, adding considerations of quality and equity to discussions of cost reduction and organizational efficiency.

A distinguishing feature of the ICPD was the recognition that each country would pursue a combination of services appropriate to local needs and circumstances, consistent with the general goals and timetables of the Programme of Action. Implementation of the Programme of Action was not conceived of as a mechanistic "one-size-fits-all" process, but one in which each country could proceed according to its own national priorities and capacities, consistent with the overall goals and principles of the reproductive health approach.

PROGRESS TO DATE

Pre-existing conditions and capacities have created substantial variation in the progress realized to date, as reported in the CIC country studies. In South Africa, a human rights and equity approach to health was elaborated independent of ICPD by the new majority government. Countries such as Mexico and Egypt, where vigorous family planning programs were underway before 1994, had already begun to anticipate the changes needed to incorporate the broader vision elaborated in the Programme of Action. Bangladesh, which until ICPD had focused on promoting the use of contraceptives to reduce population growth, has embarked on a promising effort to understand and implement the approach. Indonesia has shown great reluctance to deviate from its perceived successes in family planning, and Tanzania continues to debate the expenditures for reproductive health in the face of other competing demands.

Yet, even in the four short years since the ICPD, there is evidence of notable advances. The language of reproductive health has been embedded in policy and strategy documents, and has begun to be translated into programs in many countries. For instance, Tanzania has formulated the Reproductive Health and Child Survival Strategy; and Bangladesh has developed an essential services package that includes components of reproductive health as part of its Health and Population Sector

Programme. In Egypt, in response to ICPD, the government modified its population and health strategy placing a greater emphasis on universal health coverage and high quality reproductive health services. In South Africa, overall improvements in the provision of primary health care included policy and program emphasis on sexual and reproductive health care. In Mexico, laws and standards were created or modified in order to implement the new Reproductive Health and Family Planning Program; the present Health Law, for the first time, incorporates the concept of reproductive health.

The potential for improved quality and access to services exists across the range of developing countries. For example, the Mexico study suggests that efforts to decentralize services, along with strategies to improve outreach programs and the dissemination of information, can make health care more accessible to many more women. Moreover, by providing greater opportunity for clients to address a wider range of health issues with less effort, integrative services conceivably can achieve multiple objectives in terms of reducing fertility, reproductive mortality and morbidity.

Local, national and international NGOs need to be supported in their roles as advocates and service providers

In a number of countries, notably Egypt and Bangladesh, institutional changes signal an operative commitment to provide great access to quality health services for women. In Egypt, a new Ministry of Health and Population was created to centralize, upgrade and integrate all population, family planning and reproductive health services and activities; the population and health strategy was modified placing greater emphasis on universal health coverage and high quality reproductive health services. In Bangladesh, a reform program is underway to reorganize service delivery and program management in order to implement the new reproductive health approach, which integrates women's health and family planning services for the first time.

In countries such as Bangladesh and Egypt, efficiency and cost-effectiveness concerns have directed policy makers' attention to the reproductive health approach. There is some evidence to suggest that integration of services result in cost savings on several fronts -- in the administration of programs and in the delivery of services. The experience of Mexico in particular demonstrates that cost reduction can be achieved by providing more than one service to a client in a single visit. Calculations based on average staff time suggest a fifty percentage savings when three services are provided per consultation rather than one. Furthermore, integrating services in a single visit to a primary health care facility encourages clients to seek out a wider array of consultations and treatments that otherwise might be deferred.

Importantly, ICPD has provided impetus for the growing consensus among governmental and non-governmental actors on the importance of information, education, and counseling on the prevention and control of STD/HIV/AIDS. In Bangladesh, for instance, discussions of STD/HIV/AIDS prevention were initiated by national governments with non-government actors for the first time in preparation for and follow-up to the ICPD. And since the ICPD, there seems to be greater willingness, in most of the countries studied, to debate responses to the problem, develop appropriate methods for incorporating solutions into services, and train health service providers accordingly, although much work remains to be done.

CHALLENGES TO PROGRESS

The ICPD Programme of Action recommends that all countries provide, through the primary health care system, reproductive health care that includes a combination of services and adheres to the principles of the reproductive health approach. However, our case studies reveal several ongoing challenges that deserve special attention.

CONTINUING DOMINANCE OF FAMILY PLANNING IDEOLOGY IN GOVERNMENT PROGRAMS

The reproductive health approach is still not widely understood, even within countries that have incorporated the approach into policy and strategic documents. This has led to concerns in some developing countries, such as Egypt and Indonesia, that the momentum gained through family planning programs in containing population growth will be lost if the reproductive health agenda is adopted. Vested interests and ideological positions also impede progress in implementing the reproductive health approach. Until facts and resources are mobilized in support of the reproductive health approach, it is likely to be an "add on" to family planning programs rather than encompassing them.

THE HEALTH SECTOR REFORM PROCESS

Implementation of the reproductive health approach is embedded in a broader context of health sector reform taking place in many developing countries. The process of reform will significantly affect the ways in which health services are prioritized and delivered, and will largely determine the extent to which reproductive health care is implemented. In some countries, such as Bangladesh, Mexico and South Africa, health sector reform strategies call for an "essential services package" or "basic package" that incorporates many aspects of reproductive health care as envisioned in the ICPD Programme of Action. Yet, in many instances, health sector reform is driven by concerns with cost-reduction and organizational efficiencies, and may proceed independently of the policy and program changes necessary for incorporating the reproductive health approach.

DECENTRALIZATION AND LIMITED CAPACITIES

A process of decentralization has taken root in many developing countries, shifting responsibility, authority, and decision-making for the management, funding and implementation of programs to local authorities. However, the case studies of Tanzania, Bangladesh, Mexico, Indonesia and South Africa make clear that existing human and technical capacities are underdeveloped, vary regionally and locally, and are generally not conducive to implementing reproductive health care programs envisioned in the Programme of Action. Effective decentralization cannot rest simply on the transfer of authority, functions, and resources from national to local authorities but must be accompanied by a range of measures, including adequate training, designed to support the newly empowered localities.

INSTITUTIONALIZING THE REPRODUCTIVE HEALTH APPROACH

The reproductive health approach can be most effectively realized when health providers, both governmental and non-governmental, have the competencies needed to deliver a "combination" of services required by women and families. Although institutional

reorganization can be a positive step on the road toward health sector reform, staff training is needed to support it. The success of change will ultimately depend on effective integration of the principles of the approach into service delivery, management and evaluation of programs. All the case studies raise concerns that managers and health service providers may view the reproductive health approach only as a new rubric under which to continue traditional family planning and maternal health programs. Personnel with decades of commitment to family planning programs may continue to resist the move towards the reproductive health approach.

DEMONSTRATING THE EFFECTIVENESS OF IMPLEMENTATION AND MANAGEMENT

While advances to date hold out substantial promise for the reproductive health approach, it is still too soon to be able to demonstrate definitively the effectiveness of the approach from client and provider points of view. Reproductive health indicators are not yet in place. Evidence of cost containment and improvements in quality of services is only beginning to be collected. Furthermore, the impact of the reproductive health approach on population growth cannot yet be determined. Finally, it remains to be seen how bureaucratic reorganization and job restructuring will affect the performance of public sector departments beyond hoped-for cost savings.

RESOURCE CONSTRAINTS LIMIT IMPLEMENTATION

Even where understanding, interest, and political will are strong, resource constraints have limited the capacity of a number of countries to implement the reproductive health approach. Debt burden in most developing countries, coupled with structural adjustment programs, limits public expenditures in the health sector overall. In Tanzania, for example, high levels of debt severely constrain the government's capacity to implement reform. In these circumstances, it is not entirely surprising that public demand for other provisions, like food and water, seem to take precedence over health care. In other countries, the predominance of HIV/AIDS requires levels of resource allocation that limit the scope of action in other health care areas. And economic crisis, as seen in Indonesia in 1997, severely impacts public sector spending and the provision of all health care services.

AREAS REQUIRING MORE ATTENTION

Although the needs of each country are unique, certain issues related to the reproductive health approach are being neglected, at both policy and program levels, in many countries. Most studies indicate that the needs of older women, and often of adolescents as well, are being sidelined due to the prevailing emphasis on women of reproductive age. In addition, there seems to be little commitment to developing effective strategies for increasing male participation in reproductive health programs. In Tanzania, the issue of HIV/AIDS is still cloaked in silence despite high rates of infection. In Indonesia, serious policy discussions on STDs have been limited. Abortion, which remains stigmatized in most countries and is legally restricted in Mexico, Egypt and Indonesia, requires further discussion and attention, especially given the high incidence of unsafe abortion and resultant illness and death. Finally, reproductive rights are often dealt with rhetorically without sufficient program action necessary to enable people to understand and realize these rights.

III. FINANCING THE REPRODUCTIVE HEALTH APPROACH

The ICPD Programme of Action is one of the few international consensual agreements to cost out the financial requirements for its implementation. It estimated (on the basis of 1993 dollars) that combined domestic and international resources of $17 billion would be required for implementing a core set of reproductive health programs, including family planning, in 2000, increasing to $18.5 billion in 2005, $20 billion in 2010 and $21.7 billion in 2015. According to a sharing formula, developing countries and countries in transition would be responsible for two-thirds of these estimated costs with international donor countries contributing the remaining one-third. Stipulating that "...adequate mobilization of resources at the national and international levels will be required... from all available mechanisms, including multilateral, bilateral and private sources," the Programme of Action called on international donor countries to provide increasing investments that would reach $5.7 billion in 2000 and $7.2 billion in 2015. No definite commitments were made on the specific shares of funding of respective donor and developing countries for any of the years. Furthermore, resources required for other development goals of the ICPD Programme of Action, such as the education and empowerment of women, were not enumerated.

Although formidable obstacles in the identification and tracking of financial commitments stand in the way of thorough analysis (see Box), two fairly clear patterns in the financing of the Programme of Action seem to have emerged. First, despite an initial spike in global financing, support from international donors has declined, making it virtually impossible to meet the goals set out in the Programme of Action. A major gap is evident in anticipated funding to meet the $5.7 billion target stipulated for 2000 (Appendix 2: Table 1). Secondly, while overall health sector financing within most of the developing countries studied appears to be increasing, support for health and population activities represents a relatively small portion of public sector funds. While sufficient funds were made available to initiate some very promising reproductive health activities around the world, these two factors conspire to create serious challenges to their sustainability.

INTERNATIONAL FINANCING

The limited number of significant international donors and trends in their funding patterns do not hold out much promise for meeting the financial goals of the ICPD Programme of Action. As noted in Appendix 2: Table 1, twenty bilateral donors contributed $1.37 billion in 1995, some $3.6 billion short of the total bilateral and multilateral targets projected for 2000. Four countries -- the United States, Germany,

the United Kingdom. and Japan -- accounted for 73.39% of the total bilateral assistance. The U.S. was by far the lead donor, providing nearly four times the amount of the second largest donor, Germany. The United Kingdom, the Netherlands, Norway and Sweden made substantial contributions in relation to their national output.

Unless there is a major recommitment of funds by current donors or an increase in the number of donor countries, it is highly unlikely that global funding of the magnitude projected by the Programme of Action will be available over the next twenty years. Unfortunately, current funding patterns suggest that there is likely to be some uncertainty about the levels of financing even in the near term. This is attributable to several factors, chief among them the decreasing levels of assistance from the United States, relatively low levels of financing from a handful of countries committed to the Programme of Action, and a lack of commitment on the part of other potential donors.

Studies of donor countries reveal the extent of the dilemma, and certain paradoxes. For example, the United States played an important leadership role in enlisting support from Europe and Japan in the run-up to ICPD. Its leadership was evident through 1995 when the U.S. Agency for International Development (USAID) managed to marshal substantial levels of assistance for reproductive health programs. These levels could not be maintained post-1995, however, due to restrictions imposed by a newly-elected Congress concerned that family planning involves abortion. There has, therefore, been a steady decline in U.S. funding over the past three years (Appendix 2: Table 2). Despite the continued support for the reproductive health approach from the President and USAID, there is little immediate prospect for funding recovery in the near term.

For its part, Sweden has maintained a consistent level of reproductive health financing in its overseas development program over the years, but neither it nor its neighbors can be expected to make up the anticipated shortfall in global funding. In singularly generous

LIMITATIONS OF AVAILABLE DATA

SEVERAL LIMITATIONS IN THE NATURE AND SCOPE OF DATA AVAILABLE, BOTH WITHIN DEVELOPED AND DEVELOPING COUNTRIES, MAKE ANALYSIS OF FINANCES DIFFICULT

- National financing data in developing countries includes expenditures by government entities and private sector entities, including households and individual users. Precise estimations of household and consumer expenditures, which constitute a large proportion of expenditures in many countries, cannot be made.
- Accounting standards were changed and definitions of health and population data were broadened post-ICPD making time-series analysis difficult.
- A variety of definitions are used for reproductive health and population activities.
- National budgets of developing countries itemize expenditures differently. Precise data on the reproductive health element of many budgets cannot be determined. Comparisons across all countries on many of the elements of reproductive health are impossible due to lack of common categories of data.
- There is no central source of comprehensive financial information on reproductive health services (as defined in ICPD POA: 7.6) in any country, developed or developing.
- Funding periods and fiscal years differ among and across donors and national governments.
- Donors report data in many ways. Data is reported as obligations (funds committed to be spent), expenditures (funds actually spent) and appropriations (funds allocated by, for example the U.S. Congress, in a year) – all of which may be different. There is also a considerable time lag between initiation of new activities by donors, obligations to these initiatives and actual expenditures.

fashion, the United Kingdom doubled its commitment to reproductive health between 1993 and 1997. Direct U.K. bilateral aid to developing countries, primarily to public sector reproductive health programs in Africa and South Asia, increased more than threefold during the same period. However, even this level of generosity alone will not begin to achieve the amounts stipulated as necessary in the Programme of Action.

As long as the burden of financing reproductive health programs continues to lie primarily with a small group of developed countries, there is little likelihood of approximating current goals. Unfortunately, a vast majority of developed countries, all signatories to ICPD, show very little intent, through action or finances, to honor their endorsement of the ICPD. For example, France, Belgium and Switzerland, all of which have the capacity to contribute far more than they do at present, have evidenced little inclination to support the Programme of Action. Significant levels of donor funds have been available for initial implementation of reproductive health care in the developing countries studied, but the unpredictable nature of donor funds creates considerable uncertainty about sustainability.

NATIONAL FINANCING

The ICPD Programme of Action emphasizes the central role of developing countries in mobilizing resources for their own action plans and a good faith effort seems to be underway. A wide variation in this effort is evident due to local economic conditions. In Bangladesh, Egypt and South Africa, national financing in the health and population sector increased post-1994, whereas in Tanzania, total allocations to health have fallen due to the increased pressures of debt servicing and tightened fiscal management. Economic crises, in Indonesia in 1997 and Mexico in late 1994, led to reduced health spending, although the Mexican health and family planning budgets improved in 1997. Overall, the studies raise doubts as to whether efforts to mobilize national resources are sufficient for further implementation of the reproductive health approach let alone whether the mobilization can be sustained.

In general, the allocation of public sector resources to health and population comprises a small proportion of total public sector expenditures. In Bangladesh, for example, 1997 expenditures on health and family planning amounted to 7.3% of total public sector expenditures and only 1.3% of GDP. Given competing claims for scarce public funds, it is prudent to assume that the majority of developing countries studied will require donor assistance, at least in the near term.

Consider the case of Tanzania. A review of the 1997-2001 budget of the Reproductive Health and Child Survival Unit—the unit within the Ministry of Health principally responsible for implementing the reproductive health strategy—suggests that $10 million per year might be available for population and reproductive health programs. However, this new unit is extremely donor dependent, and the bulk of funds are intended for contraceptive procurement. Hence, Tanzania's reproductive health strategy is hardly ensured. Indeed, in 1996, 98.5% of all population/reproductive health expenditures in Tanzania were funded by external donors (Appendix 2: Table 4), with half (bilaterally or through NGOs) coming from the United States. The U.K.,

Netherlands and Sweden accounted for another 30%, making Tanzania's health programs overall entirely dependent on four major donors. Furthermore, Tanzania's serious debt burden could divert health-sector funds to debt-financing, leaving even fewer domestic resources for reproductive health.

In Indonesia, the overall health sector budget of the government rose steadily between 1994-1997 while donor funds declined. However, the financial crisis of 1997 engendered competing claims on resources and has diverted attention of the government from reproductive health to broader issues of primary health care and other critical areas of concern, such as employment, food and social stability. Government and donors alike have had to grapple with the effect of currency collapse on the provision of health and family planning services. Immediate responses to the crisis have focused largely on the supply of contraceptives. Allocation of resources towards broader reproductive health needs is negligible and does not appear to be forthcoming -- although it should be noted that inadequate attention to the reproductive health approach long predates the current crisis.

National governments will need to assume greater responsibility for resource mobilization and program implementation.

The economic crisis affecting Mexico in late 1994 led to a contraction in public sector spending after four years of steady growth. Both total public sector and health sector budgets dropped in 1995 and improved in 1996-1997. However, as a percentage of total budget, health budgets dropped slightly from 11.1% in 1996 to 10.9% in 1997. National family planning budgets dropped by half during 1994-1995, compounded by local currency devaluation, and then rose slowly in 1996, only to jump in 1997 to $238 million, the highest level in a decade. Since ICPD, UNFPA has been reducing its level of assistance to Mexico; and USAID support, the most important form of assistance over the last five years, is being phased out. Consequently, Mexico is attempting to move toward sustainability, while acknowledging that key areas of donor assistance -- research, training, program improvement and decentralization, and information and education -- could suffer.

In Egypt, national resource mobilization is still in its infancy. Public spending in the health and population sector has increased but remains low. In 1995, health care spending represented 3.7% of GDP, markedly below the 4.8% of GDP regional average for Middle East and Africa. International donors account for a significant portion of health and population sector costs. Some donor assistance is directed towards integrating reproductive health into existing services, but assistance from major donors such as USAID, slated to phase-out in 2006, is primarily directed towards promoting cost-effective programs and financial and institutional sustainability. Egypt is undergoing structural adjustment programs coupled with expected decreases in donor funds; thus the future of reproductive health programs in the ICPD host country remains uncertain.

The case of Bangladesh offers both promise and cause for concern. Public spending on health and family planning as a proportion of total public sector expenditures has increased from 4.8% in 1984 to 7.3% in 1997, although the level of public expenditures remained more or less unchanged at around 17% of GDP during this period. Family

reproductive health approach. Despite the government's commitment to the HPSP, the resource challenge seems formidable given the prospects of increased costs for improvements in quality and services, and the level of additional resources required from the public sector. Analysis of 1994-95 data reveals that households provide 46% of the funds for health and population activities, and 97% of household expenditures are directed toward private sector services, resulting in an extremely low level of cost recovery for public sector programs.

Among the case studies, South Africa alone suggests an alternative to donor financing, although it must be recognized that this country is a special case. South Africa generally eschews external donor funding, particularly in the form of loans, in order to limit indebtedness. In 1996-97, for example, only 1.2% of total health expenditures was donor funded (Appendix 2: Table 4). US$1.7 billion of public sector funding went towards primary health care, yet even this amount falls short of $2.13 billion estimated as being required to meet optimal primary (including reproductive) health care needs. Nevertheless, the nation's current process of reprioritizing health care resources has the potential of making adequate finances available for implementation of the reproductive health approach.

IV. Sustaining the Reproductive Health Approach

Decreasing levels of donor support, especially from the United States, uncertainties with regard to domestic levels of financing, and competing priorities for scarce resources pose a triple threat to the future of the reproductive health agenda of ICPD. Unless international donors recommit and additional funds can be mobilized within the countries themselves, prospects for sustaining the reproductive health approach will be dim. As the Programme of Action states, "In mobilizing resources for these purposes, countries should examine new modalities such as increased involvement of the private sector, the selective use of user fees, social marketing, cost-sharing and other forms of cost-recovery." The capacity to mobilize such resources internally will ultimately depend on locating ownership for policies and the development of program priorities within countries themselves. This, in turn, should be dictated by client demand.

When client needs serve as the basis for decisions on health policies and provision of services, every individual and the society as a whole stands to benefit. But health care improvements will not accrue through rhetoric alone; efforts must be made to inform communities of their new opportunities and responsibilities. Although levels of financing are important, more attention to the following areas may well increase the potential for sustaining the reproductive health approach, it should, however, be noted that these are necessary but not sufficient conditions for sustainability:

BUILDING EFFECTIVE CLIENT DEMAND

ICPD placed the well-being of individual women, men and families at the epicenter of every activity. This client-centered approach should continue to guide policy formulation, implementation and evaluation, and the magnitude and direction of financing. It would make sense to develop systems to determine and evaluate such demand, and incorporate it into priorities for policy and program design. Yet in most countries studied, implementation of the reproductive health approach largely follows a "top down" strategy; the demand-side of the equation is still seriously underdeveloped. Client knowledge of health-related problems and possible solutions to these problems are generally limited by the biases of health clinic staff and the availability of a pre-selected package of services. In addition, communications by community-level workers are mostly limited to women. Strategies to increase the involvement of men in reproductive health programs have yet to be widely developed.

The issue of human rights and equity is central to the process of building effective demand Clients farthest away from the centers of decision-making and with the greatest problems of access should be the focus of outreach efforts. Simultaneously, activists, health professionals, and service providers have to relay client needs and demands to implementing institutions and policy makers. Information must flow in both directions.

FOSTERING OWNERSHIP OF PRIORITIES

The reproductive health approach is a process that is best driven and owned by national actors, and based on national priorities. Yet in most countries studied, the reproductive health approach is being translated into selected programs at the insistence of international donors. Although donor pressure is welcomed among advocates of the reproductive health approach, there is reason to be concerned that national mobilization of resources and community ownership of priorities will remain underdeveloped, affecting long-term sustainability.

In Bangladesh, for example, the Health and Population Sector Programme for 1998-2000, which incorporates the reproductive health approach, emerged primarily due to strong donor pressure to conceptualize and implement the program along the lines of the ICPD. Similarly, in Tanzania, the strong influence of international donors resulted in framing the 1998 Reproductive Health and Child Survival Strategy (RH/CS) establishing the RH/CS unit within the Ministry of Health. This, coupled with near total reliance on donor support, leads to strong concerns over whether reproductive health is a priority for the Tanzanian government and people, and whether lack of national ownership and future changes in donor priorities will limit the program's sustainability.

Transparency and accountability need to be established as key elements of international cooperation.

STRENGTHENING NATIONAL CAPACITIES

The reproductive health approach, however well understood and fully owned within a country, cannot be sustained without the development of national capacities for program planning and implementation. This need is especially acute in countries undergoing a process of decentralization, where local capacities to implement the programs are weak. Here again policy makers must consider equity of service and access, for the comparative advantage of local-level institutions to implement programs lies predominantly in their proximity to individual clients, their priorities and needs.

In Mexico, for example, the implementation of the Reproductive Health and Family Planning Program is being undertaken by state-level population councils and non-governmental organizations. State-level human and technical capacities are still underdeveloped, hence implementation of programs through local groups may not be immediately effective in addressing client needs. Similarly, in South Africa a primary challenge to sustaining the reproductive health approach lies in the lack of management and personnel capacities at the provincial and district levels.

MANAGING BETTER WITH EXISTING RESOURCES

Several studies point to considerable overlap and duplication in the administration of separate health and family planning bureaucracies. Management of diverse projects by separate, uncoordinated departments can lead to inefficient use of both human and material resources, with donor funds often spread over a multitude of uncoordinated projects. By integrating health, population and, in some cases, gender and development services, governments may achieve both efficiencies and cost-savings in management structures and service delivery.

EXAMINING ALTERNATIVE SOURCES OF FINANCING AND COST-SHARING MECHANISMS

Given uncertain donor financing and the long-term mobilization of national public sector resources, alternative sources of financing, such as user fees and social insurance, are being tested in various forms. Partnerships between the public and private sectors also are being promoted as a means to finance and deliver health services.

In Bangladesh, cost-sharing strategies are receiving considerable attention as a means to achieve financial sustainability in the new health sector program. Cost-recovery programs are being piloted, in collaboration with select NGOs, to assess the potential of these programs in generating revenues and improving quality of services. Cost-sharing is also an integral part of the Tanzanian government's reform strategies and has gained widespread support as a revenue generating mechanism for the health sector. Health care is now available on a fee-for-service basis at all hospitals within a "generalized system of cost-sharing," where large numbers of people pay small charges. Yet revenues generated from these schemes have thus far been small in relation to what is needed to sustain the health care programs.

Social health insurance schemes are also being examined as a means of underwriting health care costs while opening up a broader range of choice in services. Such schemes, also being piloted by the government in Bangladesh, build on experiences of successful health insurance programs being implemented by non-governmental organizations. In Egypt and Indonesia, national insurance schemes, funded jointly by government contributions and individual premiums, are being established to support the financing and provision of health services.

Most of these cost-sharing programs are in quite early stages of development and the extent to which they can operate without damaging the principles of equity and quality embodied in the reproductive health approach demands careful review. In circumstances where information is scarce and choice limited, cost-sharing does not always fulfill the ICPD mandate to extend health services to all members of society. Applied too ambitiously, user fees can exclude low-income individuals from quality health care. The Bangladesh study suggests that given the biased resource allocation pattern within households on the basis of age and gender, such fees may actually worsen the relative health status of women and children. A study conducted in government hospitals in three districts of Tanzania showed a 53.4% decline in utilization after fees were introduced.

ESTABLISHING PARTNERSHIPS

The enormity of tasks yet to be accomplished in implementing the reproductive health approach makes the ICPD principle of increased partnerships a necessity. Cooperation with both non-governmental organizations and corporations on the various aspects of reproductive health care holds promise for increasing the range of services to a larger portion of the population and facilitating domestic sustainability of programs.

Public sector collaboration with NGOs can be beneficial in many ways: in developing innovative, cost-effective, and nationally replicable models; in providing services at the community level and in under-served areas; in promoting outreach activities to educate clients; in drawing attention to neglected issues; in mobilizing

activities to educate clients; in drawing attention to neglected issues; in mobilizing community support; and in creating effective demand among clients and communicating clients' needs for the purpose of program monitoring, evaluation and policy-decisions.

Consider the case of Bangladesh, where NGOs are allowed to function without extensive public sector control and regulation. Many current features of the government's family planning program were initially developed and field tested by NGOs. In Mexico, non-governmental organizations such as MEXFAM (Fundacion Mexicana Para La Planeacion Familiar) and FEMAP (the Mexican Federation of Private Associations in Health and Community Development), together account for a large share of health service provision; and NGOs such as GIRE (Grupo de Informacion en Reproduccion Elegida) have been influential in drawing attention to often unattended areas of women's health, such as cervical cancer. In South Africa, a wide spectrum of NGOs were involved in developing and upholding the reproductive rights content in the new constitution and abortion legislation.

Despite a clarion call for increased partnerships with the corporate sector, the role of corporations is for the most part limited to social marketing campaigns. Indeed, the Social Marketing for Change (SOMARC) worldwide project funded by USAID, remains, by far, the only significant initiative to involve the commercial sector. Since its inception in 1981, the project has worked closely with a number of pharmaceutical companies to develop distribution networks and pricing structures that encourage low-income consumers to purchase essential health products at affordable prices.

Private foundations have played a significant role in promoting the reproductive health agenda of the ICPD Programme of Action. While it is difficult to specify their collective financial contribution, UNFPA 1996 data indicate that their aggregate funding places them sixth among international donors. NGOs depend largely on the contributions of private foundations for their crucial program innovation, service and advocacy activities.

In addition to non-governmental organizations, corporations and foundations, private doctors and pharmacies account for a large share of health-service delivery and serve large segments of populations in many developing countries. In several of the countries studied, the low quality of services at public health facilities results in increasing reliance on private health care facilities. In Egypt, 62% of clients utilized private clinics, pharmacies and doctors to obtain contraceptive supplies. In Bangladesh, 97% of all 1995 household expenditures on health and population related services were directed towards private sector providers. Private sector care does not equal quality care, however, especially in countries lacking well-established regulatory structures for the conduct of practitioners and the protection of clients. Public-sector partnerships with private health care providers should, therefore, be established only after careful assessment of the nature and extent of services required and the resulting improvements to cost, quality, and access.

IV. CONCLUSIONS

The reproductive health approach advanced at the ICPD holds promise to improve health care and quality of life for billions of people. It should and must be sustained. The challenges to implementation identified in this report are not insurmountable. Even in the face of financial uncertainty, it is possible to build incrementally and progressively on the positive aspects of existing programs, and to demonstrate over time that the reproductive health approach does work.

International donor support is critical to this effort and will require a sustained commitment. It is imperative to view the ICPD Programme of Action as a long-term goal, achievable through diverse program strategies that are appropriate in different country contexts. Donors must exercise responsibility over the long term, as well as flexibility in their funding, in order to ensure that the reproductive health approach, that many donors so energetically promoted, is able to take root and become sustainable within developing countries.

The developing countries themselves must exercise wisdom and foresight in balancing investments in social programs, such as reproductive health, against anticipated future gains. This is especially true in countries affected by severe economic crisis or under the strain of foreign debt. Good health is a prerequisite to development. The urgent need to maximize the effective use of scarce resources makes this an opportune time to press for greater integration across sectors and demonstrate the efficiencies that an integrated approach to development can bring about. NGOs can help ensure that the reproductive health approach is central to these development activities. Ultimately, however, consumers must create the demand that legitimizes public expenditures for the reproductive health approach and the combination of services recommended in the Programme of Action

V. RECOMMENDATIONS

The recommendations that follow address key issues affecting future implementation and sustainability of the reproductive health approach advanced at the ICPD. They are intended for a variety of stakeholders, primarily for bilateral and multilateral donors, but also for national governments and non-governmental organizations working at both the international and local levels. They reflect a widely-held concern that a concerted effort is needed to deepen and extend the reproductive health approach and realize its full promise. While financing is a critical focal point, the recommendations reach beyond the question of resource mobilization into the political, institutional and human requirements for sustainability.

In making these recommendations, we recognize the increasingly important role national and local institutions, both public and private, will need to play in order to realize the positive outcomes envisioned in the Programme of Action. We also emphasize the critical, even obligatory, role that donor governments need to play in fulfilling the commitments they have made to the reproductive health approach. National governments cannot do it alone; nor can a handful of donor governments be expected to carry the full burden. Authentic international partnerships -- based on a shared vision, common program goals, and agreed principles of transparency and accountability -- will be essential if the goals established at the ICPD are to be fulfilled.

1. THE LONG-TERM VISION OF THE REPRODUCTIVE HEALTH APPROACH WARRANTS REAFFIRMATION.

The five-year review of the Cairo Conference, ICPD + 5, provides an excellent opportunity to reaffirm the principles and goals of the reproductive health approach and to determine effective strategies for meeting them over time. These strategies must be based on realistic assessments of the conditions and needs in each country and should utilize the lessons learned to date from successful implementation of reproductive health policies and programs. Clear demonstration of the positive impact of these programs will be needed to sustain current levels of funding and to mobilize additional public and private resources both nationally and internationally.

To this end:

- The effectiveness of the reproductive health approach in meeting the health needs of women and their families, in terms of quality of care as well as cost savings, should be vigorously publicized.
- The capacity and appropriateness of the reproductive health approach as a means of effectively addressing the ongoing population growth concerns of many developing countries should be documented and made clear to policy makers and family planning practitioners.

2. LOCAL, NATIONAL AND INTERNATIONAL NGOS NEED TO BE SUPPORTED IN THEIR ROLES AS ADVOCATES AND SERVICE PROVIDERS

Implementing the reproductive health approach has been most successful under conditions in which NGOs are allowed to operate freely and in the public interest. NGOs have been key players in the development and implementation of reproductive health policies and programs, internationally and nationally. They have been influential in establishing policies, setting priorities, developing and testing innovative programs, translating client needs and demands, and holding governments accountable for their actions.

Reproductive health advocates should:

- Encourage governments to provide the legal framework necessary for NGOs to have the freedom of action and financial means needed to carry out their work.
- Provide support to strengthen the fundraising, program management and administrative capacities of local and national NGOs, especially at the district and local levels in the context of decentralization.
- Encourage foundations to increase their efforts to support program innovation and testing through NGOs as well as government agencies.

3. NATIONAL GOVERNMENTS WILL NEED TO ASSUME GREATER RESPONSIBILITY FOR RESOURCE MOBILIZATION AND PROGRAM IMPLEMENTATION.

As agreed in Cairo, it is incumbent on national governments to provide access to effective reproductive health services for their citizens. While private sector contributions are useful in offsetting expenses and promoting innovation, the public sector will remain responsible for establishing policies, mobilizing resources and implementing programs. Moreover, while international support may be important for continued progress, local ownership of policies and programs provides the only basis for sustainability.

National governments should:

- Exercise strong and creative local leadership to ensure the flow of resources to reproductive health programs.
- Provide strong incentives, backed by budget line items, to firmly embed the reproductive health approach in the institutions responsible for health and family planning services. Integrate reproductive health and family planning services, and encourage collaboration across ministries and departments to develop cross-sectoral strategies supporting the reproductive health approach.
- Further explore and test the potential of alternative funding mechanisms, including user fees, social insurance and other cost-sharing measures as a means of raising public revenues for health care. Apply these schemes progressively with careful monitoring to ensure that access for the poor is not limited and that the burden of health costs are not shifted to those less able to pay.
- Develop authentic partnerships based on shared values and an effective division of labor between the public and private sectors. Carefully consider the appropriate roles of non-governmental and corporate actors in the provision of health services.
- Improve and extend training programs to enable health care providers to better understand and deliver on the reproductive health approach, to develop a service ethic

that respects the rights of individuals, and to develop the necessary expertise to provide a "combination" of quality services to women and families.

• Support outreach efforts that build knowledge and awareness of the reproductive health approach among consumers in order to create effective demand for quality services. Develop mechanisms to bring these client-centered demands to the attention of policy makers so they are incorporated into national program design, implementation and evaluation.

• Integrate the principles and values of the reproductive health approach into general health sector reform. Make policy makers aware that adherence to the reproductive health approach will extend the intended benefits of the health sector reform process beyond efficiency and cost-effectiveness to better health care services for the sector as a whole.

4. THE COMMITMENT OF INTERNATIONAL DONORS IS ESSENTIAL.

The programmatic and financial support of the international community will continue to be necessary for many developing countries to advance in the implementation of their national plans of action. International funding commitments will need to be more widely shared among all the countries that endorsed the ICPD Programme of Action so that financial goals can be better approximated and less subject to the will and capacity of a few countries.

Donors should:

• Base international funding firmly on local needs and priorities, as reflected in national programs of action. Donor countries must work together to maximize the programmatic and regional coverage of their funding, and to avoid duplication and wastage.

• Incorporate the reproductive health approach into all international health financing activities and development aid. Efforts to integrate reproductive health into development and poverty reduction programs should be carefully monitored and evaluated.

• Structure the shift from external funding to local sustainability responsibly so that promising initiatives are not curtailed or abandoned prematurely.

5. TRANSPARENCY AND ACCOUNTABILITY NEED TO BE ESTABLISHED AS KEY ELEMENTS OF INTERNATIONAL COOPERATION.

International donors and national governments are to be commended for their good faith efforts in promoting and implementing the reproductive health approach. However, they also need to be held accountable for the commitments they have made if the approach is to progress and be sustainable. ICPD + 5 provides an excellent opportunity for governments and NGOs to work together to produce agreed standards of performance and accountability.

Developed and developing countries should:

• Establish common systems for tracking and monitoring bilateral and multilateral donor aid flows. Improve methods for collecting and reporting data to better reflect expenditures for reproductive health care, and make data available on a regular basis in published reports.

• Create central and open sources for statistical information in each country to track

the allocation and use of donor funds as well as national expenditures for reproductive health care.

- Monitor and report on implementation at regular intervals and according to agreed benchmarks.
- Fund research to develop indicators of reproductive morbidity, of client demand for reproductive health services, gender equity in health service provision, and quality of care.
- Review and revise the global estimates of costs for reproductive health programs for the years 2000-2015 in order to set realizable goals for both donor and developing countries.

APPENDIX 2: TABLES

Table 1

DONOR FUNDS FOR "POPULATION ASSISTANCE" IN 1995 AND POSSIBLE PATTERNS FOR 2000

	Primary funds for population assistance in 1995	Funds needed for ICPD target of $5.67 billion from donors, using GDP (1995) distribution	Shortfalls
	$ MILLIONS	**$ MILLIONS**	**$ MILLIONS**
Australia	27	57	(30)
Austria	3	38	(35)
Belgium	6	44	(38)
Canada	37	93	(56)
Denmark	50	28	22
Finland	22	21	1
France	13	252	(239)
Germany	145	395	(250)
Ireland	3	10	(7)
Italy	4	178	(174)
Japan	94	837	(743)
Luxembourg	1	3	(2)
Netherlands	87	65	22
New Zealand	1	9	(8)
Norway	47	24	23
Spain	1	93	(92)
Sweden	45	37	8
Switzerland	17	50	(33)
United Kingdom	98	180	(82)
United States	667	1157	(490)
SUB TOTAL (B)	**1,368**	**3,570**	**(2202)**
Multilateral, dev't Banks and private	662	2,100	(1438)
TOTAL	**2,030**	**5,670**	**(3640)**

Source: "Meeting the Goals of the ICPD: Consequences of Resource Shortfalls up to the Year 2000", Report of the Executive Director, DP/FPA/1997/12 (Annex) – 10 July 1997. (For France and Spain, 1993 data were used. For Sweden, 1994 data were used. Due to rounding, columns may not sum exactly to totals.)

Table 2 : Flow of Funds from (project's selection of) Donors

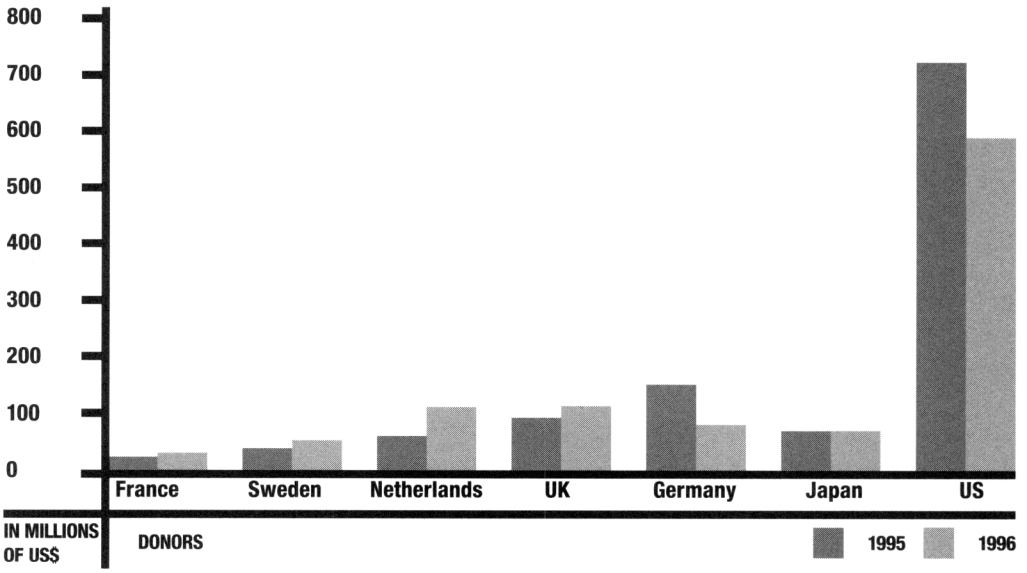
000'S OF CURRENT US$					
	1993	**1994**	**1995**	**1996**	**1997**
U.K	47,914	70,913	98,341	109,319	119,880
USA	622,500	643,000	717,300	599,800*	552,500*
Sweden	37,005	44,686	44,686	57,923	55,736
France	13,422	13,422	13,422	16,500	N/A
Switzerland	6,146	8,225	17,098	16,212	13,092
Belgium	2,281	2,869	5,594	5,475	N/A

Source: Compiled by the Center on International Cooperation from country case studies of the respective countries [Appendix 1]. Data used in the studies were from the reporting of itemized expenditures of the following sources: USA (USAID obligations for "Population and Reproductive Health Assistance"); U.K. (DFID expenditures for "Population, Sexual and Reproductive Health Statistics"); Sweden (SIDA expenditures for "sexual and reproductive health and rights and HIV/AIDS/STD control" and UNFPA report on "population assistance"); Switzerland (SDC allocation for "population activities" and UNFPA report on "population assistance"); and France and Belgium ("population assistance" reported by UNFPA). Data compiled was converted to US current dollars using the period average exchange rates reported by the "International Financial Statistical Yearbook, 1997" of the International Monetary Fund (see Appendix 2: Table 5)

Note: i) UK expenditures from 1994 onwards includes HIV/AIDS expenditures.

II) Figures are approximated to the nearest thousand. * Decrease in funds post-95 in the U.S. is primarily due to a shift in power to majority Republican Congress which imposed restrictions on family planning assistance. The 1996 and 1997 figures include $385 million in "population" assistance, restricted since 1996 to be maintained at that level.

Table 3 : Flow of Funds from Selected Donors (five major donors, Sweden and France)



Source: Appendix 2: Table 2 and UNFPA reporting of "population assistance" in Global Population Assistance Report 1996 for Germany, the Netherlands and Japan. Germany: 1995 - $145.344, 1996 - $96.033, Netherlands: 1995 –$86.601, 1996 - $111.707, Japan: 1995 - $93.76, 1996-$93.76 (all in millions)

Table 4

SHARE OF NATIONAL AND INTERNATIONAL FINANCIAL RESOURCES OF TOTAL HEALTH/POPULATION EXPENDITURES (%'S) FOR 1996

	Egypt	Indonesia	Tanzania	South Africa
National	73	89	1.5	98.8
International	27	11	98.5	1.2

Source: UNFPA/Netherlands Interdisciplinary Demographic Institute (NIDI)- "Global resource flows for population activities: Post ICPD experience" paper, 1998.
* South Africa (as reported in the CIC case study); the figure is for 1996/1997.

Table 5

SELECTED EXCHANGE RATES 1993-1997

(LOCAL CURRENCY PER U.S. DOLLAR, UNLESS OTHERWISE SPECIFIED)

	1993	1994	1995	1996	1997
BANGLADESH					
Period Average	39.5670	40.2120	40.2780	*41.7940*	43.8920
End-of-period	39.8500	40.2500	40.7500	*42.4500*	45.4500
BELGIUM					
Period Average	34.5970	33.4560	29.4800	*30.9620*	35.7740
End-of-period	36.1100	31.8380	29.4150	*32.0050*	36.9200
EGYPT					
Period Average	...	...	...	*...*	...
End-of-period	3.3718	3.3910	3.3900	*3.3880*	3.3880
FRANCE					
Period Average	5.6632	5.5520	4.9915	*5.1155*	5.8367
End-of-period	5.8955	5.3460	4.9000	*5.2370*	5.9881
INDONESIA					
Period Average	2,087.1	2,160.8	2,248.6	*2,342.3*	2,909.4
End-of-period	2,110.0	2,200.0	2,308.0	*2,383.0*	4,650.0
MEXICO					
Period Average	3.1156	3.3751	6.4194	*7.6009*	7.9141
End-of-period	3.1059	5.3250	7.6425	*7.8703*	8.1360
SOUTH AFRICA					
Period Average	3.2677	3.5508	3.6271	*4.2994*	4.6080
End-of-period	3.3975	3.5435	3.6475	*4.6825*	4.8675
SWEDEN					
Period Average	7.7834	7.7160	7.1333	*6.7060*	7.6349
End-of-period	8.3035	7.4615	6.6582	*6.8710*	7.8770
SWITZERLAND					
Period Average	1.4776	1.3677	1.1825	*1.2360*	1.4513
End-of-period	1.4795	1.3115	1.1505	*1.3464*	1.4553
TANZANIA					
Period Average	405.2700	09.6300	574.7600	*579.9800*	612.12006
End-of-period	479.8700	523.4500	550.3600	*595.6400*	24.5700
UNITED KINGDOM (1)					
Period Average	1.5020	1.5316	1.5785	*1.5617*	1.6377
End-of-period	1.4812	1.5625	1.5500	*1.6980*	1.6538

Source: International Financial Statistics Yearbook, 1997, IMF
(1) U. S. dollars per pound.

APPENDIX 3: PUBLICATION

Promoting Reproductive Health : Investing in Health for Development
Edited by **Shepard Forman** and **Romita Ghosh**

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Lessons Learned: The Need to Invest in Reproductive Health – **Axel I. Mundigo**

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