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Interpreting Reproductive Health

ICPD + 5 Forum, The Hague, 8-12 February 1999



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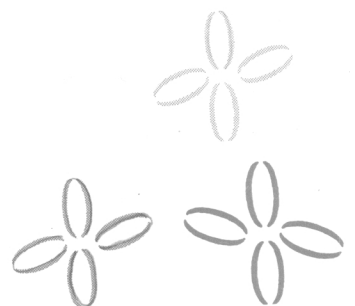
Interpreting Reproductive Health

ICPD + 5 Forum, The Hague, 8-12 February 1999

"PROGRAMA UNIVERSITARIO DE
ESTUDIOS DE GENERO" - U. N. A. M.



**World Health Organization
Geneva**



Acronyms

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
DALY	Disability Adjusted Life Year
FGM	Female genital mutilation
HIV/AIDS	Human immunodeficiency virus/Acquired immunodeficiency syndrome
HPV	Human papilloma virus
HRP	UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction
ICPD	United Nations 1994 International Conference on Population and Development, held in Cairo, Egypt
IPPF	International Planned Parenthood Federation
NGOs	Non-governmental organizations
PHC	Primary Health Care
STIs	Sexually transmitted infections
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHO	World Health Organization



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EXECUTIVE SUMMARY

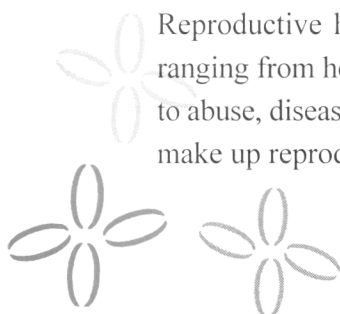
Although the term “reproductive health” has been used by scientists, practitioners, and consumer groups for some years, its widespread acceptance came in 1994 with the adoption by 178 countries of the Programme of Action of the International Conference on Population and Development (ICPD), held in Cairo, Egypt. ICPD argued that it is possible to achieve the stabilization of world population growth while attending to people’s health needs and respecting their rights in reproduction. ICPD reinforced and gave legitimacy to the language of health and rights, and validated the concerns that had already been raised by the international women’s movement and by health professionals who had recognized the needs of people in sexuality and reproduction beyond fertility regulation.

It takes time to turn institutions and thinking around, and even longer to be able to measure the impact of those changes. Still, in 1999 we are able to see that a number of important changes have taken place. The language has changed. Governments and international agencies no longer speak of population control, but of reproductive health and rights, and quality of care. New policies and programmes have been developed by many national governments as well as inter-governmental agencies, specifically to improve reproductive health. New partnerships have been formed between governmental and non-governmental organizations working to implement reproductive health and rights. Neglected groups, notably adolescents and men, have been targeted with newly developed programmes. Finally, evidence is being generated on hitherto neglected issues such as violence against women, best practices for combatting female genital mutilation, and optimal post-abortion care.

In the preparations for ICPD, the World Health Organization (WHO) contributed significantly to the technical discussions on reproductive health, defining the concept, summarizing the available epidemiological evidence, identifying the range of conditions that comprise it, and outlining principles of care. To implement the ICPD Programme of Action, WHO itself has made a number of important structural changes so that it is now better positioned to support countries in confronting the challenges of implementing the ICPD’s reproductive health agenda. For instance, the research mandate has been broadened beyond fertility regulation to include other key areas of reproductive health, and more attention will be given to improving how national and district-level health authorities meet people’s reproductive health needs.

Yet it is also now quite apparent that there are different interpretations of what reproductive health means in theory and practice. Behind the new language, people mean different things.

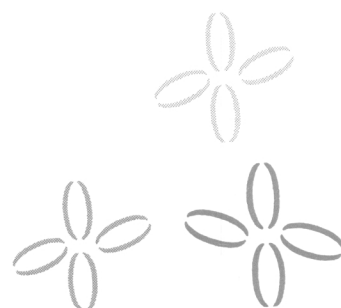
Reproductive health refers to a spectrum of *conditions*, events and processes through life, ranging from healthy sexual development, comfort and closeness and the joys of childbearing, to abuse, disease, disability and death. Profoundly life-affirming and life-threatening conditions make up reproductive health.



Reproductive health is also an *approach*. When we use the language of ICPD, we talk about health needs, but we also talk about rights, equity, dignity, empowerment, self-determination and responsibility in relationships. Reproductive health is an approach to analysing and then responding comprehensively to the needs of women and men in their sexual relationships and reproduction.

Effective reproductive health *services* have been defined. However, those services do not always reach everyone in need, and not always with the optimal quality of care. Against these already large challenges loom world economic trends that are creating greater disparities between people, and, in some places, forcing governments to radically alter their spending away from health and social services. The economic crisis and restructuring are not side issues but must be confronted as a central part of planning the way forward with reproductive health services. In addition, the Cairo Conference urged the reproductive health community to think more broadly about interventions, and to come up with concrete responses that involve other sectors such as finance, law and education.

The twenty years of experience with Primary Health Care offer some lessons for reproductive health. Most important among them are: the need to clarify concepts and to specify, in concrete examples, what the new approach means *in* health services and *for* other interventions. In reproductive health, as with Primary Health Care, it is necessary to define the division of labour among sectors and professions in promoting and carrying out an agenda that is as much about social justice as it is about health care.



INTRODUCTION

Although the term “reproductive health” has been used by scientists, practitioners, and consumer groups for some years, its widespread acceptance came in 1994 with the adoption by 178 countries of the Programme of Action of the International Conference on Population and Development (ICPD), held in Cairo, Egypt.

ICPD was indeed a landmark event. The Conference and its Programme of Action signalled a new international consensus about the interrelationship of population, development, rights and health, and presented significant innovations in thinking compared to the Bucharest and Mexico City Conferences on population of 1974 and 1984¹. ICPD argued that it is possible to achieve the stabilization of world population growth while attending to people’s health needs and respecting their rights in reproduction. We now refer to this “paradigm shift” away from family planning and population control to reproductive health as perhaps the greatest achievement of ICPD.

The success of any international gathering such as ICPD will, of course, be judged on the effective implementation of the recommendations contained in the Conference document. So where are we now, in 1999, five short years after this landmark event? How successful has ICPD been? What has changed?

It is important to remember that for nearly three decades it was difficult to distinguish between the subject of population and the dominant concern about it, namely how to control excessive population growth, particularly in poor countries. Public alarm was raised, international aid was mobilized, and governments in developing countries were encouraged to set demographic targets and establish policies, institutions, and programmes dedicated to the control of population growth. The major theorists were economists who argued that rapid population growth would not only hinder development, but was itself the cause of poverty and underdevelopment.²

While there was some initial scepticism about that paradigm in developing countries, many soon adopted the language and activities of population control. Governments were encouraged to establish free-standing family planning institutions, often separate from Ministries of Health, in order to respond rapidly and efficiently to the threat of their growing population. In effect, family planning services were often totally separate from primary or maternal and child health care, or, if located in the same physical premises, often had distinct administrative, financial, training, and supervisory structures. Family planning workers were charged with motivating and recruiting contraceptive “acceptors,” and their performance was evaluated accordingly.

The period from the 1960s through the 1980s was also a time when public health and donor agencies invested heavily in the reduction of infant and child mortality, with the overriding



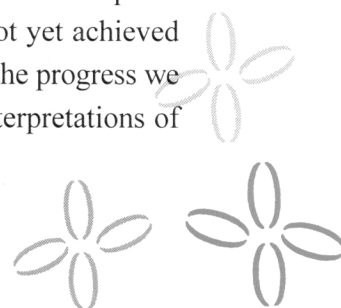
belief that technological advances would accomplish the goal of improved child survival. This, coupled with the preoccupation over population growth, led to the neglect of broader issues in reproductive health and women's health.

The gradual shift to a more nuanced understanding of population, fertility, and reproductive health is well documented.³ The impetus behind the shift came from three directions. The international women's movement strongly criticized the over-emphasis on controlling women's fertility, to the exclusion of their other needs, and began to forge strategic alliances with health providers, researchers and policy-makers to push for change. They also insisted that women's human rights in sexuality and reproduction be protected and promoted. Health professionals challenged population experts by reiterating their concern over reproductive health beyond mere fertility regulation. The 1987 Nairobi Conference on Safe Motherhood, for example, urged that broader focus. Finally, the HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome) pandemic soon showed the scientific necessity and moral imperative of responding to the consequences of sexual activity other than pregnancy, in particular sexually transmitted infections (STIs); the pandemic also underlined the urgency of understanding the social and behavioural context of health and opened for discussion within the public health community the issues of sexuality and sexual relations.

ICPD provided an exceptionally well-timed international forum to mark the shift in understanding, and also to recognize the demographic changes that have occurred in recent decades. But it takes time to turn institutions and thinking around. Realistic expectations take into account the time and effort it takes to shift the paradigm at all levels; global policy-makers must move from vertical to comprehensive thinking, and health workers need to learn to trust and listen to people. The first part of this paper presents some of the changes that have already taken place in countries and institutions.

Making changes presents the first challenge; measuring them presents the second. While many reproductive health initiatives predate the Cairo Conference, not enough time has elapsed to measure the effects of the paradigm shift on demographic and health outcomes in particular. The real success of ICPD will only be able to be measured some years into the future. In the meantime, the work by many organizations to create practical and scientifically robust indicators on which to measure progress is absolutely critical.

It may also be that making the change from population control to reproductive health requires more intellectual work on our part. Indeed, this paper argues that we have not yet achieved sufficient clarity about what reproductive health means, and that this threatens the progress we do desire. The new language appears to be masking significantly different interpretations of reproductive health. The second part of the paper addresses this concern.



WHAT HAS CHANGED

The language has changed

After three decades of naming the problem one way, the way we talk about the issue has changed. ICPD reinforced and gave legitimacy to the language of health and rights. In China, for example, which has had the world's most directive population control programme, the State Family Planning Commission has adopted the language of reproductive health and acknowledges women's demands for a higher quality of care.⁴ So too in India, well-known for the controversies associated with its contraceptive-specific target-setting, the Government has used the Cairo Programme of Action as the impetus to rethink its entire approach; it has adopted a target-free approach nationwide, and has named its large World Bank-supported population and child survival projects "The Reproductive and Child Health Programme".

Changing the language is the essential first step.

New policies and programmes have been defined, and institutions restructured

Since ICPD in 1994 many national governments have begun to develop specific policies and programmes to improve reproductive health. For instance, the countries with economies in transition, such as Belarus, Bulgaria, the Republic of Moldova, the Russian Federation and Ukraine, have all developed reproductive health policies. The two cases highlighted here, India and Zambia, underscore two different but common challenges that governments confront as they move to implement the new policies.

Zambian national reproductive health policy

Zambia does not have a long history of publicly supported family planning; the first government-supported clinic opened only in 1988. Yet after ICPD, the Government of Zambia created a comprehensive national plan to improve reproductive health using WHO guidelines for a broad participatory and multi-constituency process to identify reproductive health needs.⁵ The priorities identified include : maternal health, family planning, HIV/AIDS/STI prevention and management, violence, adolescent sexual and reproductive health, and the prevention of unsafe abortion and management of its complications.

Health sector reform in Zambia moved planning and budgetary decision-making away from the national level to District Health Boards and hospital Boards of Management. Based on local evidence, district level managers had to decide which of the national priorities are also the priorities of their district, and then draw up plans, budgets and programmes accordingly.⁶



While decentralization holds the potential of a more effective response to people's health needs, it does place substantial new demands on district level managers. The experience of such a change in policy has many lessons for other countries attempting health sector reform through decentralization and sector-wide investment strategies.

Target-free India : new reproductive and child health programme

In 1951-52, India was first among nations to establish a Government-run family planning programme with clearly specified demographic objectives and numerical contraceptive targets. The targets were a controversial part of India's programme and led to abuses; among the best publicized were the forced sterilizations that occurred in the Emergency Period of 1975-76.

In April 1996, less than two years after ICPD, the Government of India took the dramatic step to declare all of India target-free. A year later, in October 1997, it launched a nationwide Reproductive and Child Health Programme to provide comprehensive, good quality services, planned and monitored in a participatory and decentralized manner.

India should be applauded for this bold policy change, but early assessments indicate just how difficult it is to shift to a truly client-oriented approach. Previously, field workers had to recruit a centrally determined number of IUD and sterilization acceptors each year. These numbers were the basis on which they planned their logistical requirements and they also served as the measure against which their performance was evaluated. Now, the calculations are made based on what is called "the unmet need" of actual couples in their districts. The field worker or administrator determines this "unmet need", based on the number and sex of a couple's surviving children. It is unclear whether the couple's stated reproductive intentions are taken into account.

The traditional methods of logistical planning and performance appraisal are no longer appropriate in the client-centred approach, but satisfactory alternatives have not yet been put in place. This is a major challenge for all countries, not just India.

Another lesson of interest to the global community will be how the Indian programme shifts the attitudes of service providers and managers away from past approaches that deny clients' rights toward those based on trust and respect. India's experience may provide clues about what works best to shift attitudes — in-service training, new modes of performance appraisal, new partnerships with NGOs that demand accountability, and methods of positive reinforcement, alone or in combination.⁷

Bureaucratic realignment is a required but often thorny step in implementing the new policies and programmes. Technical agencies, funding institutions, and teaching and research centres are also now having to make parallel structural and management changes. The World Health Organization (WHO) itself is a case in point.

WHO, the agency responsible for health in the UN system, has four main functions: advocacy, setting norms and standards, technical support to countries, and support for research. WHO has always supported family planning within the context of better health. In the area of research, the initial focus of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP)⁸ was on expanding the choices of fertility regulation available to women and men by improving existing family planning methods and developing new



methods that would be effective, safe, acceptable and inexpensive. Created in 1972, HRP was managed and funded separately from the parts of WHO responsible for technical support to countries for programmes in maternal and child health, family planning, and sexually transmitted infections.

In the preparations for ICPD, WHO contributed significantly to the technical discussions on reproductive health, defining the concept, summarizing the available epidemiological evidence, identifying the range of conditions that comprise it, and outlining principles of care.⁹

Subsequently, to implement the ICPD Programme of Action, WHO itself has made a number of important structural changes. In 1995, the World Health Assembly, WHO's governing body, endorsed WHO's role in improving reproductive health worldwide and requested the Director-General "to develop a coherent programmatic approach for research and action in reproductive health and reproductive health care to overcome present structural barriers to efficient planning and implementation."

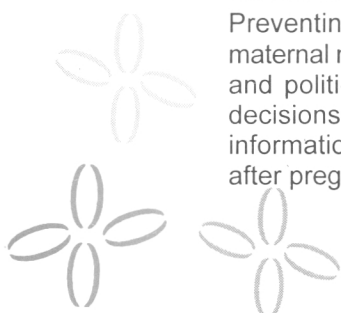
In 1999, WHO is now better positioned structurally to support countries in confronting the challenges of implementing the ICPD's reproductive health agenda. The Department of Reproductive Health and Research, which combines the basic functions of research (HRP) linked to action, is now located in a programmatic cluster that includes child and adolescent health and development, women's health, HIV/AIDS/STIs and health systems. The research mandate has been broadened beyond fertility regulation to include other key areas of reproductive health, and more attention will be given to improving how national and district-level health authorities meet people's reproductive health needs.

Expanding choice of fertility regulation methods. A new approach

The ICPD Programme of Action recommended that the international community mobilize the full spectrum of biomedical, social, behavioural and programme-related research on sexuality and reproductive health,¹⁰ and underscored the need to expand reproductive choice through new and improved methods of fertility regulation. WHO has recently developed a new approach to expanding contraceptive choice in countries. Learning from the difficulties encountered in the introduction of new contraceptives into public sector programmes in several countries, the WHO strategy shifts attention from the promotion of one particular technology to an emphasis on the needs of the population, the mix of methods offered, and the capacity of the system to provide services of high quality. The strategy employs a participatory approach to the research and planning, involving women's health advocates, researchers, health providers and public sector managers in the process.¹¹

The Sri Lanka message on safe motherhood

Preventing maternal death and illness is an issue of social justice. Redefining maternal mortality from a "health disadvantage" to a "social injustice" provides the legal and political basis for governments to ensure that women have the right to make decisions about their own health, free from coercion and violence, and based on full information; and have access to quality services and information before, during and after pregnancy and childbirth.



At the 1997 inter-agency meeting held in Sri Lanka to assess progress toward Safe Motherhood, ten key actions were identified. They are: promote Safe Motherhood as a good investment; emphasize Safe Motherhood as a human right; delay marriage and first birth; acknowledge that every pregnancy is at risk; ensure skilled attendance at delivery; improve quality and coverage of care; increase contraceptive choice; address unsafe abortion; foster partnerships; and monitor and evaluate.¹²

New partnerships have been formed

In the lead-up to ICPD, non-governmental organizations (NGOs) were actively encouraged to participate in the preparatory meetings and they did so with alacrity: negotiating, arguing for their positions, and crafting language for what would ultimately become the Programme of Action. At Cairo itself, official country delegations often included members of NGOs and, in many instances, NGOs lobbied their national delegations and provided language to help out in the official negotiations on the Programme of Action. Most important, NGOs promised that they would not retreat after ICPD and would hold governments accountable for the commitments made in Cairo.

In some places, those new partnerships between governments and NGOs are enduring, albeit with ups and downs as groups earn each others' trust, prove that their motivations are decent, and learn that they have some mutual benefit from collaboration. Members of NGOs have been invited to sit on newly formed policy bodies, advising on reproductive health legislation, policies and programmes. NGOs are also now being looked to for innovations in approaches, and as sites for learning lessons about how best to provide high-quality reproductive health care.

Partnerships for reproductive health in South Africa

Follow-up to ICPD in South Africa must be viewed against the backdrop of the political and social transformations taking place there since the first democratic elections in 1994. In 1995, South Africa endorsed the Platform of Action adopted by the Fourth World Conference on Women in Beijing and ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). In 1996, the Constitutional Assembly approved a new Constitution and Bill of Rights, which define the right of all South Africans to reproductive choice and reproductive health care. In 1997, the Government passed legislation on Choice on Termination of Pregnancy which makes abortion legal and provides free abortion services to all women in public health facilities. This legislation aims to reduce back street (unsafe) abortions and hence to reduce maternal mortality. NGOs played a significant role with Government in drafting the legislation and regulations.

South Africa has also adopted a National Contraceptive Policy, which reinforces the concept of rights; underscores the notion of equity in contraceptive service provision; stresses the need for a minimum level of quality of care with an emphasis on informed choice and improved provider-client relations; and promotes the integration of family planning with HIV/STI prevention and care.



A specific partnership project, the Transformation of Reproductive Health Services Project, was initiated in 1995 through a collaboration between the Women's Health Project, a South African NGO, and the Departments of Health and Welfare in North West, North Cape and Northern Provinces. The project seeks to improve the reproductive health services by identifying the systemic barriers to the quality of care and by increasing an understanding of the impact of social inequality, especially gender inequality, on health and health services.

Based on experience to date, the project highlights the need to involve all levels of workers in the health system — from primary health care workers to middle and senior managers — in the process of diagnosis and change.

They also have learned about the value of partnership between governmental and non-governmental organizations: NGOs often bring different analytical perspectives to the table when they work with governmental organizations. The Women's Health Project, with its commitment to addressing gender, race and power relations in health care, brought to the partnership this overriding concern when analysing factors that limit the quality of care in reproductive health services.¹³

Mexican NGOs join together to work with the Government

In 1993, seventy Mexican women's NGOs and academic institutions founded the National Forum of Women and Population Policy (*Foro Nacional de Mujeres y Políticas de Población*). The Forum is dedicated to the effective implementation in Mexico of the ICPD Programme of Action, working with government at federal, state and local levels.

Effective working relations had to be built out of mutual distrust. Many women's organizations were not accustomed to negotiating or even talking to government officials, and similarly, government officials saw NGOs in general and the feminist movement in particular as critics and adversaries. Over time, however, some important partnerships have been created, aided by the changing political climate in Mexico encouraging citizen participation in public affairs and the decentralization of government structures.

At the national level, the Forum succeeded in having two members on the national delegation of Mexico to ICPD; since then CONAPO, the governmental body that oversees all population activities, has invited Forum members to participate in discussions on the implementation of the ICPD Programme of Action.

At the state level, Forum members have been working with State Population Councils to include a broader reproductive health approach in their activities, and to work with other sectors. Forum members have suggested, for example, that UNFPA funds in three states be used for educating rural women on reproductive health and rights, and for training health care providers in reproductive health and gender perspectives.¹⁴

Common ground meetings

Beginning in 1991, WHO organized a series of "dialogue" meetings to bring together representatives of women's groups, researchers, service providers and policy-makers to provide a forum for exchange of information among those working on women's and reproductive health, and to learn where common ground could be found. These meetings, held in Geneva, Manila, Nairobi, Santo Domingo, Yaounde and Casablanca, have provided a useful forum for exchange of perspectives.

Some important lessons have been learned about the *process* of bringing people together who have radically different perspectives and different statuses. Careful



attention to group dynamics is key, and the principles of how best to work together need to be made explicit. Because health advocates often feel disempowered in discussions with policy-makers and scientists, and recognize that their experience may not be counted as “evidence”, a number of steps need to be taken to bring them into the discussion as equal partners. Advocates should contribute to drawing up the meeting objectives and agenda, be given background briefings on the technical aspects of issues to be discussed, be asked to co-chair sessions with health professionals and policy-makers, and then contribute equally to the crafting of recommendations and planning follow-up activities.

At a number of the “dialogue” meetings, the subject of ethics in research was raised; women’s groups were concerned that issues such as informed consent were not adequately addressed by investigators. As a result, WHO is undertaking an initiative on informed consent in reproductive health research, examining what the process of informed consent means for women who come from different educational and class backgrounds than the researchers.¹⁵

Neglected groups are being addressed

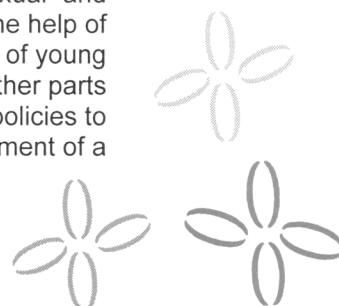
In many countries, reproductive health services are available only to married people, and the sexual and reproductive health of young people remains a neglected area of public health. Today’s young people mature physically earlier than did their parents, they marry on average later, and they are exposed to different social influences than were their parents. Yet, young people are often denied access to the information and services that could help them make wise decisions around sexuality and reproduction. Given the age structure of many populations in developing countries, vast numbers of young people are entering their reproductive years ill-prepared to protect themselves and their sexual and reproductive health.

New methods for assessing the needs of adolescents

WHO’s work on adolescent health has had, as a central aspect, the development of culturally-sensitive methods to elicit from young people their perspectives on their health needs and the solutions to their problems. To plan activities for improving adolescent health, the Ministry of Health in Guinea, for example, used the “narrative research method” to collect qualitative and quantitative information from young people. Results highlighted the link between sexual and reproductive health and other issues such as substance abuse, gender relations, and access to schooling and jobs. The information was used in drafting the national youth policy and Guinea’s reproductive health programme.¹⁶

Estonia creates a programme for adolescents

To respond to the pressing need for better care for adolescents, Estonia, with assistance from Sweden and WHO, established adolescent health centres attached to clinics in three major towns. These centres offer counselling, sexual and contraceptive education for groups, and provision of contraceptives. With the help of the media initially, these centres are now used by an ever-growing number of young people. They have served as a model for the establishment of centres in other parts of the country, and this process has contributed to a variety of government policies to improve reproductive health. The centres have also stimulated the development of a sex-education programme in schools.¹⁷



WHO-sponsored research on adolescent reproductive health

Thirty-five studies undertaken in Africa, Asia and Latin America on sexual behaviour and reproductive health have highlighted a lack of basic knowledge of the body's reproductive functioning and of contraception; little use of contraceptives among sexually active adolescents; increasing sexual activity among adolescents at younger ages; the detrimental effects of single motherhood and abortion; the growing problem of sexually transmitted infections. For example, information and services on sexual and reproductive health offered to unmarried people in China are limited, yet two studies in China — one in urban Shanghai and another in a rural district — found that from 69 to 93 per cent of young women reported premarital sex.¹⁸

The emphasis on controlling women's fertility in the past three decades rendered men almost invisible in reproduction. While men have their own distinct needs in sexual and reproductive health, they also have a strong influence on the reproductive health of the women around them. They may or may not support women's use of contraceptives, or be willing to use contraceptives themselves. When men have multiple sexual partners, they put their partners at risk of sexually transmitted infections, particularly if they are unwilling to use condoms. Men's awareness and support can also help women get essential life-saving care. For instance, a woman experiencing a serious obstetric complication may have her life saved by a husband who recognizes the gravity of the situation, mobilizes alternative support for her domestic work and the care of other children, locates transportation, and pays any charges required at the medical facility.

Roles of men

To understand better how to promote and enable male responsibility in reproductive health, WHO is supporting research on male sexual behaviour, adolescent male sexuality and contraception, male contraceptive practice and men's roles in decisions about fertility and family size. Studies are ongoing in twelve countries of Africa, Asia and Latin America. A study in Thailand, for example, found that, while 79 per cent of husbands report having sex with a sex worker at least once in their life, the discussion of extramarital activity, use of sex workers, and the use of condoms within marriage was difficult or impossible.¹⁹

Evidence is being generated on neglected issues

The ICPD Programme of Action contains an entire chapter on Gender Equality, Equity, and the Empowerment of Women. The chapter recommends that countries take actions to eliminate discrimination against women and girls, and that neglected issues be addressed. Nowhere does gender discrimination seem clearer than on the issues of violence against women, and female genital mutilation, both of which have an impact on the reproductive health and well-being of women. Research can aid action in different ways, as described in the following examples.



Multicountry study on violence

WHO is supporting a seven-country study on the prevalence, risk and protective factors and health consequences of violence against women. The study will obtain reliable estimates of the prevalence of family violence against women; document the health consequences of family violence against women; identify and compare risk and protective factors for violence within families, within and between settings; and explore and compare the coping strategies used by women experiencing violence from family members. An advisory group established within each of the countries will support the implementation of the study and ensure the dissemination of the results.²⁰

Best practice for combatting FGM

Female genital mutilation (FGM) encompasses a range of procedures that involve partial or total removal of the external genitalia for cultural or other non-therapeutic reasons. It is estimated that up to 130 million girls and women have undergone some type of FGM and two million others are at risk of FGM each year. Although NGOs have been active in addressing FGM for the past 15 years, few evaluations have been conducted to learn which activities are the most effective for the prevention and the elimination of FGM at the grassroots level. WHO is planning to derive and disseminate “best practices” from research work in six countries in Africa.²¹

Among other issues for which new evidence has been generated, is unsafe abortion. The ICPD Programme of Action speaks of the need to reduce greatly the number of deaths and morbidity from unsafe abortion, on the basis of a commitment to women’s health and well-being.

Information for policy on abortion care

Over the past decade, WHO has undertaken a major research initiative on practices, beliefs and experiences with induced abortion in 16 countries with different legal contexts, with a view to informing programmes and policy. The studies carried out show that abortion clearly emerges as a prevalent and persistent threat for many women of reproductive age, regardless of their particular socio-economic and cultural background, and the policy context of the country in which they live. The research highlights the need to focus more directly on the needs and preferences of the women who seek abortion, as well as on the attitudes and skills of providers of abortion services. The quality of abortion care needs to be addressed within the given legal contexts of these countries, since certain fundamental elements of abortion care that profoundly affect women continue to be widely neglected, even in places where safe abortion is widely available. The information generated by these studies has been used by health professionals, unions, NGOs and governmental institutions to stimulate public debate in all the countries involved, and in some have brought about policy changes, and improvements in the quality of care.²²



INTERPRETING REPRODUCTIVE HEALTH

The ICPD Programme of Action also contains an entire chapter on reproductive rights and reproductive health. The chapter underlines the importance of reproductive health information and services, voluntary decisions on childbearing, and a life cycle approach in analysing reproductive health needs. The definition of reproductive health was the focus of considerable negotiation at the Conference but in the end international consensus was achieved on Paragraph 7.2.

ICPD Programme of Action, Paragraph 7.2

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for the regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

Some progress has been achieved in the five short years since ICPD. Yet it is also now apparent that there are different understandings about what reproductive health means in theory and in practice. Paragraph 7.2 of the ICPD Programme of Action has not provided sufficient clarity or guidance. While using the same new language, people mean different things. For instance, reproductive health is sometimes used to mean only family planning. Some people imply that it means treating clients better. Others suggest that AIDS is not a reproductive health issue. In addition, the translation of “reproductive health” in different languages brings in different nuances and understandings.

Further progress in implementing the ICPD recommendations, we believe, is threatened by this difference in interpretation. Bureaucratically-inspired categories, past and present, are fostering this imprecision and hindering a proper conceptualization of reproductive health. This section attempts to clarify some of the issues by proposing that reproductive health can be interpreted in three different ways: reproductive health as a human condition, reproductive health as an approach, and reproductive health services. In fact, these distinctions were acknowledged at Cairo and in the Programme of Action, but they have become blurred since then.



Reproductive health is a human condition

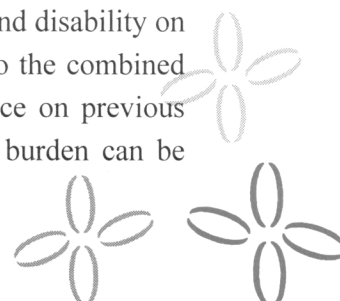
Reproductive health is not just the absence of disease or infirmity of the reproductive system, or of its processes. It refers to a spectrum of conditions, events and processes throughout life, ranging from healthy sexual development, comfort and closeness and the joys of childbearing, to abuse, disease and death. Perhaps more than with any other health conditions, the social, psychological and physiological factors are interrelated in reproductive health.

As a public health community, we are, in many ways, ill-equipped to deal with the complexity of reproductive health. We use “health” in common parlance to mean its opposite: “disease.” Reproductive health as a *spectrum* of conditions from the positive to the negative creates a daunting menu from which to select priorities. Understandably, those on the negative end are most compelling; the moral imperative is to intervene, especially when effective interventions are well-defined, problems can be prevented and suffering alleviated.

Yet the conversations that led up to Cairo, were held in Cairo, and have continued since Cairo, have demanded a broader focus. Considering that broader focus does not mean that we abandon efforts to prevent pressing problems and to alleviate suffering.

It does mean, however, that non-biomedical viewpoints on what needs to be addressed are considered as priorities are set. Women’s health advocates, for instance, have repeatedly argued for the need to consider the positive dimensions of sexual and reproductive health. At a recent meeting on NGO contributions to Sexual and Reproductive Health and Rights in Latin America²³, delegates recommended that programmes and policies on reproductive health incorporate positive dimensions of health and sexuality, including concepts of affection, tenderness, pleasure, self-determination, and equity in gender relations. In the spirit of Cairo, a dialogue between these groups, health providers, epidemiologists and biomedical scientists could identify some concrete steps to address these concerns. Similarly, a review of innovative NGO experiences in promoting sexual health could provide concrete examples of what is being done and what might be done on a larger scale.²⁴

Even when the focus is on reproductive health in the negative, that is, those conditions of psychological trauma, physical injury, acute illness, disability and death related to sexuality and reproduction, a large list emerges. Practically, then, how are we to put boundaries around this complex subject? As an example of how difficult it actually is, WHO recently convened an informal consultation on using the Disability Adjusted Life Year (DALY) to assess the global burden of disease due to the negative consequences on health of sex and reproduction.²⁵ The DALY is a measurement tool that attempts to quantify the burden of disease and disability on human populations, and is a composite measure of the overall burden due to the combined effects of premature death and non-fatal disability. It represents an advance on previous analyses that assessed the disease burden by mortality alone. Before the burden can be



measured, a precise working definition must be established. Even using fairly narrowly-defined biomedically-based ill-health conditions, the authors came up with *six* alternative definitions of reproductive health.²⁶ They did not advocate the adoption of any one.

Global Burden of Disease — six definitions of reproductive health

Option A: Consequences of sex in adults

Sexually transmitted diseases in the sexually active population, maternal causes, the fraction of adult cancers, HIV and hepatitis B that is sexually transmitted

Option B: Consequences of sex in children and adults

Add to everything in Option A: the burden of congenital anomalies and conditions arising in the perinatal period, the burden in age groups 0-4 and 5-14 from sexually transmitted diseases

Option C: Conditions of the reproductive organ system

All sexually transmitted diseases, maternal conditions, and the reproductive cancers

Option D: Conditions managed through reproductive health services

All causes of burden in children 0-4 years and maternal conditions

Option E: Burden of the reproductive age group (15-44 years)

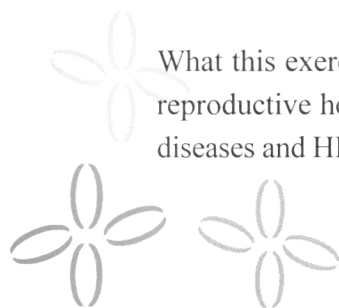
All causes of premature mortality and disability in both men and women

Option F: Health problems predominantly affecting the reproductive age group (15-44 years)

All causes of disease and injury for which the age-specific DALY rates are more than 1.5 times higher than the crude DALY rate for all age groups. These conditions include: sexually transmitted diseases, HIV, Chagas disease, unipolar major depression, bipolar affective disorder, schizophrenia, alcohol dependence, multiple sclerosis, drug dependence, obsessive-compulsive disorder, panic disorder, self-inflicted injuries, and violence. In women, the list is similar with the inclusion of maternal causes and the exclusion of violence

At the informal WHO consultation on DALYs and reproductive health, experts identified other conditions — not covered by any of these six options — that could conceivably be defined as reproductive health problems. That list includes stillbirths, the side-effects of contraception, violence related to sexuality and reproduction, morbidities attributed to HIV, gynaecological morbidities such as genital herpes, human papilloma virus (HPV) infection, bacterial vaginosis, and female genital mutilation, and complications in pregnancy from other diseases, such as malaria and hepatitis.

What this exercise shows is the diverse range of negative conditions that may be considered reproductive health problems. Among women aged 15-44 in developing countries, maternal diseases and HIV/AIDS/STIs represent 22 per cent of the total burden; among men of the same



age group HIV/AIDS/STIs represent 3 per cent of the burden of disease and disability (1998 data). Clearly, countries will need to consider existing epidemiological evidence and other information from clinical practice and consultation with community groups in deciding which conditions are most important in their setting. For example, a country with hepatitis B at epidemic levels may well need to consider complications of hepatitis arising during pregnancy as a reproductive health condition that needs to be addressed. In other places, it may not be an issue.

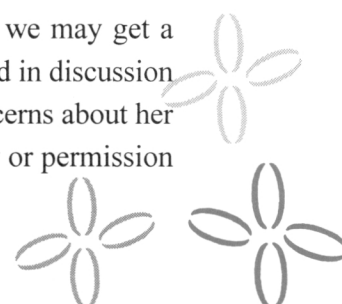
As countries move from conceptualization to action, they may wish to consider the following sequence of steps: (1) recognize the range of human conditions that comprise sexual and reproductive health; (2) review existing epidemiological literature to determine the local magnitude of negative conditions; (3) elicit different perspectives on what is important to promote and to prevent in sexual and reproductive health; (4) taking into full consideration the spirit and values put forward at the ICPD, create a locally meaningful definition of reproductive health; (5) building on the considerable international work on reproductive health indicators,²⁷ define locally useful indicators that capture the conditions comprising reproductive health.

Reproductive health is also an approach

Reproductive health is also an approach to analysing and then responding to the needs of women and men in their sexual relationships and reproduction. When we use the language of ICPD, we talk about health needs but we also talk about rights, equity, dignity, empowerment, self-determination and responsibility in relationships. So, reproductive health is also about transforming the status quo, away from the unfairnesses and indignities of the present, toward a situation that is more equitable, and with a higher quality of life for all.

To consider reproductive health as an approach, then, we must take a holistic view of women and men — in their societies, in their families, in their sexual relationships — and look at their lives and their needs comprehensively. This demands that we include but move beyond the biomedical model which tends to look at individuals out of context, and is insufficient in its analysis of the causes of ill-health.

If we look at old problems through the new reproductive health lens, more appropriate interventions may emerge. Take, for example, one commonly stated programme objective of addressing the unmet need for family planning. When a woman tells a survey interviewer that she wants no more children but is not using any form of contraception, we call this “unmet need.” If we consider fully her life, her family, and her sexual relationship, we may get a different and more profound understanding of her “needs” than is usually offered in discussion of unmet need. In fact, she may not be sexually active, but may have other concerns about her ageing body or reproductive system for example. She may need time or money or permission



to go to a clinic to seek care for herself. She may not have the power to convince a reluctant partner of her wish to use contraception, or she may not want to risk angering the man on whom she depends economically. By applying a reproductive health approach, by considering needs holistically, even the seemingly straightforward issue of unmet need looks different and suggests alternative interventions.

The question here is: If we want to sustain and to improve reproductive health, can we afford *not* to employ the reproductive health approach?²⁸

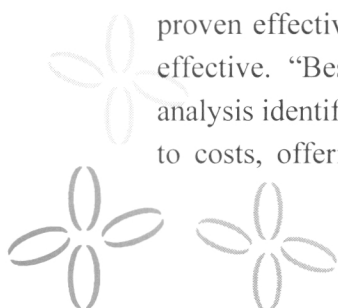
Reproductive health services

Reproductive health and *reproductive health services* are often equated. Our ultimate goal is to improve the sexual and reproductive health — that is, the human condition — of men and women everywhere. The *ultimate* goal is not to improve services; improved services are merely a means to the end of improved health. And health services by themselves are, in fact, only one of the means.

Without a doubt, better and more reproductive health services are needed. Effective health service interventions are already well-defined, and they include: family planning, safe abortion (within countries' legal systems), cervical cancer screening, delivery by trained and skilled birth attendants, emergency obstetric interventions, and STI counselling, prevention and treatment. The ICPD Programme of Action challenges us to ensure that such interventions are accessible to all people, including the most vulnerable, and that they are provided with a high quality of care.

In 1999 this is no small challenge given the economic reality of most countries.²⁹ For many people and many countries, the economic situation has deteriorated since Cairo. Welfare states, with publicly-financed national health systems, are being re-evaluated. The down-sizing of the public sector, due in many places to economic restructuring and/or severe economic crisis, is shredding the health and social safety net on which many of the most vulnerable people depend. The across-the-board encouragement of privatization of curative care means that some services, such as emergency obstetric care, are actually beyond the reach of many of those in life-threatening situations. Furthermore, the private sector rarely provides holistic care, but focuses on the treatment of symptoms.

Given this situation, we are now faced with the double challenge of defining interventions proven effective from a biomedical viewpoint and promoting ones that are rigorously cost-effective. “Best buys” and “essential packages” are now being discussed and defined.³⁰ One analysis identifies the following reproductive health services as having a high ratio of benefits to costs, offering substantial benefits external to the direct user (“public goods”) and of



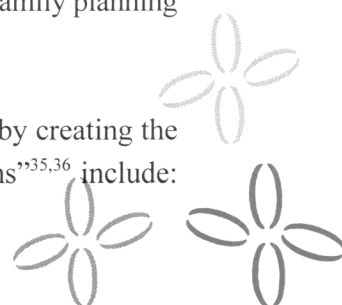
preferential benefit to the poor: family planning, personal hygiene and sanitation, STI treatment, community education about emergency obstetric care, use of condoms to prevent STIs, and STI treatment programmes for high-risk groups.³¹

What is missing from this analysis of cost-effectiveness, and what is critical to bear in mind post-Cairo, is essentially what is implied by the reproductive health *approach* applied to services. That approach stipulates that we address the needs of women and men in sexuality and reproduction *comprehensively*. Although STI treatment will cure the infection that is present and reduce the risk of acquiring HIV in the short term, STI treatment alone will have a sub-optimal cost-benefit ratio in the long term if the situations that put people at risk of STIs are not changed, risk behaviour is not questioned, responsibility to partners not raised, and a comprehensive approach in prevention and treatment not promoted.

The discussions about the integration of services, another of the ICPD challenges, will have to tackle what it means to be comprehensive in approach and cost-effective at the same time. There are questions about what integration means; is it the “supermarket” or “one-stop-shopping” approach where new services are added onto an existing set in one physical setting, or does it mean pragmatic and selective linkage and referral? Are front-line health workers expected to be competent at everything, from giving vaccinations to counselling on how best to prevent a sexually transmitted infection, or is some division of labour among specialized health workers envisaged? There is some evidence to suggest that the community-based “supermarket” may not be appropriate for certain groups, such as adolescents, who may prefer services outside the community, designed specifically for them, services that offer non-judgmental counsel and can guarantee privacy and confidentiality.³² There is other evidence that integration actually improves the quality of care. For example, the Western Hemisphere Regional Project on Integration of the International Planned Parenthood Federation (IPPF) found that integrating HIV/STI prevention into their family planning services did not dilute their provision of contraceptives but, on the contrary, enhanced the quality of the interaction between providers and clients and improved overall satisfaction.³³ In general, however, experience with integration of services is mixed and there is an urgent need for further research to determine under what conditions integration can work.

Returning to the point raised earlier in this section: to *equate* reproductive health or indeed to *reduce* reproductive health to health services, is to miss one of the most important challenges of Cairo. Other interventions that *directly* affect reproductive health include: laws³⁴ or policies that prohibit sexuality education for young people; laws that restrict free and informed choices of people related to sexual and reproductive health; laws on the legal age of sexual consent and marriage; and public financing decisions that affect the coverage and quality of family planning and maternity and perinatal care.

Still other interventions, in other sectors, *indirectly* affect reproductive health by creating the conditions for dignity and choices in daily life. These “enabling conditions”^{35,36} include:



political reform and greater democracy that encourage popular participation and stress public accountability; economic policies that minimize disparities between people and maximize basic security; policies that encourage girls to stay in school and women to assume leadership positions in public institutions; and social movements such as the “zero tolerance for violence” or others that push men and women to question their gender roles.

What then should the public health community do vis-à-vis the non-health service interventions to improve reproductive health? What role should it play in addressing the enabling conditions? Health professionals are, after all, trained to provide health services. Some answers may be gained from looking at what we have learned from Primary Health Care

Insights from Primary Health Care

At this juncture, five years after ICPD, the experience of a parallel, but earlier, development in health, namely Primary Health Care, offers some thought-provoking lessons in terms of both potential pitfalls and the possible role of the public health community in an agenda that has a large social justice component.

The Primary Health Care concept emerged in the 1960s and 1970s out of a dissatisfaction with existing approaches to health care, which were based on mass disease eradication campaigns and expensive curative medical care in urban settings. That dissatisfaction was crystallized at the International Conference on Primary Health Care, held in Alma Ata in 1978, which defined Primary Health Care as an *approach* or philosophy, and also a *level* of care.³⁷

As an approach, Primary Health Care (with its vision of Health for All) was a radical departure from the status quo. It offered a social analysis of health, explaining that the causes of poor health were not common diseases in themselves, but prevailing socio-economic conditions; political structures and philosophies; nutrition and the environment. Thus the links between health and development were underscored. The Alma Ata Conference put forward a vision for action based on five underlying principles: equitable distribution, community involvement, focus on prevention, appropriate technology, and a multisectoral approach. This vision called for a dramatic re-ordering of priorities, relevant to the entire health system, not just the first-level-of-contact.

In the years following the Alma Ata Conference considerable confusion existed about Primary Health Care. Was it an *approach*, or a *level* of care?

As an *approach or philosophy*, Primary Health Care used the language of social justice, urged transformation of systems to serve the neediest, challenged all actors to see health as a right,



argued that a proper analysis of the determinants of health be made, stressed the necessity of community involvement, and pushed for a science-based intersectoral response.

As a *level* of care, Primary Health Care was widely seen as only community-based, the first level of contact, only for poor people, a core set of services, “low-tech”, and cheap. Many of the debates about Primary Health Care unfortunately have centred on these issues, rather than on the more fundamental and more radical philosophical challenges of the Alma Ata conference. Thus, in reviewing the literature on Primary Health Care, we note the immediate reference to ‘selective primary health care’ — reducing primary health care to basic care, consisting of several cost-effective medical interventions.³⁸ In the eagerness to use selective cost-effective packages, the much harder part of the ‘Health for All’ agenda to do with rights and equity was sidelined. Medical care, again, became the way to improved health. However, WHO still advocates for comprehensive primary health care as the approach to increasing access to quality health care and improving health status.

Recently, on its 50th anniversary, WHO reinvigorated the call for ‘Health for All,’ and reasserted these values, which are equally relevant to reproductive health five years after the Cairo Conference:

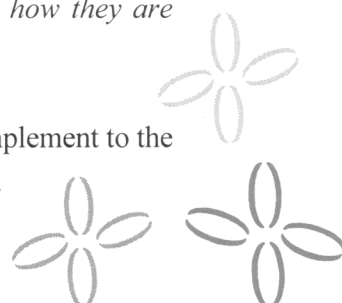
- providing the highest attainable standard of health as a fundamental right
- strengthening application of ethics to health policy, research, and service provision
- implementing equity-oriented policies and strategies that emphasize solidarity
- and incorporating a gender perspective into health policies and strategies.³⁹

Our challenge in reproductive health is, as we define cost-effective interventions and essential service packages, to not forget about reproductive health *as an approach* that requires us to address health in the context of lives and to address the basic causes of ill-health.

At a recent meeting in Mexico,⁴⁰ HERA, an international working group of 24 women from 19 countries who promote implementation of the ICPD agreements, issued a Call to Action that included this message:

“We understand Cairo to mean that the sexual and reproductive health of people is determined by the conditions in which they live; poverty or wealth and growing inequity; and their ability to exercise their basic human rights. We believe that the implementation of the Cairo Programme of Action is only possible with greater partnerships to overcome the constraints of inequity, inequality, injustice, and lack of accountability. The determination of what these concepts mean and how they are realized must include women’s diverse perspectives.”

In this sense, then, the Programme of Action adopted in Cairo is a powerful complement to the Alma Ata Declaration and the re-elaborated *Health for All in the 21st Century*.



THE CHALLENGES AHEAD

1 First, governments must commit themselves publicly and precisely to carrying out the recommendations agreed upon at Cairo. To translate words into action, the actual functioning of health systems must be faced directly. Health sector reform presents an opportunity to redirect services to meet more effectively the needs of people in sexuality and reproduction. On the other hand, the economic crisis affecting some countries and the economic restructuring affecting others place substantial constraints on the public sector whose mandate it is to ensure that everyone is adequately reached by reproductive health services. Women experiencing an obstetric emergency will always need a functioning health system, one that recognizes the gravity of their situation, and refers and then provides them with the appropriate care. We will not make motherhood safe until we invest in appropriate health care systems.

2 Second, health providers, policy-makers, and the public health community at large must hold discussions about their best respective roles in a social justice agenda. If we have learned anything from the experience of Primary Health Care it is that scientists and health providers do not often believe this is the best use of their training, and they are understandably uncertain about what is their best role, in advocating non-health interventions. At global and national levels, it may be a straightforward application of our moral authority and substantial power where financing decisions are made. We can and should say in public policy fora: “No woman should die of preventable causes in pregnancy — maternal health services must be adequately funded”. At the level of the individual provider, perhaps it is simply recognizing that a problem exists and knowing where to go for the right kind of help. Take the issue of violence related to sexuality and reproduction. Rather than ignoring the uncomfortable and resorting to inaction, a health provider might be encouraged to link the individual in need with other caregivers and non-medical systems of support. In any case, a concrete division of labour — deciding which sectors, institutions, professions, persons do what — needs to be worked out in an agenda based on rights, equity and dignity.

3 Third, more intellectual work is urgently needed to clarify the conceptual framework for reproductive health. One starting point could be the explicit recognition of the three dimensions of reproductive health: as a human condition, as an approach, and as services. As part of this intellectual work, we need to be clearer about what it means to define interventions *comprehensively* and to carry them out in an integrated manner. Cost-effectiveness is clearly a critical issue everywhere, but cost-effectiveness calculations should always be scrutinized. An important consideration in this context is not to focus on short-term gains at the expense of long-term benefits.



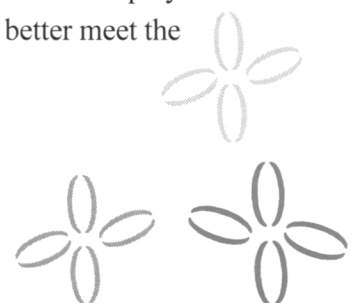
4 Fourth, while reproductive health *as an approach* is universally relevant, countries will have to define the programmatic response to reproductive health that is appropriate given the epidemiological, social, political and economic realities that they face. As a concrete step, country strategies for reproductive health might be defined through participatory priority-setting exercises. These exercises invite the participation of multiple stakeholders or constituencies, including the public health sector and other ministries such as justice, finance, economy, education; the health and other helping professions; private-sector health providers and institutions; women's and men's health advocates; and biomedical, public health and social scientists. Together, they are asked to analyse the reproductive health situation in the country and to make recommendations for action. The analysis would typically include a review of the epidemiological evidence, a 'situation analysis' of the health system itself, and some assessment of the priorities of different groups. Participatory priority-setting exercises provide a powerful opportunity for learning and for consensus-building.

5 Fifth, more attention needs to be paid to education and training. The curricula of academic institutions, such as medical, nursing, midwifery, and public health schools have not caught up with the concept of sexual and reproductive health, as a condition, as an approach, or in terms of comprehensive approaches to services. Our future experts and specialists are leaving their educational institutions with prestigious degrees ill-equipped to lead in the world changed by ICPD.

6 Sixth, more attention also needs to be paid to the task of translating rights in sexuality and reproduction into laws. Much more can be done to strengthen laws that directly affect reproductive health, and those that create an environment that enables reproductive health. A detailed report and guidance for the formulation of national reproductive health laws can be found in a discussion paper published recently by WHO.⁴¹

7 Seventh, country case studies conducted by many organizations as part of the ICPD+5 review suggest that donors and technical agencies do not coordinate their support for programming for reproductive health at the country level. Innovative approaches to planning and financing reproductive health in sectorwide approaches may hold some lessons. If progress is to be made, coordination is vital, and working together is the way forward.

8 Eighth, and finally, we the public health community must reaffirm the values that underlie reproductive health as agreed upon at ICPD, and that are the basis of Health for All. Equity and solidarity: together they provide the engine for transforming our systems to better meet the needs of all women and men in reproductive health.



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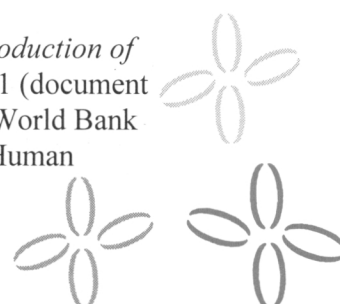


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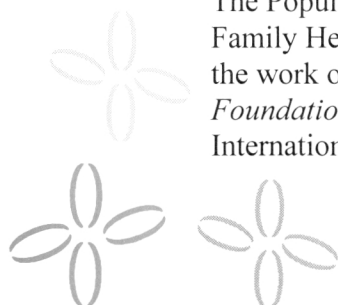
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25. *Report on the Informal Consultation on DALYs and Reproductive Health, Geneva 27-28 April 1998*. Geneva, World Health Organization (unpublished document of the Division of Reproductive Health Technical Support).
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- Selecting reproductive health indicators: a guide for district managers*. Geneva, World Health Organization, 1997 (document No. WHO/RHT/HRP/97.25).
28. This question is raised by the analysis in: Bangser M. *Stakeholder analysis of sexual and reproductive health in Uganda*, 1998 (unpublished report submitted to the WHO office, Kampala, Uganda).
29. Klugman B. *Implementing Cairo: the challenges for justice and equity in achieving sexual and reproductive rights and health*. Keynote address at the conference on Confounding the Critics: Cairo Five Years On, 15-18 November 1998, Cocoyoc, Mexico.
- Boonyoen D et al. *The impact of the crisis on population and reproductive health in Thailand*. (Unpublished paper presented a seminar on the effects of the financial and economic crisis on the attainment of the ICPD goals in the East and Southeast Asian Region, Bangkok, October 1998).
30. See, for example: World Bank. *World development report 1993; investing in health*. Oxford, Oxford University Press, 1993
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31. *Value for money in reproductive health*. Washington, DC, The POLICY Project, 1999 (forthcoming).
32. See note 17.
33. Integrating STD management into family planning services: what are the benefits? Draft report prepared by Heidelberg School of Tropical Medicine and London School of Tropical Medicine.
34. See, for example: Cook RJ and Dickens BM. *Considerations for formulating reproductive health laws: a discussion paper*. Geneva, World Health Organization, 1998 (Document No. WHO/FRH/WOM/98.1).



35. The following organizations have conducted in-depth country case studies to assess implementation of the Cairo Programme of Action:
- The Danish Family Planning Association*. See Jakobsen L and Rasmussen N, eds. *Women's voices - women's choices on reproductive health*. Copenhagen, The Danish Family Planning Association, 1998. Case studies in: Brazil, Burkina Faso, India, Indonesia, Nicaragua, Uganda, Viet Nam and Zimbabwe.
- Family Care International* (Jennifer Catino, Coordinator, Implementation of ICPD Commitments on Women's Reproductive and Sexual Health). Case studies in: Bangladesh, Burkina Faso, Cote d'Ivoire, Nepal, Pakistan, Sri Lanka, Uganda, and Zambia.
- Health Empowerment, Rights and Accountability (HERA)*. Case studies in: Brazil, Cambodia, Canada, Chile, Colombia, Dominica, Grenada and Carriacou, Guyana, India, Indonesia, Laos, Malaysia, Mexico, Namibia, Nicaragua, Peru, Philippines, Poland, South Africa, Swaziland, Trinidad and Tobago.
- New York University, Centre on International Cooperation* (Romita Ghosh, Coordinator, Health, Population and Development: Policies and Financing Post-Cairo). Case studies in: Bangladesh, Belgium, Egypt, France, Indonesia, Mexico, South Africa, Sweden, Switzerland, United Kingdom, United Republic of Tanzania, and the USA.
- Organisation for Economic Co-operation and Development (OECD)/DAC Expert Group on Women and Development* (Rounaq Jahan, Team Leader). Case studies in: Bangladesh.
- Population Reference Bureau* (Lori Ashford, Coordinator, Cairo in Action Project) Case studies in: Brazil, India, Morocco and Uganda.
36. Koivusalo M and Ollila E. *Making a healthy world: agencies, actors and policies in international health*. London, Zed Books, 1997.
37. Tarimo E and Webster E. *Primary health care concepts in a changing world: Alma Ata revisited*. Geneva, World Health Organization 1997 (document No WHO/ARA/CC/97.1)
38. Walsh J and Warren K. Selective primary health care: an interim strategy for disease control in developing countries. *New England journal of medicine*, 1979, **301**:967-974.
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41. See note 34.

